Minimizing Health Center Malpractice Risk

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Pertaining to malpractice risk for our Community Health Center operation, this presentation will hopefully provide you a basic understanding of the following issues:

1. Pertinent and general aspects of tort law;
2. The four elements of a tort lawsuit and how they apply in a medical malpractice case;
3. The essential components of a legally adequate informed consent to treatment;
4. Fundamentals of medically and legally adequate documentation of medical care;
5. General aspects on minimizing liability risk for FQHC and its licensed practitioners.

Table of Contents:

<table>
<thead>
<tr>
<th>Topics</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defining Tort Law</td>
<td>2-3</td>
</tr>
<tr>
<td>Breach of Contract</td>
<td>2</td>
</tr>
<tr>
<td>Negligent tort</td>
<td>2-3</td>
</tr>
<tr>
<td>Intentional tort</td>
<td>3</td>
</tr>
<tr>
<td>Basis for jury decisions</td>
<td>3</td>
</tr>
<tr>
<td>Four Principal Elements of Tort Law</td>
<td>4-9</td>
</tr>
<tr>
<td>Legal Duty</td>
<td>4-6</td>
</tr>
<tr>
<td>Breach of Legal Duty</td>
<td>7-8</td>
</tr>
<tr>
<td>Legal or Factual Causation</td>
<td>9</td>
</tr>
<tr>
<td>Damages</td>
<td>9</td>
</tr>
<tr>
<td>General Aspects on Minimizing Risks</td>
<td>10-16</td>
</tr>
<tr>
<td>Credentials of practitioners</td>
<td>10</td>
</tr>
<tr>
<td>Liability insurance</td>
<td>10</td>
</tr>
<tr>
<td>Written clinical protocols</td>
<td>10</td>
</tr>
<tr>
<td>Preventive health protocols</td>
<td>10</td>
</tr>
<tr>
<td>Patient encounter analysis</td>
<td>11</td>
</tr>
<tr>
<td>Details of patient appointments</td>
<td>11</td>
</tr>
<tr>
<td>Patient phone calls</td>
<td>11</td>
</tr>
<tr>
<td>Office diagnostics</td>
<td>11</td>
</tr>
<tr>
<td>Invasive office procedures</td>
<td>11-12</td>
</tr>
<tr>
<td>Medical emergencies</td>
<td>12</td>
</tr>
<tr>
<td>Patient education</td>
<td>12</td>
</tr>
<tr>
<td>Practice information</td>
<td>12</td>
</tr>
<tr>
<td>Patient tracking</td>
<td>13</td>
</tr>
<tr>
<td>Medical record documentation</td>
<td>13</td>
</tr>
<tr>
<td>Non-compliant patients</td>
<td>13-14</td>
</tr>
<tr>
<td>Patient termination</td>
<td>14</td>
</tr>
<tr>
<td>Specialty consultation &amp; hospitalizations</td>
<td>15</td>
</tr>
<tr>
<td>Billing issues</td>
<td>15</td>
</tr>
<tr>
<td>Third-party payer denial of services</td>
<td>15</td>
</tr>
<tr>
<td>Infection control</td>
<td>16</td>
</tr>
<tr>
<td>Facility issues</td>
<td>16</td>
</tr>
<tr>
<td>Decision Grid for Office Staff in Handling Patient Phone Calls</td>
<td>17</td>
</tr>
</tbody>
</table>
DEFINING TORT LAW

Tort Law

- A tort is a private or civil wrong or injury, other than breach of contract, for which the court provides a remedy in the form of an action for damages.
- Tort law serves as a regulation for relationships between individuals. The presumption is that people should act reasonably.
- For legal prosecution, the burden-of-proof for tort law differs from criminal law.
- The burden-of-proof for tort law only requires the prosecution to demonstrate a ‘preponderance of evidence’ (greater than 50%) that proves the applicability of the portrayed wrong or injury, in favor of the prosecution.
- Criminal law requires the prosecution to demonstrate evidence that proves beyond a shadow of doubt the applicability of the portrayed wrong or injury, in favor of the prosecution.
- Tort law is a law of compensation where a remedy must be specified to make the proposed ‘wrong’ right again; or an alternative remedy must be specified which is often monetary compensation.

Breach of Contract (Warranty of Work)

- If the surgeon informs a patient that the intended surgical procedure will alleviate the person’s medical or cosmetic problem, without fail, the physician has established a warranty of work.
- A warranty of work is an implied contract.
- Therefore, ‘contract’ issues can be a basis for a malpractice action (breach of contract).
- Tort lawsuits far exceed breach of contract lawsuits relative to malpractice action.

Negligent Tort

1. As part of Standard Jury Instruction, the judge instructs jurors as follows:
   - When I use the word negligence, I mean the failure to do something which a reasonably careful person would do, or the doing of something which a reasonably careful person would not do, under the circumstances which you find existed in this case. It is for you to decide what a reasonably careful person would do or not do under such circumstances.
2. To establish negligence, it must be determined what is in fact reasonable.
3. What is in fact reasonable varies from circumstance to circumstance.

Illustration:

EMS is first to arrive at a severe auto wreck scene. The car is partly consumed with flames. Gasoline is leaking. The driver lies unconscious in the front seat. Rather than first taking the time to stabilize the C-spine of the victim, EMS workers decided to pull the victim out of the burning and leaking car and get everyone to a safe
distance, before the car explodes. Even though EMS might have contributed to severe irreversible spinal injury, it was reasonable in this circumstance to act in the manner they did.

**Intentional Tort**

1. An intentional tort is a wrong perpetrated by one who intends to do that which the law has declared as wrong as contrasted with negligence in which the individual (tortfeasor) fails to execute that degree of care in doing that which is otherwise permissible.

2. An intentional tort in certain circumstances is tantamount to assault and battery.

**Illustration:**

During the course of labor, a woman (Gravida 6, Para 5, and 5 healthy children) sustained a uterine rupture. Intra-operatively, the uterus was noted to be massively torn in multiple areas. The infant survived the ordeal. The uterine repair took a team of doctors, including an urologist to repair a lacerated ureter. The obstetrician came to the conclusion that this woman would be risking her life if she were ever to get pregnant again. Therefore, he performed bilateral tubal ligation in order to ensure sterilization. No consent for the sterilization procedure was obtained from the patient, who was a Catholic. Because no consent was obtained for the non-emergency sterilization procedure, the physician performed an intentional tort. Even though the intended outcome of the sterilization procedure is likely to be beneficial to the patient, without consent, it is considered an intentional tort.

**Tort Law Basis for Jury Decisions on Malpractice Cases**

- What are the **facts** surrounding the case:
  1. **Medical** facts of the case are taken into consideration to support or defend the case.
  2. **Circumstantial** facts of the case are taken into consideration to support or defend the case.

- What is the **law** supporting the case:
  1. **Statutory Law** is taken into consideration to support or defend the case. Statutory law is established by state jurisdictions passed by state legislatures. Failure to follow a statute (i.e., failure to provide treatment to minors in certain allowable circumstances without parental consent) might lead to the ‘presumption of negligence’.
  2. **Common Law** is taken into consideration to support or defend the case. Previous court rulings and decisions establish common law in the USA; thereby, establishing precedents for the handling of various malpractice case scenarios. The ‘law of extensible agency’ allows for the application of common law to the case, unless there is a prevailing reason not to follow the established precedent.
FOUR PRINCIPAL ELEMENTS OF TORT LAW

The four principal elements of Tort Law are as follows:

1. Legal Duty
2. Breach of Legal duty
3. Legal or Factual Causation
4. Damages

Relevance of the Four Elements of Tort Law

♦ Legal defense must prevail against at least one of the elements to succeed in said defense.
♦ The burden-of-proof is on the plaintiff to demonstrate that the four elements exist and that, where applicable, the prerequisite 'preponderance of evidence’ was demonstrated.

ELEMENT 1: Legal Duty

In establishing whether a ‘legal duty’, three fundamental questions must be answered in the following order:

1. Did a practitioner-patient relationship exist?
2. If a practitioner-patient relationship existed, was the appropriate standard of care applied to the clinical situation?
3. Was there a role for Informed Consent in the clinical situation?

The basic types of practitioner-patient relationships are described below:

1. The “marriage” between a practitioner and a patient occurs when a patient registers at the health center. The practitioner initiates that care. The practitioner does not indicate to the patient, in a formal fashion, that the patient should seek care elsewhere
2. Detrimental reliance is a relationship that develops when the practitioner provides an individual curbside healthcare advice. In turn, the individual takes the advice to heart and perhaps to detriment of his/her health status. The advice turns out to be harmful advice.
   
   Illustration:
   
   An internist advises a 35 y/o female friend of the family that the chest pain she appears to be having is more than likely heartburn. She is reassured and happy with this advice. The next time she sees a doctor is 3 months later in a hospital ER. It turned out that she was probably experiencing angina all along. As a result delayed evaluation she subsequently sustained a significant myocardial infarction from single vessel disease (that might have been remedied by angioplasty.)
3. Operation of law forms a relationship between the practitioner and patient when a law or statute mandates that a practitioner take responsibility for the healthcare of an individual if he/she presents him/herself for care.
Illustration:

Federal COBRA law mandates that a typical hospital emergency department must perform a medical screening examination to rule-out a life-threatening medical condition or rule-out active labor in an expectant woman before considering whether the individual has the financial resources to receive treatment or referring his/her to another facility.

Standard of Care versus Standard of Practice as a component of the legal duty:

Once a practitioner-patient relationship is established, a legal duty exists whereby the practitioner must practice in accordance with the standard of care. If the practitioner does not practice in accordance with the standard of care, this is tantamount to negligence.

Standard Jury Instruction:

When I use the words professional negligence or malpractice with respect to the defendant’s conduct, I mean the failure to do something which a physician of ordinary learning, judgment, or skill in Family Medicine would do, or the doing of something which a physician of ordinary learning, judgment or skill would not do, under the same or similar circumstances you find to exist in this case.

The standard of care may differ from the standard of practice for a given practitioner.

Illustration:

A cardiovascular surgeon might advertise that his practice’s mortality rate is by far the lowest in the region. The surgeon relates this difference to care that exceeds the community’s standard of care. Having proclaimed this, this surgeon has now separated himself from the commoner’s standard of care and would have a difficult using the lower level of care as a component of his/her defense in a malpractice case. Additionally, the patient develops a set of elevated expectations relative to clinical outcomes. Such expectations lead to “disappointment” and increased risk for malpractice actions.

The role of Informed Consent as a component of the legal duty:

Beyond patient registration and the patient’s completion of a general consent to treat, certain procedures require specific Informed Consent (i.e., surgical procedures requiring the skill of a surgeon).

There are three basic building blocks of Informed Consent that must be recognized:

1. Establishing Competency;
2. Providing Information;
3. Executing Written Consent.

In establishing competency, barriers to effective informed consent should be considered, such as:

1. Mental status;
2. Age of patient (i.e., is this a minor);
3. Sedation (i.e., if sedated, it must be proven not to be affecting judgment);
4. Illiteracy.

In providing information relative to Informed Consent, the following 8 elements should be covered:

1. Explanation of patient’s condition should be provided in layman’s terms;
2. Proposed therapy (including rationale);
3. What to expect (i.e., results, pain?, etc) (reasonable expectations and NO GUARANTEES);
4. Significant risks;
5. Reasonable alternatives (and why these alternatives are not preferred);
6. Option of ‘no treatment’ should be explained including a description of the likely result of ‘no treatment’;
7. Offer the patient an opportunity to ask questions; then, answer all questions; and, offer an opportunity for a second opinion;
8. Emphasize that the consent can be retracted at any time, up until the actual start of the intended procedure.

The executed written consent, as part of the legal duty, should reflect the following aspects:

1. Consent should be written in plain English or the primary language of the patient;
2. Consent should incorporate, by reference, procedure specific forms utilized in the informed consent process (include specific reference to other presentations or visual aids that were utilized in the process;
3. The language should suggest the conditional nature of the consent (based on risk of harm) and based on urgency of the procedure and should allow for flexibility of the process.
4. Consent should not infer consent to negligence, by any stretch of the imagination.
5. The consent process and the execution of the consent are a non-delegable duty by the practitioner who intends to perform the procedure.
6. For legal effect, the consent should be written as if it is being written to a jury. Therefore, it should be written such that a jury consisting of laypersons can easily understand and appreciate the full and appropriate intent of the consent, upon its execution.
Four Principal Elements of Tort Law

1. Legal Duty
2. Breach of Legal Duty
3. Legal or Factual Causation
4. Damages

ELEMENT 2: Breach of Legal Duty

Once the plaintiff establishes that a legal duty existed, the plaintiff must now demonstrate with a preponderance of evidence (>50%) that the practitioner breached this duty.

The mainstay of a malpractice defense or prosecution is the evidence as presented in the medical record. The events surrounding malpractice cases occurred in the past (oftentimes, in the distant past). Few people can remember or recount the numerous details of any particular clinical case. Therefore, medical record documentation serves as the unswerving witness to the past events.

To explore the possibility of a breach of legal duty, the plaintiff’s legal team looks to the medical documentation. The following inquiry is performed, at a minimum:

1. Was there evidence in the medical documentation that the practitioner did not give this practitioner-patient relationship due diligence?
2. Was there evidence in the medical documentation that an established standard of care was not followed?
3. Relevant the procedures involved in the potential malpractice action, was there evidence in the medical documentation that proper Informed Consent was not provided by the involved practitioner?

The state of a health center’s medical records and corresponding system can make or break a defendant (our practitioner) in a malpractice case. The health center and its practitioners must promote and support a deliberate and consistent approach to medical records that assure legibility, completeness, organization, and security.

Medical Documentation Legibility:

1. The patient record must exhibit a legible permanent archive of the patient’s medical experience relevant to the interactions derived from the given practitioner-patient relationship.
2. The patient record should exhibit, when applicable, legible evidence of communication between providers involved in the care of the patient and relevant to the established practitioner-patient relationship.
3. The patient record must exhibit a legible legal defense tool for the practitioner, at all times.
Medical Documentation Completeness:

1. More is always better!

2. Progress notes should display “logic-driven medicine” as exhibited by using the S.O.A.P. format:
   - **Subjective:** Non-verifiable information related to patient complaints and current/historical patient issues.
   - **Objective:** Verifiable information related to the practitioner’s physical exam findings, clinical observations, clinical measurements, and consultative reports.
   - **Assessment:**
     a. A description of how the objective information squares with the subjective information;
     b. A differential listing of diagnoses that is consistent with the squaring of the subjective and the objective information.
   - **Plan:**
     a. Description of patient education;
     b. Description of patient counseling;
     c. Description of further diagnostic testing to narrow the differential of diagnoses;
     d. Description of the rationale and implementation of applicable therapeutic modalities; and
     e. Description of appropriate follow-up intervals.

3. Correction of errors in the medical record should consist of a line through the error with the practitioner’s initials along side the lined statement(s):
   a. Corrections in documentation must be limited to the date of entry.
   b. Corrections that are made after that point should be referenced in another progress note that makes specific reference to the error in a prior notation.
   c. If the error in entry impacts the patient’s ultimate assessment and plan, the patient should be contacted immediately to make the modifications.

Medical Documentation Organization:

1. The larger the chart, the more it needs to be organized;

2. The chart should be chronological;

3. The chart should have dividers that separate distinct sections in the chart;

4. The chart should exhibit horizontal and vertical consistency;

5. The chart must include **Medication** and **Problem** summary lists that are interactive.

Medical Documentation Security:

1. The charts should be protected from the elements.

2. Release of patient information should be in accordance with laws surrounding said release.
Four Principal Elements of Tort Law

1. Legal Duty
2. Breach of Legal Duty

3. Legal or Factual Causation

4. Damages

ELEMENT 3: Legal or Factual Causation

As part of standard jury instruction, when the words *proximate cause* are used, it is first meant that the negligent conduct must have been a cause of plaintiff’s injury, and second, that the plaintiff’s injury must have been a *natural and probable result* of the negligent conduct.

There are three defense strategies in confronting a malpractice action:

1. Demonstrate convincingly that there was no causation or association between the supposed negligent act and the wrong or injury proposed by the plaintiff;

2. Prove that there was a superseding clinical cause;

   **Illustration:**
   The family is sues the physician because mom had a stroke, claiming that the physician did not manage mom’s hypertension in a manner consistent with JNC VI recommendations. Mom also had chronic atrial fibrillation. Per medical record documentation, the family repeatedly refused to allow mom to be anticoagulated with warfarin. Expert witness testimony by a neurologist along with brain scans strongly suggested that the stroke was embolic in nature. And thus, the stroke was the *natural and probable result* of the consequences of unanticoagulated atrial fibrillation rather uncontrolled hypertension.

3. Prove that the negligent conduct had little if any impact or influence on the patient’s/plaintiff’s clinical outcome (no harm, no foul);

   **Illustration:**
   An ACLS certified physician failed to administer defibrillation joules in the standard manner when responding to a Code Blue. Autopsy findings indicated that the patient died of a massive pulmonary embolus. The physician’s negligence had no influence on the patient’s outcome.

ELEMENT 4: Damages

**Non-economic damages:**

1. Usually involves pain, suffering, or humiliation.
2. Must be approximated;
3. Very susceptible to “influence” and very subjective;
4. Is often “capped” in various statutory settings.

**Economic damages:**

1. Involves actual injury (physical or financial);
2. Different formulas are used to determine or calculate the economic value to cover expenses to make the plaintiff “whole” again.
3. These typically uncapped types of damages can lead to huge monetary awards.
GENERAL ASPECTS ON MINIMIZING PROFESSIONAL LIABILITY RISK

Community Health Centers can be sued for administrative negligence in regards to those standards that it espouse but do not reflect in its actual business dealings. Therefore, FQHC has to be vigilant in ensuring compliance and consistency in a number of areas (A through U) noted below.

A. Credentials of practitioners must be evaluated by:
   1. Verifying licensure/registration/certification;
   2. Verifying education/training;
   3. Researching claims history information;
   4. Proctoring and performing competency assessments;
   5. Maintaining information of statutory CME achieved by professional staff;
   6. Re-credentialing practitioners.

B. Liability insurance of FQHC professional staff:
   1. FQHC is covered by the Federal Claims and Torts Act (FTCA);
   2. FTCA coverage is limited to practitioners employed by FQHC, full and part-time;
   3. Relative to the acts and omissions of FQHC-employed practitioners, FTCA coverage is limited to patients registered to FQHC and treated likewise.

C. Implementation of written clinical protocols defining management of common health conditions:
   1. FQHC clinical staff establishes or revises written protocols on an annual basis to ensure broad consistency in the management of common health conditions that are frequented by our patients.
   2. FQHC espouses to generally accepted standards of care as practiced in Northeastern Ohio and supported by local institutions of learning.

D. Implementation of written protocols defining preventive health care:
   1. FQHC clinical staff establishes or revises written protocols on an annual basis to ensure broad consistency in the provision of preventive health care for patients of all ages.
   2. Adult preventive health guidelines are incorporated in specially designed flow charts that are prominently displayed in the medical record.
   3. Pediatric preventive health guidelines are incorporated in the specially-designed HealthChek forms that cover ages 0 through 20 years and are prominently displayed in the medical record.
   4. Failure to provide timely preventive health care that falls within the standard of care can be a basis for malpractice action if an individual suffers a medical consequence that could have been averted.
E. Information relating to practitioner-specific patient encounters:
   1. Patient volume of individual practitioners should be monitored to expose potential needs for increasing practitioner capacity.
   2. The number of patients (especially managed care patients) assigned to individual practitioners should be monitored to expose potential needs to limit further patient assignments.

F. Details on and analysis of patient appointments:
   1. Periodic determinations should be made as to how long it takes patients to schedule appointments.
   2. FQHC must accommodate “fit-in” or “walk-in” patients.
   3. Patient waiting times must be minimized. The rule is that patients should be advised of their wait status at no greater than 20-minute intervals.
   4. The volume and frequency of missed appointments should be assessed.

G. Handling and documentation of patient phone calls:
   1. Important communications with patients should be documented in the medical record.
   2. Written protocols in handling patient phone calls by non-medical staff should be followed in order to minimize inappropriate or untimely responses to patient symptoms.
   3. After-hours calls are forwarded to a service staffed by licensed nurses, who follow written protocols on how to advise patients.
   4. The after-hours nurse advice line also keeps abreast of staff coverage arrangements and coordinate communications between practitioners.
   5. When a patient calls the health center after-hours and is given a recorded selection of options, it is advisable that the first recorded advisement should instruct the patient to seek emergency care immediately, if an emergency condition has developed.

H. Preparation and handling of office diagnostics:
   1. FQHC must ensure that appropriately certified or qualified individuals administer and interpret various types of office diagnostics.
   2. Regarding radiology services, the health center should not routinely release the “original” films. However if required, the patient should be required to sign for the release of these films. The plaintiff’s lawyer in a malpractice often construes “Lost films” as “no films”.
   3. FQHC laboratory department should maintain CLIA rating (to moderately complex testing) and tracking systems.

I. Preparation and handling of invasive office procedures:
   1. FQHC must ensure that appropriately certified or qualified individuals administer invasive office procedures.
2. Informed consent should be obtained prior to performing invasive procedures (i.e., flexible sigmoidoscopy and oral surgery).

3. If sedation is used, FQHC must ensure that individuals are qualified to do so. Furthermore, intra-operative clinical monitoring protocols should be followed during the administration of the sedative medication, where applicable (i.e., IV conscious sedation in the setting of our oral surgery program).

J. Preparation and handling of medical emergencies:

1. It is not recommended that the practice maintain any medication (cardiac or otherwise, except for, possibly, Narcan), intubation equipment (tracheal or esophageal), ECG monitor/defibrillator, or other advance life support equipment unless practitioners are thoroughly familiar with their indications and use.

2. Emergency items should include the following:
   - Oxygen tank (allowing up to 15 liters/minute);
   - Suction equipment (including several catheters, some of which should be able to handle large particulate matter);
   - Ambubags (with appropriate face masks);
   - Several sizes of oral-pharyngeal airways;
   - Non-sterile gloves.

3. BCLS certification of medical staff is highly advisable.

4. A written emergency policy and procedure is established at each health center. In general, the office emergency procedure should be oriented toward protecting and stabilizing the patient until EMS can arrive.

5. If EMS is summoned to the health center, the procedure should also include designating a staff person to be responsible for flagging down and greeting the EMS crew in order to direct them to the stricken patient.

K. Patient education:

1. Topics of educational materials should be documented in the medical record.

2. All commercial educational material should be reviewed thoroughly before deciding on whether it is OK for patient consumption.

3. Earlier material that was dispensed to patients and documented in the medical record should be archived when they are retired from circulation. In so archiving, the practitioner should indicate the expiration date of the educational material.

L. Practice information:

1. Practice brochures should be available to patients that note the following, at a minimum:
   - Description of Health Center and office hours;
   - Practitioner information;
   - Telephone access procedures;
   - After-hours and emergency care provisions;
   - Billing procedures.
M. Patient tracking:
1. Missed appointments must be documented in the medical record.
2. Practitioners must be interactive with missed appointments by indicating in the medical record the degree of urgency, if any, of follow-up.
3. The importance of appointments for preventive health care should not be minimized. Therefore, practitioners should be interactive with these types of missed appointments as well.
4. Patients must be advised either in writing or by phone call (or both) to reschedule an appointment based upon the recommendations of the practitioner. These activities must be documented in the medical record.
5. Missed appointments and lack of action can make for a difficult defense to a malpractice case, if the missed appointment is associated with a delay in treatment or diagnostic follow-up. A delay that may have been associated with an adverse clinical outcome.
6. To minimize missed appointments, patients should be reminded of their appointments close to the appointed date.
7. Appointments should be made for all FQHC patients discharged from hospitals.

N. Medical record documentation issues:
1. Patient identification should be on each page in the medical record.
2. Allergy warning labels should be used.
3. Patient refusals of advised diagnostics and treatment modalities must be documented in the medical record. However, one refusal is not enough. Continuous efforts to persuade patients and subsequent refusals must be documented clearly in the medical record.
4. Patient refusals of preventive health care must be documented in the medical record. Again, one refusal is not enough. Continuous efforts should be documented.
5. All prescriptions, refills, and dispensed meds (i.e., samples) must be documented in the medical record.

O. Dealing with non-compliant patients:
1. One of the greatest professional liability exposures faced by practitioners is the non-compliant patient.
2. The practitioner should discern, as best as possible, the reason for the non-compliance. Some common reasons for non-compliance are the following:
   - **Cognitive limitations.** In this case, the patient, because of some cognitive impairment, either does not understand the practitioner’s instructions, or is unable to follow through on the instructions as given. (This is common with older people having trouble following medication regimens.)
   - **The Fear Factor.** Many patients fail to follow through on care, particularly some testing, because of fear of either pain or bad news.
   - **Economic Factors.** Some patients fail to follow the instructions because of the inability to pay for the needed care.
Intentional Non-Compliance. This group of patients does not fall into any of the categories noted above, however, for whatever reasons, they choose to ignore the practitioner’s recommendations. This group of non-compliant patients also tends to be very manipulative.

3. In each instance of non-compliance, the practitioner should endeavor to solve the non-compliance problems through any means at FQHC’s disposal or available in the community.

4. In the case of economic difficulties, all appropriate care should be recommended to the patient. However based upon the economic reality faced by the patient, the practitioner may be able to suggest to the patient that, while all of the care is needed, certain aspects of the care should take priority.

5. In the case of the intentionally non-compliant patient, a four-step approach is recommended: counsel, then cajole, then warn, then terminate. All termination recommendations should be referred to the Medical or Dental Director, where applicable.

6. By far the most important step that can be taken to minimize professional liability exposure flowing from non-compliant patients (other than good communication and relationships with the patient) is adequate documentation.

P. Patient termination from FQHC’s practice:

1. In certain unusual circumstances, patients may warrant termination from the FQHC practice. In rare instances when this became necessary in the past, staff abuse by patients was the general reason for the decision. Nonpayment of bills has not been a reason for patient termination. Medical noncompliance has not been a reason for patient termination.

2. The FQHC Senior Management (i.e., COO, Medical Director, or Dental Director) should handle the deliberation on and execution of patient termination process, to include the following steps, at a minimum:
   a. Sending a certified letter explaining the rationale for the termination;
   b. Enclose a ‘Release of Information’ form that can be signed by the terminated patient and offer to forward medical records to another provider designated by the individual.
   c. Establish in letter a firm date that the termination will become effective (e.g., 30 days hence);
   d. Establish in letter the scope of termination as including all the FQHC’s health centers and providers;
   e. Establish in letter that FQHC will provide urgent care until the effective date of the termination;
   f. Emphasize in letter that patient should continue to receive care from another provider;
   g. Provide in letter a listing of providers in the community that are available to serve the needs of the terminated patient.
   h. Inform all the FQHC’s health centers, in writing, of the action. Because of the rarity of patient termination, all receptionists, appointment clerks, and office managers should be made aware of the individual’s identity and effective termination date. If the patient is successful in securing care at another health center, the termination action is nullified and must be reinitiated.
Q. Specialty consultation and hospitalizations:
   1. When patients are referred for specialty consultations, return appointments should be scheduled to assure compliance. Furthermore, by scheduling return appointments, our appointment system will serve as a tickler file that assists us in the event of missed appointments.
   2. Consultative reports over the phone must be documented in the medical record.
   3. All written consultative reports must be acknowledged by the referring provider and signed (or initialed) before permanent filing in the medical record.
   4. The progress note should illustrate a summarizing statement, at a minimum, of the consultative report to demonstrate integration of the information with the practitioner’s rendering of the patient’s medical experience.
   5. New medical conditions and medications resulting from the specialty assistance or co-management should be listed in the Problem and Medication flow sheets.
   6. Details of communications from hospital-based physicians concerning hospitalized FQHC patients (and their subsequent discharges) should be documented, immediately, in the medical record.
   7. All written hospital discharge summary reports must be acknowledged by the principal FQHC provider and signed (or initialed) before permanent filing in the medical record.
   8. The progress note should illustrate a summarizing statement regarding the hospitalization to demonstrate integration with the practitioner’s rendering of the patient’s medical experience.
   9. New medical conditions and medications resulting from the hospitalization should be listed in the Problem and Medication flow sheets.

R. Billing issues:
   1. Patient billing procedures must be tolerant.
   2. Providers should be involved in decisions to turn patient bills over to collections. If for instance the patient has a condition that mandates continuous treatment, the patient should not be dissuaded from compliance due to payment problems.

S. Third-party payer denial of services:
   1. In the setting where a provider makes a referral or advises a certain procedure for a patient covered by a third-party payer, the provider is obligated to assist patients with the appeals process in appealing adverse decisions made by the third-party payer.
   2. If the provider feels strongly that a referral or procedure is indicated despite the HMO’s denial, the patient should be advised in no uncertain fashion. This advisement should be documented clearly in the medical record.
   3. Provider compliance with HMO denial decisions without protest is tantamount to concurrence with said decisions. Therefore, in the event that a malpractice action proposes that significant harm came to the patient resulting from the HMO denial decision, the concurring (non-protesting) FQHC provider could be implicated as well.
T. Infection control:

1. An Infection Control Manual should be made available to all affected staff. Use of gloves, hand washing, and disposal of “sharps” is described.
2. Position descriptions should describe applicable exposure categories.
3. Employees should be offered initial and annual OSHA training.
4. Employees should be offered Hepatitis B vaccination.
5. Where applicable, autoclave testing should be performed at appropriate intervals.

U. Facility issues:

1. Controlled substances must be securely stored;
2. Expiration dates must be checked on medications and samples;
3. Dispensing logs for sample medications must be maintained in case of drug recalls;
4. In dispensing sample medications, the physician must place the instructions on the container (box or bottle) housing the medication;
5. Prescription pads must be securely stored and patients should not have easy access to them;
6. Patients and non-medical staff should not have access to hypodermic needles;
7. Equipment maintenance logs should be kept up-to-date.
Malpractice claims often involve allegations that patient telephone requests or reported symptoms were responded to in an inappropriate and untimely manner. In handling telephone communications with patients and in deciding what information to relay to the medical staff, Office Staff (non-medical staff) should utilize the decision grid shown below.

<table>
<thead>
<tr>
<th>Telephone Conversation Situations</th>
<th>(1) Refer Patient to ER STAT!</th>
<th>(2) Refer to Medical Staff (doctor or nurse) STAT!</th>
<th>(3) Advise that Doctor will call ASAP</th>
<th>(4) Take Message; Leave with Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT CONDITIONS:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Chest Pains (severe)</td>
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<tr>
<td>Difficulty Breathing</td>
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<tr>
<td>Disoriented or Confused</td>
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<tr>
<td>Hysterical</td>
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<tr>
<td>Threatening Suicide</td>
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<tr>
<td>Bleeding Heavily</td>
<td>(1)</td>
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<tr>
<td>Severe Pain (sudden)</td>
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<tr>
<td>Severe Pain (chronic)</td>
<td></td>
<td>(3)</td>
<td></td>
<td>(4)</td>
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<tr>
<td>Reaction to Medication (mild to moderate)</td>
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<tr>
<td>Reaction to Medication (severe)</td>
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<tr>
<td>Poisoning/Overdose</td>
<td>(1)</td>
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<tr>
<td>Vomiting</td>
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<tr>
<td>Fever &gt; 102°F</td>
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<tr>
<td>Suspected Fracture</td>
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<tr>
<td>Pt. In Emergency Room</td>
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<tr>
<td>Pt. Admitted to Hospital</td>
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<tr>
<td>Hospital Needs Orders</td>
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<tr>
<td><strong>PATIENT REQUESTS:</strong></td>
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<tr>
<td>Medical Condition</td>
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<tr>
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<tr>
<td>Prescription Refills</td>
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<td>Copies of Records</td>
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<td>Records Clerk</td>
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<tr>
<td>Angry about Care</td>
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<tr>
<td>Angry about Bill</td>
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<td>Explanation of Bill</td>
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<td><strong>MISCELLANEOUS:</strong></td>
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<tr>
<td>Health/Life/Disability Ins.</td>
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<td>Records Clerk</td>
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<tr>
<td>Attorneys</td>
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<tr>
<td>Spouse or Children</td>
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