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DIPA Ambulatory

Describe. Interpret. Predict. Act.

Companion Framework

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DIPA Ambulatory

Describe. Interpret. Predict. Act.

Clinical reasoning documentation for office, outpatient, urgent care, and emergency department settings

Version 1.0 | September 2026 Companion to DIPA Framework v3.0

About this document

This is a companion to the DIPA framework, not a replacement. The four elements, the two levers of Predict, the paired-statement rule, the technology constraints, and the governing distinction between tracking a plan and detecting deterioration all carry over unchanged. Read the core framework first.

What changes in ambulatory care is the **failure mode**, and therefore the mechanism.

In the hospital, the patient is in front of you and the failure is deterioration without escalation, a documented risk that materialized while nobody was watching. The core framework addresses that with monitored escalation triggers.

In ambulatory care, the patient goes home. The failure is **the open loop**: a pending result nobody reviewed, an incidental finding nobody followed up, a referral never completed, a patient told to return who never did. Diagnostic error and failure to follow up on test results are among the largest categories of ambulatory malpractice claims, and they share one structure, the clinical reasoning was sound, the plan was correct, and the loop stayed open.

This document adapts DIPA to that failure.

1. Why ambulatory needs its own variant

Three differences drive everything else.

The patient leaves. There is no flowsheet, no continuous vital sign stream, no nurse at the bedside. Escalation criteria cannot be monitored by watching data; they have to be handed to the patient. That is what return precautions are, and most clinicians already write them without recognizing them as a Predict-and-Act pairing.

Uncertainty is the normal state. Inpatient documentation usually resolves toward a diagnosis. Ambulatory documentation frequently should not. A great deal of good outpatient medicine is watchful waiting with an explicit safety net, and the record rarely says so. "Likely viral, but if it is not, here is what will happen and here is what we will do" is high-quality reasoning that almost never gets written down.

The loop stays open across time. The consequential moment is often days or weeks after the encounter, when a result returns or a referral does or does not happen. Nothing in the note anticipates that moment, and nobody owns it.

2. The four elements in ambulatory form

Element	Clinician question	Ambulatory documentation output
Describe	What is happening now?	Presenting concern, duration and trajectory, relevant examination, results reviewed including outside records, change from the patient's own baseline, functional impact
Interpret	What does it mean, and why is it happening?	Working diagnosis, differential where genuine uncertainty exists, what is being ruled in and out, severity and chronicity, what remains unexplained
Predict	What is the expected course, and what would tell us this is something else?	Expected trajectory with the chosen management, findings that would change the diagnosis, deterioration signals the patient can recognize, what happens if the working diagnosis is wrong
Act	What are we doing, what are we waiting on, and when do we reassess?	Treatment, tests ordered and who reviews them, referrals and who owns them, return precautions , follow-up interval, and what would prompt earlier contact

The substance of Predict shifts. In the hospital it is deterioration the team will watch for. In the clinic it is **two things**: what should happen if the working diagnosis is right, and what would indicate it is wrong. The second is the one that prevents diagnostic error, and it is almost never documented.

3. Predict in ambulatory care

3.1 The two levers are unchanged

Clinical intuition governs. AI predictive support may surface trends, prior results, or candidate risks for the clinician to accept, modify, or reject, and never authors the prediction. See core framework §3.3. Nothing in this document relaxes that.

3.2 Predict has two halves

Expected course. What should happen if the working diagnosis is correct and the treatment works. "Fever should break within 48 to 72 hours; cough will persist two to three weeks."

Diagnostic safety net. What would indicate the working diagnosis is wrong or incomplete. "If the fever does not break, or dyspnea worsens, this is not simple bronchitis and needs reimaging."

The second half is the ambulatory equivalent of an escalation trigger. It is also the element that distinguishes documented clinical reasoning from a documented conclusion, and the element whose absence turns a reasonable diagnostic decision into an indefensible one when the diagnosis was wrong.

3.3 Return precautions are escalation triggers

The core framework requires escalation criteria written as observable conditions with thresholds. Ambulatory care already has this instrument. It is called return precautions, and it is usually written badly.

Weak	Strong
"Return if worse."	"Return or go to the ED for fever above 101 lasting more than 24 hours, shortness of breath at rest, chest pain, coughing blood, or confusion."
"Follow up as needed."	"Call for an appointment if not clearly improving by Thursday. Come in sooner for any of the above."
"ER precautions given."	Specific conditions, documented in the note and given to the patient in writing.

Return precautions written as observable conditions are better medicine, better handoff to the covering clinician, and better evidence that the clinician anticipated the risk. Written as "return if worse," they are none of those things.

3.4 The paired-statement rule, ambulatory form

A Predict statement without a corresponding Act statement is not DIPA-compliant documentation.

In ambulatory care, the Act half has three parts and all three must be present:

- 1. **What the patient does:** return precautions as observable conditions
- 2. **What the practice does:** who reviews the pending result, who owns the referral, what the follow-up interval is
- 3. **What happens if neither occurs:** the fallback when the patient does not return and the loop does not close

Part 3 is the one that gets omitted, and it is where ambulatory harm concentrates.

4. Closing the loop

The ambulatory analogue of monitored escalation triggers is **open-loop tracking**. The constraints from core framework §3.5 and §8.4 apply unchanged: the system tracks execution of a clinician-authored plan and never assesses the patient.

4.1 What can be tracked

Each of these is a commitment a clinician made, expressed in discrete data:

Loop	Opens when	Closes when	Escalates when
Pending result	Test ordered	Result reviewed and acknowledged by a named clinician	Result available and unacknowledged past the declared interval
Abnormal result	Result flagged abnormal or critical	Acknowledged and acted on, or documented as expected	Unacknowledged past a short interval
Incidental finding	Finding documented with a surveillance interval	Surveillance study completed or a decision not to pursue is documented	Interval elapsed with no study and no documented decision
Referral	Referral placed	Consultation completed and note received	Not scheduled or not completed past the declared interval
Follow-up interval	Clinician documents "return in X"	Visit completed, or patient contacted and interval revised	Interval elapsed with no visit and no contact
Diagnostic safety net	Predict statement includes a condition that should prompt re-evaluation	Re-evaluation occurs, or the expected course is confirmed	Condition is met in available data and nothing follows

4.2 Design constraints

Everything from the core framework holds, plus three that are specific to ambulatory:

- 1. Loops belong to the practice, not to an individual clinician.** Routing must account for coverage, vacation, part-time schedules, and clinician departure. An open loop that escalates to a clinician who left the practice is the exact failure the system exists to prevent.
- 2. A documented decision not to pursue closes the loop.** "Discussed surveillance imaging; patient declines, understands rationale and risk" is a legitimate close. If the system does not accept it, clinicians will order studies defensively to clear their queue, and you will have built an over-testing engine.
- 3. Patient non-adherence must be distinguishable from practice failure.** "We attempted contact three times" and "nobody noticed" are different facts with different remedies. The tracking must tell them apart, or the data will be used to blame the wrong party.

4.3 Burden is the binding constraint

Ambulatory clinicians already carry inbox volume that is a documented driver of burnout. Open-loop tracking that adds a second queue will be ignored regardless of its merit.

Three implications: start with the highest-severity loop only, abnormal and critical results, and expand only if burden measures hold. Route to the practice's existing inbox rather than a new interface. Declare a per-clinician notification ceiling before go-live and treat breaching it as a stop condition.

5. Worked example: office visit

Community-acquired pneumonia, managed as an outpatient

This is deliberately the same disease as the core framework's inpatient example. The reasoning structure is identical; the disposition and the mechanism differ.

Describe. Four days of productive cough, subjective fever, and fatigue in a 54-year-old with hypertension. T 38.2, HR 96, RR 18, BP 128/78, SpO₂ 96% on room air. Focal crackles at the right base. No confusion, no hypotension. Chest radiograph shows a small right lower lobe infiltrate. Ambulating without dyspnea in the office.

Interpret. Community-acquired pneumonia, right lower lobe. Low severity by clinical assessment, no hypoxemia, hemodynamic stability, no confusion, no significant comorbidity burden. Appropriate for outpatient management.

Predict. Expect fever to resolve within 48 to 72 hours on appropriate antibiotics, with cough persisting two to three weeks. If fever persists beyond 72 hours, or if dyspnea, hypoxemia, or hemodynamic changes develop, this represents either treatment failure or a more severe process than currently assessed, and would require reassessment and probable admission. Radiographic resolution lags clinical resolution; a persistent infiltrate at follow-up would raise concern for post-obstructive process or malignancy in this age group.

Act. - Amoxicillin-clavulanate and azithromycin, seven days - **Return precautions given verbally and in writing: shortness of breath at rest, chest pain, coughing blood, confusion, fever above 101 persisting past Thursday, or inability to keep fluids down, same-day evaluation or ED** - Telephone check at 48 hours by nursing - Office follow-up in one week - **Repeat chest radiograph in six weeks to confirm resolution, given age and smoking history, ordered today, surveillance loop opened**

Loops opened by this encounter:

Loop	Interval	Owner
48-hour nurse call	2 days	Practice
Office follow-up	7 days	Practice
Six-week resolution radiograph	45 days	Practice
Diagnostic safety net: fever past 72 hours	3 days	Patient-initiated

The six-week radiograph is the loop most likely to stay open, and the one with the most serious consequence if it does.

6. Worked example: incidental finding

Pulmonary nodule found on imaging ordered for another reason

Describe. CT abdomen and pelvis ordered for right lower quadrant pain. Appendix normal. Lung bases partially imaged; radiologist notes a 7 mm solid nodule in the right lower lobe, incidentally identified. Patient is 61, 20 pack-year history, quit eight years ago.

Interpret. Abdominal pain resolved, likely self-limited. Separately, an incidental solid pulmonary nodule in a patient with significant smoking history. Not attributable to the presenting complaint and not evaluable on this study.

Predict. Most nodules of this size in this population are benign, but the smoking history places this patient above low risk, and a nodule that grows on surveillance would change the assessment substantially. Without surveillance, an early and treatable malignancy would not be detected until it became symptomatic.

Act. - Presenting complaint: reassurance, return precautions for recurrent or worsening pain - **Incidental nodule discussed with patient; written summary provided** - **Surveillance CT chest ordered at six months per current guidance** - **Surveillance loop opened, owned by the practice, escalating at seven months if not completed** - Result and plan communicated to the primary care clinician

This encounter is the archetypal ambulatory open loop. The clinician did everything right. The nodule is documented, the plan is correct, the patient was told. And in the common failure, no one notices in fourteen months that the study was never done, because the visit was about abdominal pain and the abdominal pain resolved.

Nothing about the reasoning needs improvement here. Only the loop does.

7. Relationship to E/M medical decision making

This section describes a consequence of the framework. It is not a coding tool and must not be presented, implemented, or marketed as one.

7.1 The relationship

Medical decision making is scored on three elements, number and complexity of problems addressed, amount and complexity of data reviewed and analyzed, and risk of complications or morbidity of patient management, with two of three determining the level.

Complete DIPA documentation happens to make all three visible:

DIPA element	MDM element it makes visible
Describe	Data: what was reviewed, ordered, independently interpreted, compared to baseline, obtained from outside sources
Interpret	Problems addressed: number, complexity, acuity, chronicity, what is being ruled out
Predict	Risk: the consequences of the problems addressed when appropriately treated
Act	Risk (management chosen, including decisions to initiate or forego testing, treatment, or hospitalization) and Data (tests ordered)

The Predict-to-Risk relationship is the notable one. Risk for MDM purposes rests on the consequences of the problems addressed and on management decisions including the decision to forego testing, treatment, or hospitalization. That is anticipated clinical course, which is what Predict is.

7.2 Why this is a byproduct and not a feature

Risk is the MDM element clinicians document least well, for a structural reason: they record what they did, not what could have happened. The note says "amoxicillin-clavulanate, follow up in a week." It does not say what the patient was at risk for, why outpatient management rather than admission, or what would change that decision. The reasoning occurred. The record shows only the output.

DIPA asks for that reasoning because it is clinically useful, for the covering clinician, for the patient, and for the patient's safety. That it also renders the MDM elements visible is a consequence, not a purpose.

The distinction is not cosmetic. A framework adopted to raise E/M levels is an upcoding template, it will be recognized as one by clinicians and by auditors, and E/M level distribution is among the most scrutinized data in American healthcare. A framework adopted to make clinical reasoning explicit, which incidentally produces a record that reflects the work performed, is documentation integrity. The documents are different. The intent is different. The intent is discoverable.

7.3 Required constraints

- 1. Technology supporting DIPA must never surface an MDM level, a level-supporting suggestion, or any prompt of the form "documenting X would support moderate complexity."** This is a reimbursement-driven prompt and is prohibited under core framework §8.2 without exception.
- 2. E/M level distribution is a descriptive secondary measure only.** It is reported with the explicit statement that movement in either direction is informative and that the implementation is not designed to move it.
- 3. Under-coding is a documentation integrity finding, not a revenue finding,** and should be reported to clinical leadership rather than to finance.
- 4. No education material may present E/M levels as a reason to adopt DIPA.** If a clinician asks, the honest answer is that complete documentation tends to reflect the work performed in both directions.

8. Medico-legal considerations

The core framework's analysis applies, with a different emphasis.

8.1 The exposure is different in ambulatory care

Inpatient exposure is failure to rescue, documented risk that materialized with no response. Ambulatory exposure is **diagnostic error and failure to follow up**: the diagnosis was wrong or delayed, and the record does not show that the clinician considered the alternative or built a safety net.

8.2 Documented reasoning is protective here, more clearly than inpatient

A note recording that the clinician considered the serious alternative, explained why it was less likely, and gave the patient specific instructions for what would change that assessment is strong evidence of sound clinical reasoning, even when the diagnosis turned out to be wrong. Reasonable clinicians reach wrong conclusions from reasonable reasoning; that is defensible. A conclusion with no visible reasoning is not.

Documented, specific return precautions are among the most protective things in an ambulatory record.

8.3 The open-loop log carries the same problem as the inpatient trigger log

A record of loops that stayed open is, in the failure case, timestamped evidence that the practice knew a result was pending and nobody reviewed it. The two-layer architecture and patient safety work product structure in core framework §6.4 and §6.5 apply without modification and must be resolved before any tracking capability goes live.

8.4 Required before implementation

- Risk management and malpractice counsel review, with attention to diagnostic error and follow-up failure
- Written guidance on documenting diagnostic uncertainty, clinicians will fear that naming a differential creates liability for not pursuing it, and need explicit guidance that documented reasoning is protective
- Standard return-precaution language by condition, reviewed by clinical leadership
- Defined ownership for each loop type, including coverage and clinician departure
- Two-layer architecture and privilege structure resolved before tracking begins

9. Measurement

9.1 Primary: declare thresholds before baseline

#	Measure	Direction
1	Documentation time per encounter	No material increase (balancing)
2	Documentation completeness audit: presence of interpretation, expected course, safety net, and follow-up plan	Improvement vs. baseline
3	Return-precaution specificity: proportion written as observable conditions rather than "return if worse"	High and stable
4	Paired-statement rate	High and stable
5	Clinician-reported usefulness	Majority report clinical value
6	Inbox and notification volume per clinician per session	Within declared ceiling (balancing)

9.2 Loop-tracking measures

#	Measure
7	Loop close rate within declared interval, by loop type
8	Time to close, by loop type
9	Proportion of loops closed by documented decision not to pursue
10	Open loops at 30, 90, and 180 days
11	Escalation rate to practice-level follow-up

Measure 9 is a balancing measure in both directions. Too few suggests clinicians cannot close loops without ordering; too many, and in particular a sudden rise, may indicate dismissal rather than decision.

9.3 Descriptive only

Referral completion rate, time to follow-up visit, unplanned ED visits within 14 days of an index encounter, diagnostic revision rate, **E/M level distribution** (per §7.3).

10. Implementation sequence

Phase	Scope	Exit criterion
Baseline	30 days, measurement only	Return-precaution and documentation-completeness baselines established
A	DIPA documentation via template or smart phrase. One practice, one specialty	Completeness improves, return-precaution specificity improves, no material time increase
B	Single highest-severity loop only: abnormal and critical results	Close rate acceptable, notification volume within ceiling
C	Additional loop types, one at a time	Each holds burden measures before the next is added

Do not open all six loop types at once. Each adds inbox volume, and ambulatory clinicians will disengage from the whole system if the first week is overwhelming. The highest-severity loop alone justifies the implementation.

11. Closing

In the hospital, the risk is that the team stops watching. In the clinic, the risk is that nobody was assigned to watch in the first place.

A complete ambulatory note explains what is happening, what it probably means, what should happen next, what would mean the assessment was wrong, and who is responsible for finding out. DIPA asks for those five things. The loops keep the last one from being forgotten.

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