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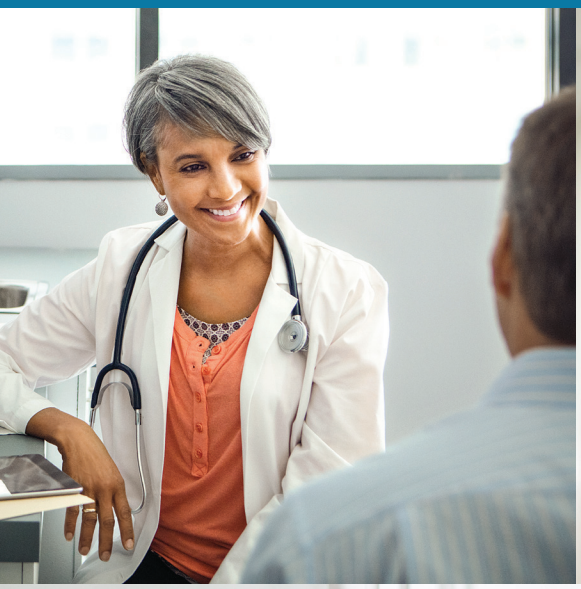
Proactive Risk Management Follow-Up Program X:
High Exposure Cases and Difficult Patient Presentations



MLMIC CME+ | **Course Workbook**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MEDICAL SOCIETY OF THE STATE OF NEW YORK
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NYSDA

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CME ACCREDITATION AND DESIGNATION STATEMENT

MLMIC is accredited by the Medical Society of the State of New York (MSSNY) to provide CME for physicians.

MLMIC designates this enduring material educational activity for a maximum of 6.5 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

NEW YORK STATE DENTAL ASSOCIATION

MLMIC is sanctioned by the New York State Dental Association (NYSDA) as an approved provider of dental education in New York State. The Company designates this educational activity for a maximum of 6.5 continuing education lecture credits. Dentists should only claim credit commensurate with the extent of their participation in the activity.

AMERICAN BOARD OF ANESTHESIOLOGY (ABA) MOC RECOGNITION STATEMENT

This activity contributes to the CME component of the American Board of Anesthesiology's redesigned Maintenance of Certification in Anesthesiology™ (MOCA®) program, known as MOCA 2.0®. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements.

AMERICAN BOARD OF INTERNAL MEDICINE (ABIM) MOC RECOGNITION STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 6.5 MOC points and patient safety MOC credit in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit.

AMERICAN BOARD OF OPHTHALMOLOGY (ABO) MOC RECOGNITION STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, earns credit toward the Lifelong Learning [,Self-Assessment and Patient Safety] requirement[s] for the American Board of Ophthalmology's Continuing Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting credit.

AMERICAN BOARD OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY (ABOHNS) CONTINUOUS CERTIFICATION RECOGNITION STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn their required annual part II self-assessment credit in the American Board of Otolaryngology – Head and Neck Surgery's Continuing Certification program (formerly known as MOC). It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of recognizing participation.

AMERICAN BOARD OF PEDIATRICS (ABP) MOC RECOGNITION STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn up to 6.5 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABP MOC credit.

AMERICAN BOARD OF SURGERY (ABS) CONTINUOUS CERTIFICATION RECOGNITION STATEMENT

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

TARGET AUDIENCE

This course is designed to provide continuing medical education (CME) for physicians participating in MLMIC's Proactive Risk Management Course Follow-Up X: High Exposure Cases and Difficult Patient Presentations. It contains subject matter that is of current interest to physicians in all medical specialties. The target audience for this program also includes dentists and other non-physician healthcare providers including advanced practice providers and medical office staff.

COURSE OVERVIEW AND DESCRIPTION

In the first module, a risk management consultant and an attorney specializing in healthcare law discuss disorderly patient behaviors and the factors contributing to their escalation in frequency and severity toward healthcare providers. This program addresses the impact that disruptive behavior can have on both patient care and staff wellness. It outlines risk management strategies that can assist physicians improve the patient experience, reduce the incidence of this behavior in their practices as well as decrease their potential liability exposure.

In the second module, a risk management consultant and an attorney specializing in healthcare law explore the mental health needs of patients in clinical areas outside of the behavioral health unit such as the emergency department, ambulatory care areas, and inpatient medical/surgical units. The associated liability risks will be reviewed, as well as strategies to mitigate these risks, which may be overlooked or difficult to address in these hectic environments. Additionally, an analysis of the factors that impact claims of malpractice will be discussed.

In the third module, a risk management consultant and an attorney specializing in healthcare law answer some of the most frequently asked questions from policyholders, addressing a wide range of legal and risk management topics.

In the fourth module, a risk management consultant and an attorney specializing in healthcare law review the findings of closed high exposure liability claims, over a recent five-year period, which resulted in payments of $1M or more. The leading causes of loss and the medical specialties at highest risk are addressed. Strategies for reducing the incidence of high exposure claims and the occurrence of patient injury are presented.

In modules five and six, a defense attorney and senior claims examiner discuss high exposure liability claims (those with indemnity payments exceeding $1M) associated with errors in diagnosis. Key factors that contribute to communication and diagnostic errors are reviewed. Legal issues are addressed including the concept of causation. The program also explores the importance of medical record documentation in building the defense of a case involving diagnostic error.

EDUCATIONAL OBJECTIVES

After completing these modules, participants should be able to:

Module 1 – Addressing the Disruptive Patient: Strategies for a Changing Dynamic

- Identify the factors that contribute to disruptive behavior.
- Discuss the impact that disruptive behavior has on the well-being of healthcare workers.
- List recommendations to safely address disruptive behavior should it occur in your practice setting.
- Outline strategies to reduce the incidence of disruptive behavior in your practice setting.

Module 2 – Managing Mental Health: Beyond the Behavioral Health Unit

- Recognize factors that lead to allegations of malpractice in behavioral health claims.
- Assess professional liability risks in clinical areas outside of behavioral health units.
- Evaluate the effect of crisis on patients and healthcare professionals.
- Create risk management strategies to promote patient and staff safety.

Module 3 – Frequently Asked Questions (FAQs)

- Identify appropriate indications to provide access to medical records and patient information.
- Describe current recommendations for documentation in the open notes environment through the 21st Century Cures Act.
- Describe the need for a provider to obtain the patient's informed consent for the use of telehealth.
- Evaluate the scope of practice for office staff and identify the types of services an unlicensed assistant can perform.

Module 4 – High Exposure Liability: Million Dollar Claims - What we know What you can do

- Recognize the drivers of large loss claims, including but not limited to, allegations, contributing factors, and the claimant profile.
- Discuss the impact implicit bias may have on diagnostic outcomes.
- Evaluate the role process plays in diagnostic decision making.
- Identify the principal elements included in patient selection in relation to location for surgical procedures.
- Incorporate the RM Trifecta strategies presented into operations to mitigate future claims and suits.

EDUCATIONAL OBJECTIVES (CONT.)

After completing these modules, participants should be able to:

Module 5 – High Exposure Liability: Case Study Analyses – Part 1

- Describe ways to effectively communicate the results of diagnostic imaging studies.
- Formulate strategies to ensure adequate tracking and follow-up of diagnostic tests that are ordered.
- Identify potential cognitive biases when establishing provisional diagnoses for patients.
- Discuss the negative impact of finger pointing between defendants in a malpractice case.

Module 6 – High Exposure Liability: Case Study Analyses – Part 2

- Explain the importance of addressing and documenting new, significant patient complaints.
- Recognize and address the negative effects of gender bias in clinical decision making and healthcare.
- Discuss the concept of "causation" and its significance in claims related to diagnostic error.
- Describe vicarious liability for attending physicians that are supervising advanced practice providers.

FACULTY AND DISCLOSURES

Module 1 – Addressing the Disruptive Patient: Strategies for a Changing Dynamic

- **Mirsade Markovic, Esq.**
  Mercado May-Skinner
  Ms. Markovic has no relevant financial relationship(s) with ineligible companies to disclose.
  The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.
- **Shelly Kriete, BS, CPCU**
  Risk Management Consultant
  MLMIC Insurance Company
  Ms. Kriete has no relevant financial relationship(s) with ineligible companies to disclose.

Module 2 – Managing Mental Health: Beyond the Behavioral Health Unit

- **Donnaline Richman, MN, BSN, Esq.**
  Mercado May-Skinner
  Ms. Richman has no relevant financial relationship(s) with ineligible companies to disclose.
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- **Mark Ambrose, DNP, MBA, RN**
  Risk Management Consultant
  MLMIC Insurance Company
  Mr. Ambrose has no relevant financial relationship(s) with ineligible companies to disclose.

Module 3 – Frequently Asked Questions (FAQs)

- **Al Anthony Mercado, Esq.**
  Mercado May-Skinner
  Mr. Mercado has no relevant financial relationship(s) with ineligible companies to disclose.
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- **Deanna Mirro-Altmann, RNC**
  Risk Management Consultant
  MLMIC Insurance Company
  Ms. Mirro-Altmann has no relevant financial relationship(s) with ineligible companies to disclose.

Module 4 – High Exposure Liability: Million Dollar Claims – What We Know What You Can Do

- **Brenna Gubala, Esq.**
  Mercado May-Skinner
  Ms. Gubala has no relevant financial relationships with ineligible companies to disclose.
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- **Joyce McCormack, BS, RN**
  Risk Management Consultant
  MLMIC Insurance Company
  Ms. McCormack has no relevant financial relationship(s) with ineligible companies to disclose.

FACULTY AND DISCLOSURES (CONT.)

Module 5 – High Exposure Liability: Case Study Analyses – Part I

- **William P. Hassett, Esq.**
  Mercado May-Skinner
  Mr. Hassett has no relevant financial relationship(s) with ineligible companies to disclose.
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- **Linda Padilla-Diaz**
  Vice President, Claims
  MLMIC Insurance Company
  Ms. Padilla-Diaz has no relevant financial relationship(s) with ineligible companies to disclose.

Module 6 – High Exposure Liability: Case Study Analyses – Part 2

- **William P. Hassett, Esq.**
  Mercado May-Skinner
  Mr. Hassett has no relevant financial relationship(s) with ineligible companies to disclose.
  The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.
- **Linda Padilla-Diaz**
  Vice President, Claims
  MLMIC Insurance Company
  Ms. Padilla-Diaz has no relevant financial relationship(s) with ineligible companies to disclose.

- **MLMIC Insurance Company CME Planning Committee**
  John Lombardo, MD, Chief Medical Officer; Tim Krieg, Esq., Chief Operating Officer; Tom Gray, Esq., Sr. VP, Risk Management; Matt Lamb, Esq., AVP, Risk Management; Carol Gladis, AVP, Risk Management; Brian Felton, Esq.
  None of the planners for this educational activity have relevant financial relationship(s) with ineligible companies to disclose.

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Mercado May-Skinner
ATTORNEYS & COUNSELORS-AT-LAW

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Module 1

Addressing the Disruptive Patient: Strategies for a Changing Dynamic

Mirsade Markovic, Esq.
Mercado May-Skinner
Shelly Kriete, BS, CPHQ
MLMIC Insurance Company

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The Difficult Patient

Objectives

- **Upon completion of this presentation, participants should be able to:**
  - Identify the factors that contribute to disruptive behavior.
  - Discuss the impact that disruptive behavior has on the well-being of healthcare workers.
  - List recommendations to safely address disruptive behavior should it occur in your practice setting.
  - Outline strategies to reduce the incidence of disruptive behavior in your organization.

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Why Are We Talking About This?

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Why Are We Talking About This?

It Can Become an Emergency

- **Healthcare providers and staff (including practices) need to be able to respond to a variety of emergency situations:**
  - Medical
  - Environmental
  - Violence-related
- **Anticipation, recognition, and preparation can help the healthcare team protect patients, families, visitors, and themselves during emergencies**
- **Traditional disgruntled behaviors are unpredictable and can escalate to violence rapidly**

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Why Are We Talking About This?

It's a Global Issue

- **Disruptive patient behavior is common: According to the AHA, healthcare workers are 4Xs more likely to be involved in serious workplace violence**
- **"Dealing With Violence and Challenging Patients" in a recent MDU Journal addressed "the sad reality of healthcare workers facing violence in the course of their job…"**
- **The World Health Organization - Health workers are at high risk of violence: Healthcare workers hesitate to report violence episodes; employees report only 50% of cases of verbal abuse and less than 40% of cases of physical assault**

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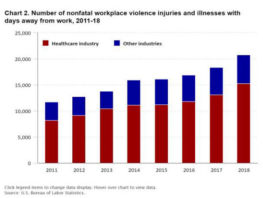
Why Are We Talking About This?

It's a Global Issue

Healthcare and social service workers experience the highest rates of injuries caused by workplace violence and are five times as likely to be injured because of workplace violence than workers overall
(Oct 11, 2021)



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Why Are We Talking About This?

In the News: Oneida Health November 10, 2021

Unruly Behavior Disrupts – Community Letter from Oneida Health President and CEO

- **"The airlines today are often in the media for unruly passengers and how it impacts the safety of the flight… What's not talked about as often, or even at all, is the current situation in healthcare with unruly patients, family members and visitors."**
- **"So please, control your emotions, communicate with staff and listen to what is being explained. If you don't agree or have further questions, you have a right to receive additional information. The word thank you goes a long way…our appreciation to the healthcare worker who ensures that Oneida Health is there for you 24/7/365…"**

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Why Are We Talking About This?

In the News: Becker's Hospital Review - November 11, 2021

Did the pandemic stamp out nurse bullying?
Not quite…

- **"…an uptick in inappropriate behaviors such as bullying and name-calling by patients, visitors and family members across all units during COVID-19 surges."**
- **"Overall, 72 percent of Geisinger nurses reported experiencing unprofessional behavior from a provider in the last year":**
  - 25 percent said they tolerated the behavior
  - 40 percent said they requested the behavior to stop
  - 35 percent went to their supervisor

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Why Are We Talking About This?

In the News: Charlotte Observer - January 27, 2022

- **NC doctor: Address rising violence in the ER before someone is killed**
  - A patient was escorted by law enforcement to the ER. Before a decision was made about his release, he violently assaulted a staff member and officer guarding him. With the officer's weapon, he threatens everyone around him. Hospital police use deadly force to subdue the once patient, now assailant, as staff and patients flee.
  - A Duke Emergency Medicine resident said, after witnessing the events of that recent Friday night: "I never thought I was entering a profession where I could be killed!"
  - For medical professionals, being assaulted must no longer be tolerated as "part of the job." The frequency of violent attacks on nurses, physicians and patients in our nation's emergency departments is unconscionable and unacceptable.

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Why Are We Talking About This?

It's a Threat to Patient Safety

- **According to a study of >4,500 physicians and nurses:**
  - 71% saw a link between disruptive behavior and medical errors
  - *"we falter when we witness rudeness and other bad behavior"*
  - *"interferes with our working memory and decreases our performance"*
- **A trial of 24 NICU Teams (published in 2018) indicated, "Exposure to rudeness … negatively impacts medical teams' diagnosis and procedural performance."**
  - Overall scores in both areas decreased when comparing the control group to the group exposed to rudeness
    - ***Procedural Variables 3.26 to 2.77***
    - ***Diagnostic Variables 3.18 to 2.65***

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Why the Escalation?

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Contributing Factors

Pandemics, widespread social insecurity, etc.

- **The psychological impact of such widespread events have a profound negative effect on the mental health of the nation, and is conducive to increased aggression:**
  - Distrust
  - Fears of the unknown (vaccines, finances, employment)
  - Social activity restrictions; isolation
  - Communication
  - Opposing views on recommended treatment plans/protocol
  - Changes in our familiar routines
  - Overcrowding – long wait times
- **Impact on human resources and supply chains**

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Contributing Factors

Culture Shifts and Patient Expectations

- **Patients have greater or unrealistic expectations:**
  - Advances in technology
  - Publicly reported data for comparison
  - Entitlement
- **Financial concerns:**
  - Higher co-pays and deductibles
  - Total loss of healthcare coverage
- **Social media influence - What's fact? What's fiction?**
  - Algorithms and the resultant impact on society
- **Polarization of opinions**

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Difficult Situations
Office Practice Setting

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Office Practice Setting

Left Before Being Seen

- **A mother and her boyfriend bring their infant in for a 15-month well-visit & vaccinations**
- **Due to Covid-19 protocol, only one person was allowed to accompany the baby during the visit**
- **The boyfriend became angry, contesting the requirements, and became verbally aggressive and threatening to the staff**
- **The couple stormed out to wait in their car together**
- **When the staff went out to bring mom and baby into the exam room, they had left**

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Office Practice Setting

Left Before Being Seen - How Best to Manage this Situation?

- **The provider should call the mother to determine if she plans to reschedule the visit; stressing the importance of well-check visits and keeping the immunization schedule**
- **Given the aggressive behavior exhibited by the boyfriend, the provider could ask the mother screening questions (if appropriate to do so) related to her safety and the safety of the baby:**
  - If the mother reschedules; further screening could be complete in the privacy of the exam room
- **If the mother indicates she will not be returning to the practice, send a letter confirming she has dismissed the practice from the care of her child**

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Office Practice Setting

When Do I Call Child Protective Services?

- **Unusual or unanticipated injuries or bruises etc.**
- **Child (old enough) indicates s/he has been harmed**
- **Document findings in detail including "explanations" given**
- **Contact CPS; document details of that call - CPS may request records; authorization is not required**
- **Good faith standard for reporting suspected abuse/neglect**
- **Do I reveal to the parent/guardian a report will/has been made? There is no formal obligation, but…**

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Office Practice Setting

Threats by Parent of a Minor

- **A minor is being treated for a non-life threatening, chronic condition**
- **The father, known to the staff to have a history of violence, calls and asks for copies of his son's records**
- **Staff explains it will take several days to prepare them**
- **A few hours later the father calls and yells, "if I don't get my kid's records today, there will be hell to pay!"**
- **The staff member says "OK," then calls the police**
- **The police contact the father threatening to arrest him if he goes to the clinic**
- **The records are forwarded to the son's new physician**

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Office Practice Setting

Threat by Parent of a Minor - How Best to Manage this Situation?

- **Father's threat was not violent – merely angry**
- **Responses should be based upon the type of threat:**
  - Definitive threat of specific criminal act
  - General intimidation, office disruption or harassment
  - Serious acts of crime
- **Send written confirmation the parent has dismissed the practice from the care of the child**

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Office Practice Setting

- **When can I call the police?**
  - Criminal conduct on premises, against a person or property:
    - Trespassing – asked to leave and they refuse
    - Physical "assaults" or actions (breaking things) or serious fear of harm
- **Can I press charges?**
  - Yes, based on criminal conduct as noted above
- **Should I get a restraining order?**
  - There are occasions when patient violence prompts requests for an order of protection - Staff cannot be denied their right

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Can I Discharge a Patient From The Practice?

- **Despite a physician's best efforts, sometimes a patient's problems with the practice cannot be resolved and the physician needs to terminate the professional relationship with the patient**
- **A Patient May Be Discharged If:**
  - There is no urgent or emergent condition; where dismissal would impact their ongoing care
  - A pregnant woman is less than 6 months pregnant, and the pregnancy is uncomplicated
  - Continuous treatment without gap is not required for his/her current medical condition
- **Sometimes, the patient discharges the physician:**
  - Send a letter to confirm the discharge. There is no requirement to offer the patient care and treatment for 30 days for emergencies in this scenario
- **Every case is different, seek legal counsel**

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Can I Discharge a Patient From The Practice?

Additional considerations

- **Use discretion with multiple family members:**
  - Consider discharge of the entire family, rather than just one patient
  - Send individual discharge letters
  - Never discuss one family member with another family member
- **Discharge the patient from the entire group**
- **Once a patient is discharged from the practice, they should not be permitted to rejoin the practice:**
  - Communicate to the providers and office staff of patient discharges

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Can I Discharge a Patient From The Practice?

Additional considerations

- **Do not refuse to provide copies of medical records for subsequent providers**
- **If the patient is a member of a managed care organization, verify their requirements for termination of care**
- **30-Day Emergency Period:**
  - If the physician determines a true emergency exists
  - Patient must be seen if within the 30-day period.
  - If appropriate, the patient may be referred to the ED
- **If on call for the Emergency Department and asked to come in for a discharged patient, you must do so (EMTALA)**

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Difficult Situations
Hospital Setting

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Hospital Setting - ED

EMTALA - Patients Cannot be "Discharged" from the ED Like the Office Setting

- **EMTALA and 10 N.Y.C.R.R. §405.9 (f)**
  - Patients can not be discharged or transferred to another facility based upon source of payment. 405.9(f)(7)
  - Discharge/transfer must be in the patient's best interest, benefits must outweigh risks
  - Nearly impossible to restrict someone from the emergency room as the hospital has responsibility to provide a Medical Screening Exam to all seeking care:
    - Extreme caution should be exercised in restricting access
    - A person could be restricted from the place of employment which could include a hospital - in a situation calling for a restraining order: this would need to be addressed at the initial arraignment

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Hospital Setting - ED

"Frequent Flier".....

- **A chronically ill patient frequents the ED; it is the closest to his home; irritates staff with inappropriate behavior and verbal assaults:**
  - ED manager senses the staff is reticent in their treatment of the patient:
    - Kept longer than necessary in the waiting area
    - Staff seems to ignore or gloss over his complaints
- **In addition to potential EMTALA issues, the staff is professionally obligated to assess and treat the patient:**
  - May incite escalation of the behavior
  - Failure to do so can result in medical malpractice issues and jeopardize the practitioners' licenses

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Hospital Setting – ED

Known Violent Behaviors

- **A patient's violent behavior during a previous visit resulted in the issuance of a restraining order (staff or facility):**
  - At a later date, the patient returns to the ED and requires admission
- **How do you protect staff that has a protective order?**
  - Although rare, accommodations may need to be made on a case-by-case basis
  - Hospital security/local law enforcement may need to be present for any and all interactions
  - Reassigning staff to another area may be difficult/impossible

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Hospital Setting- Inpatient

Non-Compliance

- **A man is brought to the ED by the police then admitted for pneumonia:**
  - There is a warrant for his arrest; the police want to be notified of his discharge
- **The patient eloped and was found drinking at the local VFW hall:**
  - The police were called and returned the patient to the hospital
- **Later that evening he was swearing and screaming:**
  - He was advised of the rules of conduct in the hospital, and he said he understood them but 15 minutes later, his behavior resumed:
    - A staff member asked if he wanted to sign himself out AMA, and he did
- **Recommending that the patient leave AMA can be dangerous and creates risk of professional misconduct**
- **The police were advised of his discharge; this is legally problematic**

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Hospital Setting

When Do I Call The Police?

- **Only after internal options have been exhausted:**
  - Security
  - De-escalation team response
- **Emergent safety threat or criminal conduct on premises:**
  - Trespassing – asked to leave and they refuse
  - Physical "assaults" or actions (breaking things)
  - Anything less than a crime or safety issues, contact your Risk Manager or Security
- **Calling the police to return patient to hospital may violate patient's rights:**
  - Consider patient age, mental capacity and danger to self or others

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Hospital Setting

Can the police be asked to remain on-site?

- **If the patient is not under arrest/in custody, there is not an obligation for them to stay:**
  - If the patient appears to be a threat to staff, they can give consideration to staying
- **It is important for hospitals to have relationships with key law enforcement officials**
- **Policies and procedures should be in place to address calling the police**

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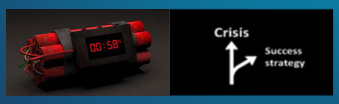
How Do We Navigate Disruptive/Violent Behaviors? How Do We Thrive?



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Management

Plan Ahead – Prioritize Workplace Safety

- **Develop a structure for violence reduction and response:**
  - Identify responsibility for safety/security initiatives
  - Personalize for your organization
  - Establish a multidisciplinary group for violence prevention
  - Clearly define unacceptable behavior
  - Train staff on de-escalation techniques
  - Maintain transparent communication
  - Develop expertise in safety management
  - Monitor external requirements/recommendations

- **Coordinate and plan with appropriate emergency and law enforcement agencies**

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Management

Plan Ahead – Prevention, Intervention and Response – Anticipate Emergencies

- **What is the likelihood of aggression/violence in your area?**
  - Population served
  - Location
- **Assess measures and resources we have in place now:**
  - Security staff
  - "Panic buttons"
  - Concerns from employees/culture of safety surveys
  - Physical space assessment and awareness
- **Who will be our spokesperson for phone calls/media?**

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Management

Plan Ahead – Prevention, Intervention and Response – Anticipate Emergencies

- **Pre-employment background checks:**
  - Staff histories related to violence
- **Code of Conduct – zero tolerance:**
  - Staff, patients/visitors, and vendors
- **Allow for accommodations for employees with difficult situations outside of the workplace:**
  - Work hours/tasks
  - Remote work where feasible
  - Parking (escort)
- **Known patient-specific issues:**
  - Assess signs and history of disruptive (aggressive) behavior
  - Identify safety plan (flags); communicate to all staff

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Management

Plan Ahead – Prevention, Intervention and Response – Education

Patients

- **Rights and responsibilities:**
  - Zero tolerance – make behavior expectations clear
  - Consequences for disruptive behavior
  - Visitor guidelines
  - Treatment contracts
  - Prescription refill policy
- **Scope of services:**
  - Hours/after hours
  - Portal and email utilization

Staff

- **Recognizing & reporting signs of potential aggression:**
  - Divorce/Loss of custody/domestic violence
  - Loss of job/insurance
  - Capacity/impaired
  - Known patient-specific issues
- **Safety measures:**
  - Expectations
  - Procedures
  - De-escalation techniques
  - Physical and non-physical interventions
  - Documentation and/or reporting requirements

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Management

Plan Ahead – Prevention, Intervention and Response – Education for Staff – Drills

- **Drills are a crucial education**
- **Walk through potential scenarios (tabletops and drills):**
  - Participate with community where appropriate
- **Make written policies and procedures easily accessible; BUT:**
  - Knowing the general content is critical as there might not be enough time to "grab" the document
- **Use visual aids**

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Management

Plan Ahead – Prevention, Intervention and Response – Event Response

- **Talk to the person (staff trained in de-escalation techniques):**
  - Assist the person to manage their emotions/behavior
  - Use calming and gentle interventions to avoid escalation
- **Safety 1st - Manage any injuries (if needed)**
- **Call security/violence response team or 911/law enforcement before situation turns violent (if possible)**
- **Try to isolate the person**
- **Escort off premises and evacuation plan:**
  - Staff/patients/visitors

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Management

Plan Ahead – Prevention, Intervention and Response – Recovery and Evaluation

Post event response, investigation, and support

- **Debriefs:**
  - Managed by the designated leader
  - Team approach – those involved
  - Potential Regulatory Reporting Requirements
- **Staff wellness - Victim Support:**
  - Medical Screening (confidential)
  - EAP Support and/or spiritual care/leave time
- **Ongoing evaluation:**
  - What does the future hold for the patient (termination, discharge, etc.)
  - Changes in the environment, patient population, staff situations, etc.

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Management

Plan Ahead – Prevention, Intervention and Response – Patient Medical Record

- **Careful documentation of the encounter should be entered into the medical record:**
  - Be objective
  - Use quotes when appropriate
  - Remember patients have the ability to see your notes
- **Is patient non-compliant?**
  - Emphasize in the chart that the patient was instructed to return to the office
  - Avoids future allegations of patient abandonment

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Management

Plan Ahead – Prevention, Intervention and Response – Support Staff

A comprehensive plan to support all facets of their staff's welfare is critical; ensure their safety, well-being and that they are thriving

- **Assess your staff; recognize:**
  - Their psychological needs
  - Signs of trauma and burnout
  - Maintain open communication
- **Be transparent and clear about your strategies:**
  - Solicit questions, feedback, suggestions, and needs
- **Support any need for external expert help**
- **Provide on going training**

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Management

- **Currently, there are no federal requirements healthcare employers must follow to protect employees from workplace violence**
- **Occupational Safety and Health Administration offers guidance**
- **As of 11/1/16, New York State Felony Assault Law 120.05 (3-C) now covers direct patient care providers working in:**
  - hospitals, nursing homes, residential health care facilities, general hospitals, government agencies including any chronic disease hospital, maternity hospitals, outpatient departments, emergency centers and surgical centers
- **Distinction of new law: Intent to cause "physical injury" v. (former) "serious physical injury."**

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Summary

- **The violence against healthcare workers is at an all-time high and has recently been referred to as an epidemic**
- **The escalation in negative behaviors are likely to continue:**
  - Fortunately, organizations have begun to take actions by establishing requirements to help prepare
- **Be aware of the impact these situations have on both patient care and staff wellness**
- **Plan ahead! Formalize safety plans for your workplace**
- **Seek expertise**
- **Educate staff and drill**
- **Debrief and do a thorough after-event review**
- **Don't be afraid to raise concerns**
- **Support each other**

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Management
Planning Resources
• Crisis Prevention Institute Responding to Abusive Patient Behavior
• American Hospital Association Hospitals Against Violence
• AHRQ Reducing Workplace Violence with TeamSTEPPS®
• AMA-International Association for Healthcare Security & Safety Creating Safer Workplaces
• CDC - NIOSH Workplace Violence Prevention for Nurses
• OSHA Guidelines for preventing Workplace Violence for Healthcare and Social Service Workers
• American Academy of Family Physicians - Medical Emergency Preparedness In Office Practice
• International Committee of the Red Cross - COVID-19 and Violence Against Health-Care – Safer COVID-19 Response: Checklist for Health-Care Services
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Management
Planning Resources
•ASHRM Workplace Violence Toolkit
•TJC Sentinel Event Alert 59: Physical and verbal violence against health care workers
•TJC Quick Safety Issue 47: De-escalation in health care
•TJC Workplace Violence Prevention Compendium of Resources
(roughly 76 links)
Burnout - Wellness
• American Psychiatrists Association Well-Being Resources
• Mayo Clinic Library Guide
• Nurse Journal Top Tips From Nurses on Dealing With Burnout
• CDC - Healthcare Personnel and First Responders: How to Cope with Stress and Build Resilience During the COVID-19 Pandemic
• American Hospital Association - COVID-19: Stress and Coping Resources
• Becker' Hospital Review - 6 resources for healthcare leaders on curbing employee burnout
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Tip #18: Discontinuing the Physician-Patient Relationship Properly

The Risk: Once the physician-patient relationship is established, physicians have a legal and ethical obligation to provide patients with care. However, there may be circumstances when it is no longer appropriate to continue the physician-patient relationship. A physician may choose to discharge a patient for a variety of reasons such as non-compliance with treatment, failing to keep appointments, or inappropriate behavior. Properly discharging a patient from care can be a complex issue. In order to avoid allegations of abandonment, providers should consider establishing a formal process for discharge.

Recommendations:

1. The discharge of each patient must be determined by the physician on an individual basis and based on medical record documentation of patient non-compliance or disruption. We recommend that you contact Mercado May-Skinner* for specific advice.

2. A formal patient discharge should be made in writing. You must give the patient at least 30 days from the date of the letter to call you for an emergency in order to avoid charges of abandonment. This time period may be longer depending on the patient's condition and the availability of alternative care.

3. The three most common reasons why physicians discharge patients are:
    - nonpayment;
    - noncompliance with the physician's recommendations; and
    - disruptions in the physician-patient relationship.

4. The discharge is to be effective the date of the letter.

5. Refer the patient to the local county medical society, their health insurer, or a hospital referral source to obtain the names of other physicians.

6. Provide the patient with prescriptions for an adequate supply of medication or other treatment during the 30 day emergency period.

7. Use the USPS certificate of mailing procedure, not certified mail, to send the discharge letter so it can not be refused/unclaimed by the patient, and it can be forwarded if the patient has moved.

8. When the patient to be discharged is in need of urgent or emergent care or continuous care without a gap, is more than 24 weeks pregnant, or has a disability protected by state and federal discrimination laws, the question of whether the patient can be discharged should first be discussed with counsel since discharge may not always be possible.

9. Become knowledgeable about the requirements regarding any restrictions on discharge imposed by the third party payors with whom you participate.

10. Promptly send the patient's records to the patient's new physician upon receipt of a proper authorization.

11. Flag the office computer or other appointment system in use to avoid giving the patient a new appointment after discharge.

12. Document the problems that have led to the discharge in the patient's record.

13. Form letters and a memorandum on the discharge of patients are available from Mercado May-Skinner.

*The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.

Mercado May-Skinner
ATTORNEYS & COUNSELORS-AT-LAW

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Module 2

Managing Mental Health: Beyond the Behavioral Health Unit

Presented by:
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Mercado May-Skinner

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Managing Mental Health
Objectives

At the end of the presentation, participants will be able to:
- **Recognize factors that lead to allegations of malpractice in behavioral health claims**
- **Assess professional liability risks in clinical areas outside of behavioral health units**
- **Evaluate the effect of crisis on patients and healthcare professionals**
- **Create risk management strategies to promote patient and staff safety**

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Managing Mental Health
Settings

- **Primary Care**
- **Emergency Department**
- **General Inpatient Medical Unit**

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CLAIMS DATA

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Managing Mental Health
Liability Exposure

- **Frequent allegations:**
  - Insufficient patient assessment and/or history:
    - Failure to properly evaluate/diagnose suicidal ideations
  - Lack of safe treatment environment:
    - Failure to assess for and remove dangerous objects
  - Inadequate training:
    - Proper ordering/administering medications
    - Lack of appropriate monitoring
  - Untimely transfer to proper setting

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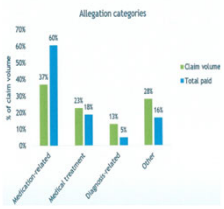
Managing Mental Health
Claims Data Snapshot: Allegations and Financial Severity

- **Medication related:**
  - Medication regimen management (83%)
    - Antidepressants & antipsychotics
  - Ordering errors (9%)
- **Medical treatment:**
  - Decision making (62%)
  - Premature discharge/abandonment (16%)
- **Diagnosis related:**
  - Delays in diagnosing depression associated with suicidal ideations, cardiac conditions associated with medications, and other drug toxicities
- **Other:**
  - Allegation of violation of patient rights, provider misconduct, and inadequate patient monitoring



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Managing Mental Health
Claims Data Snapshot: Risk Factors

- **Clinical judgment (62%):**
  - Inadequate patient monitoring medication regimens:
    - Including failures/delays in ordering diagnostic studies
  - Issues with the selection of medications most appropriate for the patient
- **Communication (35%):**
  - Poor communication related to medication regimen:
    - Failure to fully explain the risks of prescribed medications
    - Ill defined treatment expectations
  - Failed communication among providers:
    - Critical information that could have mitigated the risk of injury

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Managing Mental Health
Claims Data Snapshot: Risk Factors

- **Behavior-related (32%):**
  - Involved non-compliance with treatment, medication regimens, and follow up appointments
- **Documentation (17%):**
  - Insufficient documentation related to clinical findings/diagnosis and the rationale for specific treatment plans
- **Administrative (12%):**
  - Showed a failure to follow policies; lab testing for therapeutic medication levels and staff training

8

Managing Mental Health
Early Recognition

- **Barriers to behavioral health treatment:**
  - Reduction in psychiatric facilities and beds
  - Shortages of behavioral health professionals
  - Insufficient numbers of staff trained in recognizing behavioral health conditions requiring intervention
  - Patients:
    - Lack of health insurance coverage
    - Reluctant to seek care because of the stigma of behavioral health disorders

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Managing Mental Health
Early Recognition

- **One in five adults experience mental health disorders**
- **One in seven adolescents age 12 to 17 had a major depressive episode in the past year**
- **Only 3% to 5% of violent acts are committed by individuals with a serious mental illness**
- **Signs and symptoms of escalating behaviors:**
  - Repeatedly rude and abusive
  - Yelling and using profanity
  - Intimidating demeanor

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PRIMARY CARE SETTING

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Managing Mental Health
Primary Care Setting

- **Educate staff:**
  - Recognize early signs of behavioral health needs
  - Non-judgmental approach
  - De-escalation techniques
- **Identify patients at risk for aggression:**
  - Not every mental health patient is aggressive
  - Not every aggressive patient has mental illness
- **Perform a comprehensive assessment**

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Managing Mental Health
Primary Care Setting

- **Patient Assessment:**
  - Family history:
    - Mental illness
    - Depression
    - Alcohol/drug dependency
  - Social history:
    - Major life events:
      - Death of a family member/loved one
      - Job loss
      - Relocation
      - Divorce
      - Isolation

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Managing Mental Health
Primary Care Setting

- **Integration of mental health treatment in the primary care setting:**
  - One in five adults in the U.S. has a clinically significant mental health or substance use disorder
  - Onsite behavioral health clinicians within primary care
- **American Academy of Family Physicians:**
  - Provides mental health clinical guidelines:
    - Help to determine what is manageable in an office setting
    - Must meet the standard of care

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Managing Mental Health
Primary Care Setting

- **Major barriers to integrating behavioral health into medical care:**
  - Reimbursement
  - Lack of mental health providers
  - Inability to share/access the treatment record:
    - Interoperability
    - HIPAA
    - Potential relief with CURES Act
  - Medication reconciliation:
    - Potential interactions with psychiatric medications and medically related prescription drugs are of concern
    - Medication side effects

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Managing Mental Health
Tarasoff

- **Caregivers can provide a permissive warning to protect potential victims of violence if a patient indicates suicidal or homicidal intent:**
  - California Supreme Court 1985 ruling that mental health professionals are obligated to use reasonable care to protect potential victims if an individual indicates intentions to commit a violent act
  - Governed by individual state laws (NY Mental Hygiene Law 9.46)
  - Consult legal counsel

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Managing Mental Health
Extreme Risk Protection Order (ERPO)

- **New York State SAFE Act:**
  - Petition NYS Supreme Court to obtain Extreme Risk Protection Order (ERPO):
    - Decided same day
  - Keep guns away from people who are at a high risk of using them to hurt others or themselves:
    - ERPO can order that individuals not:
      - Have a firearm, rifle or shotgun
      - Buy/attempt to buy a firearm, rifle or shotgun
    - Must relinquish any firearms, rifles or shotguns

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EMERGENCY DEPARTMENT

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Managing Mental Health
Emergency Department

- **Gateway for many patients**
- **Often, poorly suited for behavioral health patients:**
  - Leading to increased anxiety:
    - ED crowding
    - Insufficient space
    - Long wait times
    - Security presence
- **Inappropriate ED utilization:**
  - Police
  - Group Homes
  - Family/Significant Others

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Managing Mental Health
Emergency Department

- **"Boarding":**
  - Awaiting transfer to behavioral health unit/facility and/or awaiting sobriety
  - Taxing to providers, staff, patients, and families
  - May limit ability to care for others
  - Likely not receiving behavioral health treatment:
    - Causing agitation and frustration
    - Worsening symptoms
- **Elopement**
- **Inappropriate discharge:**
  - Risk of self harm may be conveyed and must be validated by evaluation

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Managing Mental Health
Emergency Department

- **Conduct an initial risk assessment:**
  - Proper room placement:
    - Quiet area
    - Safe area:
      - Place in gown
      - Belongings safely stored
    - Ensure supervision
- **Rule out medical etiologies:**
  - Use caution with multiple visits
- **Minimize the visit duration:**
  - Streamline access to behavioral health services

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Managing Mental Health
Emergency Department

- **Conduct frequent risk assessments and provide interaction to decrease symptoms**
- **Reduce stress and anxiety:**
  - Show empathy
  - Offer medication as indicated
  - Recognize PPE may increase patient anxiety
- **Define or create an overflow area:**
  - Identify an area that is less stimulating for those waiting for admission

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Managing Mental Health
Emergency Department

- **What worsens behavior:**
  - Threat/inappropriate use of force
  - Lack of staff/provider training:
    - De-escalation techniques
    - Violence prevention
  - Lack of respect
  - Prolonged isolation
  - Lack of food, water, medication

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Managing Mental Health
Emergency Department

- **Manageable operational risks:**
  - Workforce:
    - Staffing guidelines/grids
    - 1:1 observation
    - Training and competency
    - Psychiatrist availability
    - Security personnel
    - Use evidence-based protocols and P&P

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Managing Mental Health
Emergency Department

- **Manageable environmental risks:**
  - Place all patients in a hospital gown
  - Remove items from patient's possession:
    - Weapons such as guns, knives, and scissors
    - Objects such as metal, glass, and medications
  - Exam rooms:
    - Eliminate ligature and self-harm risks
  - Sight lines:
    - Waiting Room
    - Triage
  - Video/camera monitoring

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INPATIENT MEDICAL UNIT

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Managing Mental Health
Inpatient Medical Unit

- **One out of every three hospitalized adult patients have behavioral health needs**
- **Challenges:**
  - Staff:
    - No interest in "psych"
    - Minimal training/awareness:
      - Behavior interventions
      - Medication
  - Unsafe treatment environments
  - Focus on medical conditions
  - Lack of system support
  - Limited transfer options

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Managing Mental Health
Inpatient Medical Unit

- **Profile of suicidal patient:**
  - Older males
  - No history of psychiatric or suicidal behavior
  - Pain, depression, or physical distress
  - New onset of chronic disease
  - Experiencing recent major life stressor
- **Suicide risk prediction models:**
  - https://healthitanalytics.com/news/suicide-risk-prediction-models-prove-cost-effective-in-healthcare

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Managing Mental Health
Inpatient Medical Unit

- **Identify individuals who are at high risk for suicide**
- **Take action to safeguard these individuals:**
  - Remove personal items
  - Manage medical equipment
  - Observe visitor interactions
  - Inspect items brought in by visitors
  - Bathroom safety
  - Communicate any risks with patient handoffs

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Managing Mental Health
Inpatient Medical Unit

- **Environmental self-harm risks:**
  - Ligatures
  - Sharps
  - Accessible light fixtures
  - Breakable windows
  - Medications
  - Harmful substances
  - Plastic bags
  - Oxygen tubing
  - Call bell cords

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Managing Mental Health
General Inpatient Medical Unit

- **Complex patients with significant agitation require close and frequent follow-up:**
  - Psychiatric team
  - Hospitalist
  - Medication management
- **Problems arise with significant medical comorbidities:**
  - Dementia
  - Substance abuse disorders
  - Delirium/confusion/agitation

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Managing Mental Health
Inpatient Medical Unit

- **Safe discharge planning:**
  - Identify risk factors that might increase the likelihood of relapse of mental illness or substance abuse use:
    - Noncompliance
    - Discontinuance of medication
    - Loss of a significant other
  - Include family members in the discharge process:
    - Provide the patient and caregivers with the national suicide prevention number or local crisis hotlines
    - Educate the patient on medications
    - Provide follow-up appointment information
    - Document a final risk assessment

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Managing Mental Health
Barriers to Integration

- **Regulations and reimbursement siloes**
- **Public Health Law §2807(2-a)(f)(ii):**
  - Article 28 outpatient hospital clinics can only bill for social worker services provided to <21, and pregnant women - up to 60 days postpartum
- **Adequate reimbursement and parity-many laws, but still struggling:**
  - Mental Health Parity and Addiction Equity Act (US)
  - Affordable Care Act (US)
  - Timothy's Law (NYS)
  - Mental Health and Substance Use Disorder Parity Reporting Act (NYS)
- **HIPAA patient record restrictions, 42 CFR Part 2:**
  - Patient consent required
  - Records managed separately

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MENTAL HEALTH DURING CRISIS

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Managing Mental Health
Mental Health During COVID-19

- **Global issues:**
  - Military conflicts
- **Economy**
  - Loss of income
  - Inflation
  - Loss of home
- **Loss of loved ones**
- **Fear of becoming ill**
- **Social media:**
  - Misinformation is linked to increased depression and anxiety

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Managing Mental Health
Mental Health During COVID-19

- **Potential effects:**
  - Sleep disturbances
  - Changes in appetite
  - Anxiety
  - Emotional instability
  - Worsening of pre-existing mental health disorders
  - Increased risk for physical/verbal/sexual abuse

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Managing Mental Health
JC Sentinel Event Alert: Voices from the Pandemic

- **55% of Physicians Know a Physician Who Considered, Attempted, or Died by Suicide:**
  - Impacts from the pandemic:
    - 61% report feelings of burnout, an increase from 40% in 2018:
      - Only 14% sought treatment
    - 46% of physicians noted they withdrew or isolated themselves
    - 34% cited feelings of hopelessness or having no purpose
    - 8% indicated they have increased their use of medications, alcohol, or illicit drugs

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Managing Mental Health
JC Sentinel Event Alert: Voices from the Pandemic

- **All healthcare providers:**
  - Fear of:
    - The unknown
    - Getting sick or getting a loved one sick
  - Staffing shortages and other issues:
    - Communication
    - Mandates for healthcare workers:
      - Mask
      - Vaccine
      - Overtime
    - Working with travel nurses:
      - Wage disparities

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Managing Mental Health
JC Sentinel Event Alert: Voices from the Pandemic

- **Leadership commitment to cultivating open and transparent communication that builds trust and morale, reduces fears and sustains efficiency**
- **Remove barriers for clinicians seeking mental health support**
- **Protect worker safety via the National Institute of Occupational Health and Safety Hierarchy of Controls framework**
- **Adopt a flexible workforce that allows for remote work**
- **Provide opportunities for collaboration, leadership and innovation**

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RISK MANAGEMENT STRATEGIES

40

Managing Mental Health
Risk Management Strategies

- **Select screening tools to identify at risk patients:**
  - New research has found formalized assessment tools to have predictive validity
  - Help staff identify which patients require a more in-depth comprehensive suicide risk assessment
  - Should be appropriate to the setting and patient population
  - The Joint Commission:
    - Suicide Prevention Resource to support Joint Commission Accredited organizations implementation of NPSG 15.01.01

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Managing Mental Health
Risk Management Strategies

- **Control the controllable:**
  - Environmental design
  - Contraband
  - Visitors
  - Waiting area monitoring
  - Change the culture:
    - Staff education:
      - Focus on destigmatizing aggressive behaviors
      - Practice de-escalation techniques
      - Design drills for behavioral health response teams

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Managing Mental Health
Risk Management Strategies

- **Clinical judgment:**
  - Be aware that inadequate patient assessment might be a result of cognitive biases, inadequate medical and family history taking, or inadequate sharing of information among providers
  - Recognize that delays in obtaining consults/referrals, and a narrow diagnostic focus are two of the top driving factors behind diagnostic claims

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Managing Mental Health
Risk Management Strategies

- **Communication:**
  - Give thorough and clear instructions:
    - Focus on patient education related to follow-up expectations and risks of medications
  - Ensure care coordination with other specialists:
    - Determine who is responsible for what specific treatment
- **Behavior-related:**
  - Engage the patient as an active participant
  - Consider health literacy and other barriers
  - Recognize patterns of patient non-compliance:
    - Focus on documenting efforts encouraging compliance

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Managing Mental Health
Risk Management Strategies

- **Documentation:**
  - Assessment of behavior and mood
  - Direct quotations of suicidal intent
  - Secure hazardous materials
  - Continuous observation
  - Other actions to keep patient safe
  - Verify that documentation supports the clinical rationale for the method of treatment
  - Update medications and history at each visit

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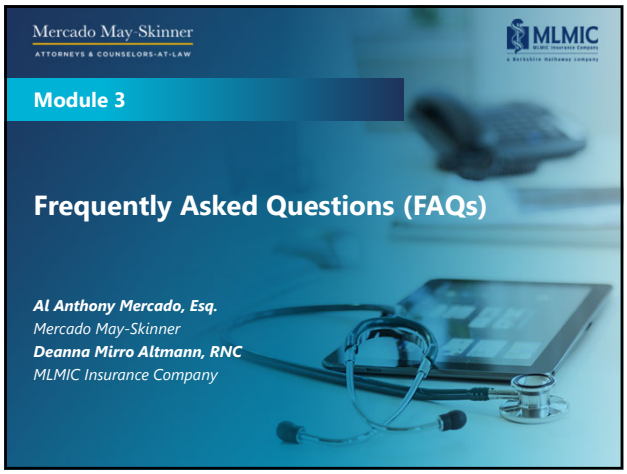

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Objectives:

- Describe appropriate indications for providing access to medical records and patient information.
- Review current recommendations for documentation in the open notes environment through the 21st Century Cures Act.
- Outline strategies to obtain the patient's informed consent for the use of telehealth.
- Evaluate the role and scope of practice of LPNs and RNs in performing telephone triage in the office practice.

2

Costs Associated with Medical Records

3

Access to Patient Information

- **What can I charge for the release of medical records?**
  - For medical records stored on paper only, under New York State law, you can charge up to 75 cents per page.
  - For duplication of radiographic films, you may charge for the actual costs of duplication. However, as most radiographic films are now stored electronically, you would likely have to follow the rule for electronic records.
  - If records are stored electronically, under the HITECH law, you can charge up to $6.50 to place the records on a CD and send to the requestor. You cannot charge to reproduce mammograms.

4

Access to Patient Information

- **What can I charge for the release of medical records? (cont.)**
  - You can charge your postal fee for sending the records.
  - If the patient has access to the records under the practice's portal, there should be no charge, but those records are likely retrievable without the need to file a request.
  - While there is some dispute as to whether the $6.50 limitation applies to entities such as requesting insurance companies, we recommend you apply the $6.50 fee, as time and cost of disputes with such entities would likely exceed any reimbursement you would receive for requested records.

5

How to Handle a Subpoena for Records

6

Handling a Subpoena for Records

- **What should the subpoena contain and how should the practice respond?**
  - Identify if the subpoena is accompanied by either an authorization signed by the patient or their representative, or an order of the court.
  - To release the records without either of these things may be a breach of the patient's privacy.
  - If those are lacking, or you are unsure of what to do, always call our office for assistance.
  - As for complying with the subpoena, you should only send the records as authorized in the patient's authorization, or the court's order. Again, if unsure, contact our office for assistance.

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Talking to Parents About the Care of a Minor Patient

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8

Handling a Subpoena for Testimony

- **What are a physician's obligations when the parents of a minor patient are involved in a child custody dispute and the doctor is served with a subpoena for testimony? Often, an attorney for at least one parent would like to speak with the physician prior to the family court proceeding.**
  - The medical provider cannot discuss the substantive nature of the case with any of the attorneys involved without proper legal authority, and that generally requires a written authorization.
  - The provider should always request a copy of the most recent custody order to determine who has the authority to execute written authorizations.
  - A valid authorization does not grant an attorney carte blanche access to the provider and the provider is not obligated to meet or discuss the case with either party's attorney prior to the proceeding.
  - It is always better to consult with counsel.

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Written Requests for Medical Records

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Request for Medical Records of a Minor Patient

- **Does a pediatric practice need a HIPAA compliant release from a parent to release medical records on behalf of their child?**
  - No, NYS Public Health Law § 18(2) requires that upon written request from a patient or a qualified person, a physician or hospital must release and deliver copies of all patient information, including x-rays, medical records, test results, and original mammograms within 10 days.
  - A parent is considered a qualified person for purposes of the statute and a HIPAA compliant release is not required to comply with this request.

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Request for Medical Records of a Minor Patient

- **However, in certain situations minor patients are authorized by law to give consent for release of a copy of their records. Therefore, authorization to release information, even to a parent, must be sought directly from the minor patient. Such situations include:**
  - *Sex-related treatment,* such as contraception, abortion, pregnancy, treatment of sexually transmitted diseases or information regarding HIV testing.
  - *Records of drug and alcohol treatment programs.* This exception applies specifically to formal treatment programs, and not simply a reference in the patient's history.
  - If a parent gave consent for the treatment, the parent may obtain the minor patient's records. However, both the minor and parent must sign the authorization. 42 C.F.R§2.14(b)-(d)

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Request for Medical Records of a Minor Patient

- **Such situations include: (cont.)**
  - *Psychiatric outpatient treatment.* State law allows a minor who meets certain criteria to receive psychiatric outpatient treatment without parental consent. A parent's authorization to obtain records from a treatment program may not be valid without the minor's consent or court order. Release of a copy of the record containing a reference to a history of mental health problems does not require the minor's consent.
  - *If the parent, guardian or person acting in place of a parent agrees to permit confidentiality between the minor and provider with respect to the health care service,* the parent should not be given access to the minor's medical record.

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Access to a Deceased Patient's Medical Records

14

Request for Medical Records of a Deceased Patient

- **The widow of a deceased patient called a physician and wants copies of MRI and CT (head) reports previously ordered of her late husband. She would also like to talk to the physician about these reports. The patient died almost two years ago and the doctor is aware that that the statute of limitations is about to expire. The doctor is not concerned about the care or the two studies, but he is seeking guidance relative to discussing the case with the widow and whether an authorization is needed to release the records.**
  - New York State law permits the release of a deceased patient's medical record to a "distributee." A "distributee" generally includes a spouse, child or sibling. The family member must make the request in writing and attach a certified copy of the death certificate.

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Request for Medical Records of a Deceased Patient

- **The doctor is seeking guidance relative to discussing the case with the widow and whether an authorization is needed to release the records. (cont.)**
  - It is also strongly recommended that the family member produce an affidavit indicating that no estate representative has been appointed.
- **This seems like an onerous task for a widow or other distributee to undertake. Is this something doctors should insist on?**
  - The answer is definitely yes. In order to protect yourself against future claims and/or allegations of inappropriate disclosure you need to have appropriate documentation in place.

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Request for Medical Records of a Deceased Patient

- **Should the doctor actually talk with the widow in an instance like this?**
  - There's no obligation to discuss the deceased patient's care with the widow. In a situation like this, it's likely that the widow is seeking information to frame a potential malpractice claim.
  - We strongly recommend that in an instance such as this, you reach out to us for assistance prior to having a conversation.
  - In this particular case, our doctor was persistent and insisted on discussing the case. It was suggested that he limit that discussion to the results of the MRI and CT and not elaborate beyond that.

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Confirming a Caller's Identity

18

Telephone Calls from the DOH

- **A physician received a call from an individual claiming to be with the NYS Department of Health (DOH) and requested information about a patient who had recently died. The patient previously suffered from dementia. The doctor has always been advised to cooperate with the DOH but felt uncomfortable with some of the questions being asked and began to doubt they whether they were speaking with someone from the DOH. Should the doctor do anything to confirm the caller's identity, and if so, what should be done?**
  - It is always recommended that healthcare providers confirm the identity of *any* caller. Confirmation could be something as simple as politely asking the caller to send over a fax with letterhead which identifies the caller's identity.

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Telephone Calls from the DOH

- **Should the doctor do anything to confirm the caller's identity, and if so, what should be done? (cont.)**
  - Alternatively, providers can ask the representative to submit a written request for information.
  - Although the above situation likely involved a legitimate caller, it is recommended that providers always confirm and verify a caller's identity and educate themselves as well as their staff about fraudulent social engineering schemes such as vishing.
  - Vishing is a scheme where fraudsters convince users to provide critical information over the phone.

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Electronic Signatures and Record Requests

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Electronic Signatures

- **A pediatric practice called about a HIPAA authorization that contained an electronic signature. The practice was slightly suspicious of the signature and seeking guidance relative to its validity. Is the medical practice required to honor the electronic signature and comply with the record request?**
  - In New York, electronic signatures have the same legal validity as handwritten signatures. Since 2000, electronic signatures have been legally binding in New York under the Electronic Signatures and Records Act (ESRA). However, it is important to understand that no government organization nor citizen is required to use electronic signatures.

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Electronic Signatures

- **Is the medical practice required to honor the electronic signature and comply with the record request? (cont.)**
  - Practices are not necessarily required to accept E-Signatures relative to HIPAA authorizations, and they can deny these requests and require an actual "wet" signature.
  - If a provider adopts a policy refusing E-Signatures, upon receipt of an electronically signed authorization, the provider should immediately notify that requesting party and advise of the office/practice policy.
  - Failure to immediately notify the requesting party of the electronic signature refusal may result in violations of both HIPAA and the NYS Public Health Law.
  - If a medical provider finds themselves questioning the validity of any authorization, they should call the requesting party and confirm the request and then document such in the medical record.

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Electronic Signatures

- **What are the instances where you cannot accept an e-signature?**
  - E-Signatures do not apply to any document providing for the disposition of an individual's person or property upon death or incompetence or appointing a fiduciary of an individual's person or property.
  - This includes wills, trusts, and "do not resuscitate orders" as well as powers of attorney and health care proxies.
  - It you have any questions about whether to accept an e-signature, please call our office for assistance.

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Addendum and the Medical Record

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The 21st Century Cures Act

- **Through the 21st Century Cures Act, patients have greater access to their records. Practices are getting questions from patients and their representatives about the documentation of medical visits. How should physicians address patients who want the content of their record changed? For example, they are embarrassed by a note or don't agree with it.**
  - Review the note for accuracy.
  - If accurate, leave the documentation, and advise the patient the reason why you are not changing it.
  - If it is inaccurate, an addendum is appropriate.

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The 21st Century Cures Act

- **What about patients who just don't like the way the physician documented the encounter?**
- **Documentation Tips:**
  - Consider the health literacy level of your patient. Use plain language in your documentation when possible.
  - It is important not to sound judgmental in your documentation. Avoid terms that may be offensive or emotionally charged:
    - "Patient reports she did not take medication" vs. "non-compliant" or "unreliable"
  - Use a supportive tone when possible:
    - "Lost five pounds and is motivated to continue" vs. "Still needs to lose another 15 pounds"
  - Document as though you are writing instructions:
    - "Check your blood sugar yourself every morning" vs. "Patient needs to monitor glucose"

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The 21st Century Cures Act

- **Documentation Tips: (cont.)**
  - Engage your patients and solicit feedback from them:
    - Encourage them to refer to the notes as this may be a reminder and increase compliance with the treatment plan
  - Finally, educate patients on:
    - How to access their information
    - How to comment on or ask questions about the documentation of their encounter
  - When documenting in the open notes environment, avoid using the copy and paste feature of the electronic health record:
    - Information may be redundant, outdated or inaccurate
    - May leave patient with wrong perception about the records, and perhaps you as a healthcare provider.

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After-hours Access to the Practice

29

The Physician-Patient Relationship

- **Is a primary care provider required to provide coverage 24/7 through an on-call service?**
  - 24/7 coverage is necessary for primary care practitioners. However, this can be accomplished using advanced practice providers, such as a physician's assistant or nurse practitioner.
  - We also strongly recommend the use of an answering service.
  - The use of answering machines or voicemail for after-hours calls is not recommended because there are no safeguards in the event of a malfunction, and simply referring the patient to the ER is an ineffective use of resources and could potentially result in licensing and liability issues.
  - Periodically call into your after-hours service to see how quickly the service follows up with you and verify the information reported is accurate.

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The Use of Chaperones

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Use of a Chaperone

- **A male physician called seeking guidance relative to a sexual assault allegation recently made by a female patient. The patient claims that she was coming in solely for a vaccination. However, she said an inappropriate breast exam was performed. The doctor denied any wrongdoing, but he did not have a chaperone in the room during the visit. When is it necessary to have a chaperone present for an examination with a patient?**
  - It is strongly recommended, regardless of a physician's gender, to have a chaperone present for any intimate examination of a patient, such as a rectal, breast or genital examination.
  - Having a chaperone present can help alleviate any misunderstandings between the physician/patient and protect against allegations of improper behavior during such consultation.

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Use of a Chaperone

- **When is it necessary to have a chaperone present for an examination with a patient? (cont.)**
  - Chaperones can also be helpful with difficult, argumentative or slightly combative patients.
  - Concise documentation should be made in the medical record indicating that the chaperone was present for the *entire* exam.
  - Allegations of intentional/criminal conduct is generally excluded from coverage under most malpractice insurance policies.

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Suspected Elder Abuse

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Suspected Elder Abuse

- **A gastroenterologist called about a 70-year-old patient who is currently living at home. At the conclusion of the procedure, the patient was asked if she felt safe at home. She responded that she did not; however, she was adamant that she did not want to leave her home. She was given information about elder abuse that included contact information for reporting and services. The physician documented all discussions in the medical record. Does the physician have an obligation to report this situation to adult protective services?**
  - In New York State, healthcare workers are mandatory reporters, and they are required to report their suspicions of elder abuse. In response to the above scenario, it will be important to gather some additional information to properly advise the physician, such as whether any abuse was indicated during an exam and whether anyone else is living in the home.

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Suspected Elder Abuse

- **Does the physician have an obligation to report this situation to adult protective services? (cont.)**
  - However, *if* the physician suspects elder abuse, then he/she should immediately contact Adult Protective Services (APS) and document such in the patient's medical record.
  - The physician should also document everything related to his/her suspicion, including statements, bruises, or any other signs that lead you to suspect potential abuse or neglect.
  - Failure to report suspected elder abuse could lead to severe professional consequences and significant liability exposure.
  - There is a good faith standard to reporting elder abuse, so if you have any suspicion, it is always best to err on the side of reporting.

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Reporting a Patient's Ability to Drive

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A Patient's Ability to Drive

- **What are a physician's obligation to notify the NYS Department of Motor Vehicles (DMV) if he/she is concerned about a patient's ability to drive?**
  - A physician has no legal obligation to report to the DMV that a patient has a medical condition that might impair his/her ability to drive. In fact, the physician will be violating state and federal privacy laws should he/she disclose protected health information to the DMV without the patient's consent.
  - The physician should make serious attempts to obtain the patient's consent to notify the DMV and dissuade the patient from driving.
  - It is also important to include family members (whenever possible) during these visits. These discussions must be documented to protect the doctor from liability to third parties.

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Discharging a Disruptive or Non-Compliant Patient

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Discharging a Non-Compliant OB Patient

- **One of the most common questions we receive involves discharging a disruptive or non-compliant patient. Can a physician/practice discharge a non-compliant patient that is entering the 27th week of pregnancy? The pregnancy has been slightly complicated, and the patient has missed multiple appointments.**
  - No, it is not advisable to discharge the patient this late in the pregnancy. This patient is experiencing complications and heading into the third trimester of her pregnancy. Generally, after 24 weeks of pregnancy, it is often too difficult to find a new obstetric provider before delivery.

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Discharging a Non-Compliant OB Patient

- **Can a physician/practice discharge a non-compliant patient that is entering the 27th week of pregnancy? The pregnancy has been slightly complicated, and the patient has missed multiple appointments. (cont.)**
  - To dismiss the patient at this point in the pregnancy could be considered professional abandonment, which has both liability and licensure implications.
  - The provider needs to accurately document any recommendations that were made and not followed by the patient, and that includes any missed appointments and all notes from telephone conversations between the physician (and staff) and the patient.
  - The OB/GYN should have strict guidelines and procedures in place to address the non-compliance.
  - Finally, the patient should be made aware of the importance and/or consequences of the missed appointments and offered the prompt opportunity to be seen.

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The Recording of Medical Visits

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Recording of Medical Visits

- **Is it lawful for the patient to record medical visits without the knowledge or consent of the provider?**
  - It is lawful to record such a visit in the New York State.
  - It is important to understand that different jurisdictions have different laws relative to recording such conversations, some states are "all party," which means that all parties must consent to the recording.
  - However, New York is currently a "one party" state, which obviously means only one party must be aware of the recording.
  - Can try to limit this practice by banning cell phones in exam rooms.
  - Always assume you are being recorded.

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Telehealth and Informed Consent

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Informed Consent for Telehealth

- **Does a healthcare provider need to obtain the patient's informed consent prior to engaging in a telehealth encounter?**
  - We do recommend that an informed consent for the use of telehealth be obtained. There are a lot of factors a patient needs to consider when using telehealth for their care.
  - First, while the provider is likely in a fairly private location, the patient may not be in a private area, and third parties may be able to overhear the conversation. Patients should understand that and decide whether they want to proceed.
  - Also, as the encounter is occurring through either a computer or mobile device, there are always cybersecurity risks to consider.
  - Finally, not all services can be provided through telehealth, and depending upon the patient's needs, there may be need for testing, procedures or even in-person follow-up. The patient should understand all of this before you proceed with the encounter.

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Informed Consent for Telehealth

- **How should informed consent be obtained?**
  - First, it should be obtained at least at the beginning of the encounter. We do have sample consent forms that we can share with MLMIC's insureds.
  - However, New York State does not require a written consent for telehealth, and practices may find trying to obtain a written consent difficult.
  - So, at a minimum, the doctor should have a conversation covering what we discussed in the last question, and document that the patient understood what they were told, that they had the opportunity to ask questions, and that they agreed to proceed with the encounter.

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Scope of Practice for Office Staff

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Scope of Practice for Office Staff

- **Can a licensed practical nurse (LPN) perform telephone triage in a practice in absence of their registered nurse (RN)?**
  - In order to alleviate any immediate confusion, **LPNs** are **not** permitted to perform triage in New York State, whether in person or over the phone. RNs in New York are licensed to perform an assessment, which is a critical part of telephone triage.
  - An RN is permitted to help patients to determine what type of care they need over the phone. For example, RNs can provide cursory assessments of patients and help them decide if the need to seek emergency treatment or make an appointment with a physician. This process *does not* result in a diagnosis.

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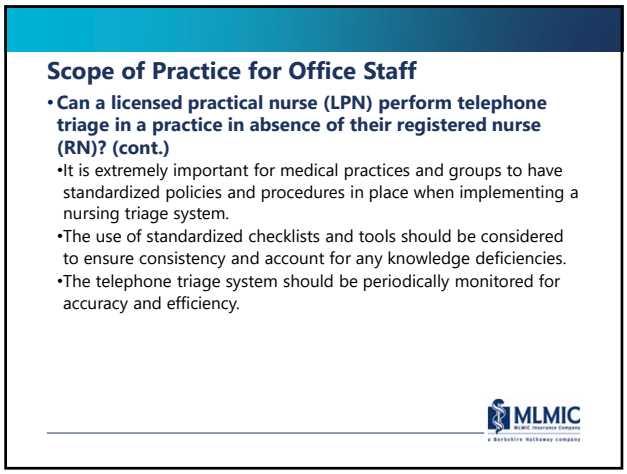
Scope of Practice for Office Staff
• Can a licensed practical nurse (LPN) perform telephone triage in a practice in absence of their registered nurse (RN)? (cont.)
•It is extremely important for medical practices and groups to have standardized policies and procedures in place when implementing a nursing triage system.
•The use of standardized checklists and tools should be considered to ensure consistency and account for any knowledge deficiencies.
•The telephone triage system should be periodically monitored for accuracy and efficiency.
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Tip #8: Management and Documentation of After-Hours Telephone Calls from Patients

The Risk: The failure to properly handle and document after-hours telephone calls can adversely affect patient care and lead to potential liability exposure for the physician. Should an undocumented telephone conversation become an issue in a lawsuit, the jury is less likely to believe the recollection of the physician, who receives a large number of calls on a daily basis.

Recommendations:

1. Establish a system to help ensure that all after-hours calls are responded to in a reasonable time frame and are documented in the patient's medical record.

2. Medical record documentation of after-hours calls should include the following:
    - Patient's name
    - Name of the caller, if different than the patient, and the individual's relationship to the patient
    - Date and time of the call
    - Reason or nature of the call, including a description of the patient's symptoms or complaint
    - Medical advice or information that was provided, including any medications that were prescribed

3. If the patient's condition warrants the prescription of medications, it is important to inquire about and document any medication allergies, as well any other medications the patient is currently taking.

4. If you use an answering service, it should be periodically evaluated for courtesy, efficiency, accuracy, and proper recordkeeping.

5. The use of answering machines or voicemail systems for after-hours calls is not recommended for the following reasons:
    - There are no safeguards in the event of a malfunction.
    - Patients do not always understand that no one will call back, even if this is stated in the message.
    - If, as a last resort, an answering machine or voicemail must be used, the message should be brief, simple, and include: (The office is now closed. If you believe you are experiencing a medical emergency, please disconnect and call 911.)

6. When after-hours coverage is provided by another physician's practice, a process should be in place to ensure that documented telephone conversations are promptly forwarded to your office.

Tip #11: Using Chaperones During Physical Examinations

The Risk: Providers must recognize that, at any time, a patient may make a complaint to the Office of Professional Medical Conduct alleging that he or she was the victim of a physician's sexual misconduct. Having a chaperone present during intimate physical examinations may be beneficial to both the physician and the patient. First, it may provide reassurance to patients, demonstrating both respect for their concerns and an understanding of their vulnerability. Second, the use of chaperones can provide legal protection for the physician in the event of a misunderstanding or false accusation of sexual misconduct on the part of the patient.

Recommendations:

1. A provider should always use a chaperone when performing breast or pelvic examinations.

2. Consideration also should be given to the use of a chaperone for:
    - The provider can simply document "chaperone in room for the entire exam" and the chaperone's initials.
    - Adding the name and title of the staff member who chaperoned the exam allows you to verify their presence at a later date, should the need arise.

3. The presence of a chaperone must always be documented in the patient's medical record.

4. A chaperone should be provided even if the provider is the same gender as the patient.

5. Chaperones should be educated about patient privacy and confidentiality issues.

6. Unless specifically requested by the patient, family members should not be used as chaperones.

7. Respect for the patient's privacy can be further maintained by speaking to the patient privately before and/or after the examination.

Mercado May-Skinner
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High Exposure Liability

Million Dollar Claims:

What we know
What you can do

Presented by:
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MLMIC Insurance Company
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Mercado May-Skinner

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Legal Disclaimer

- **This presentation has been prepared for informational purposes only:**
  - It does not, and is not intended to, constitute legal advice
  - Only your attorney can provide assurances regarding the application of this information to your particular circumstances. We always recommend you consult with your own counsel
  - The statement, views, and opinions expressed in this presentation and on the following slides are solely those of the presenters
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Objectives

- **At the end of this presentation, participants will be able to:**
  - Recognize the drivers of large loss claims, including but not limited to, allegations, contributing factors, and the claimant profile
  - Discuss the impact implicit bias may have on diagnostic outcomes
  - Evaluate the role process plays in diagnostic decision making
  - Identify the principal elements included in patient selection in relation to location for surgical procedures
  - Incorporate the RM Trifecta strategies presented into operations to mitigate future claims and suits

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The Data: Large Loss Claims

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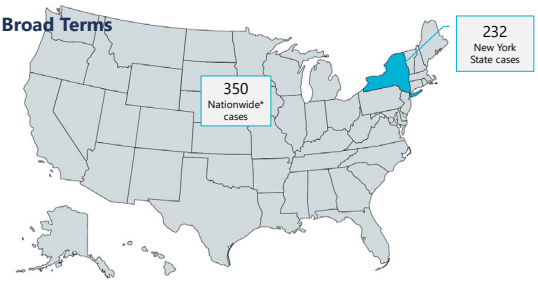
Large Loss Claims

- **In Broad Terms**



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*Nationwide case count excludes cases venued in New York.

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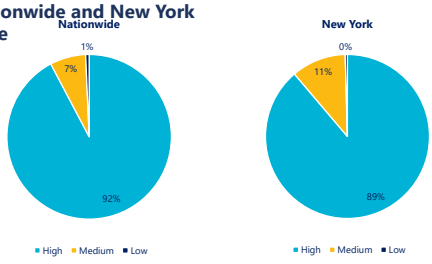
Clinical Severity*

- **Nationwide and New York State**



*National Association of Insurance Commissioners injury severity scale.
MLMIC and MedPro Group cases closed between 2017-2021, indemnity paid =/> $1M, NYS N=>200, Nationwide N=>300.

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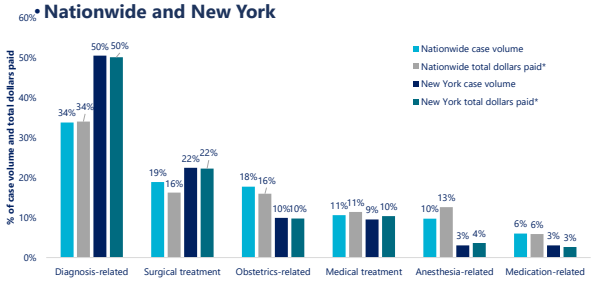
Top Allegations and Financial Severity

- Nationwide and New York



*Total paid dollars = expenses + any indemnity

MLMIC and MedPro Group cases closed between 2017-2021, indemnity paid =/> $1M, Nationwide N=>300.

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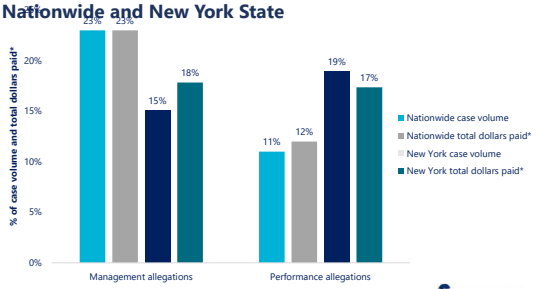
Management/Performance Allegations and Financial Severity

- Nationwide and New York State



*Total paid dollars = expenses + any indemnity

MLMIC and MedPro Group cases closed between 2017-2021, indemnity paid =/> $1M, Nationwide N=>300.

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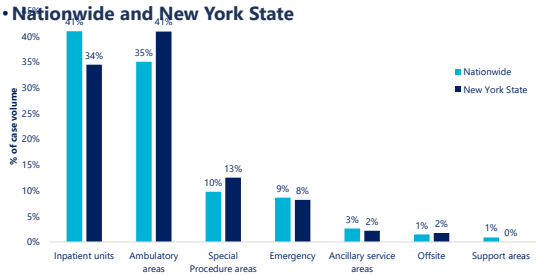
Location

- Nationwide and New York State



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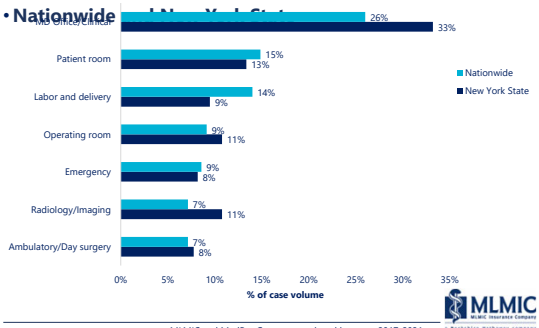
Top Location Details

- Nationwide



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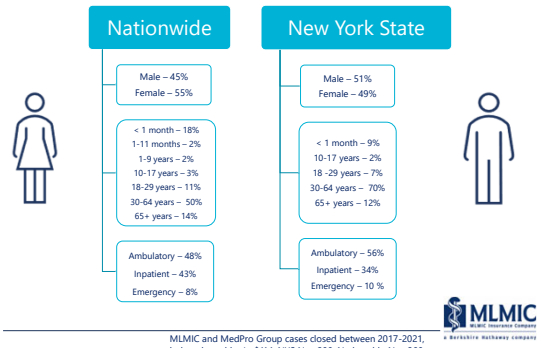
Claimant Profile

Nationwide and New York State



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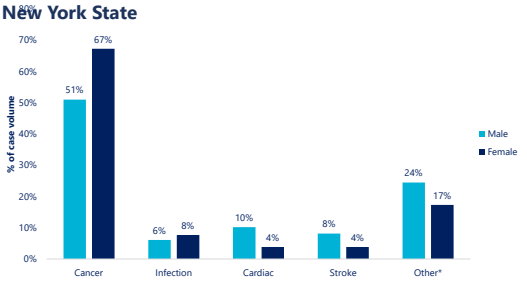
Top Diagnoses by Gender

- New York State



*Other – ex. CNS disorder, open wound, obstetrical trauma, connective tissue disease, spinal cord injury

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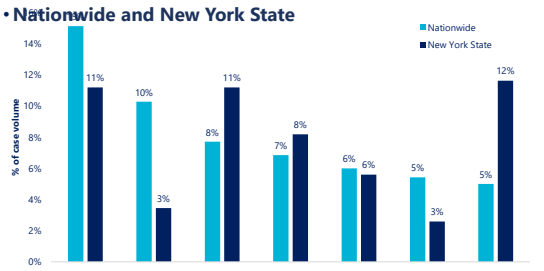
Top Responsible Service

- Nationwide and New York State



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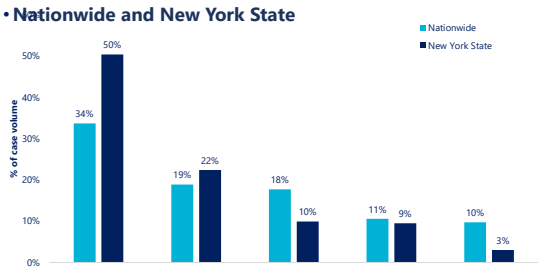
Top Allegations

- Nationwide and New York State



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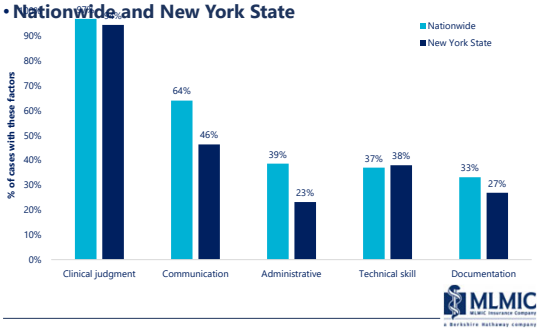
Top Contributing Factors

- Nationwide and New York State



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Top Contributing Factors

Factor	Details
Administrative	Inadequate staff training/education, triage/waiting issues, physician coverage/availability issues, credentialing issues, failure to follow policies/procedures
Clinical judgment	Inadequate assessments; these include failures to appreciate/reconcile patient signs/symptoms/test results and premature discharge, narrow diagnostic focus, delays in ordering diagnostic testing
Communication	Suboptimal communication among providers regarding patient condition and failures to read the medical record; suboptimal conversations between patient/family to manage patient expectations
Documentation	Insufficient/lack of documentation of clinical findings leading to difficult defense of case; delays and inaccuracies of documentation; inconsistent documentation
Technical skill	Recognition/management of known complications, poor technique during procedure-based care, retained foreign bodies (i.e., wound debris)

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Diagnostic Error

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Diagnostic Error

Definitions

- **Diagnostic error occurs when a diagnosis is:**
  - Missed, incorrect or delayed
- **Diagnostic error is a:**
  - Leading cause of patient harm
  - Contributing factor to patient safety events in the health care system
- **National Academies of Sciences, Engineering and Medicine (NASEM) report *Improving Diagnosis in Health Care* (2015) expanded the definition:**
  - The failure to (a) establish an accurate and timely explanation of the patient's health problem(s) or (b) communicate that explanation to the patient

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Diagnostic Error
Definitions

- **The Agency for Healthcare Research and Quality (AHRQ) adapted and applied both concepts to define a diagnostic safety event:**
  - Delayed, wrong or missed diagnosis:
    - There were one or more missed opportunities to pursue or identify an accurate and timely diagnosis (or other explanation) of the patient's health problems based on the information that existed at the time
  - Diagnosis not communicated to the patient:
    - An accurate diagnosis (or other explanation) of the patient was available, but it was not communicated to the patient (including the patient's representative or family as applicable)

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Diagnostic Error
Definitions

- **The Agency for Healthcare Research and Quality (AHRQ) developed Measure DX:**
  - To help healthcare organizations "to monitor the diagnostic process and identify, learn from, and reduce diagnostic error and near misses in a timely fashion"
  - Learning and Exploration of Diagnostic Excellence (LEDE) organizations use safety surveillance methods to create a continuous learning and feedback cycle to prevent diagnostic harm

Learning and Feedback System for LEDE Organizations

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Diagnostic Error
The Process

- **Making an accurate diagnosis is a process:**
  - Typically involves many handoffs of information
  - May evolve over time (come to light at a later date)
  - Involves a large number of participants
- **Key principles are:**
  - Accuracy
  - Timeliness
  - Communication

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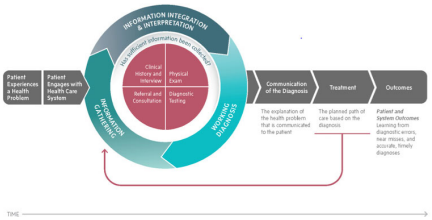
Diagnostic Error
The Process

The Diagnostic Process



Source: National Academies of Sciences, Engineering, and Medicine. 2015. *Improving Diagnosis in Health Care.* Washington, DC:

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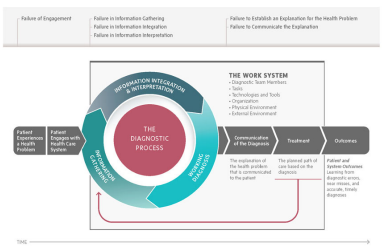
Diagnostic Error
The Process

Places in the diagnostic process where errors can occur



Source: National Academies of Sciences, Engineering, and Medicine. 2015. Improving Diagnosis in Health Care. Washington, DC: The National Academies Press

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Diagnostic Error
Cognitive Bias

- **Cognitive Biases and Diagnostic Error**
  - Identified by ECRI as a Top 10 Patient Safety Concern 2022
  - Cognitive biases contribute to misdiagnoses by skewing how clinicians gather and interpret evidence, take action and evaluate decisions

Common Clinician Biases	Definition
Anchoring Bias	The clinician adheres to their initial impression in the face of conflicting evidence
Confirmation Bias	Information is "cherry picked" to support the diagnosis
The Affect Heuristic	Actions are driven by emotions; this often manifests as strong feelings regarding a patient after an encounter
Outcome Bias	Clinical results always follow prior decisions preventing clinicians from considering feedback to improve their care delivery

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Large Loss Case Scenario:

Improper Surgical Treatment and Management

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Case Study

Improper Surgical Performance and Management

- **A 41-year-old female, presented to an ambulatory surgical center for elective abdominoplasty**
- **She went into cardiac arrest mid-procedure and later died at the hospital:**
  - Mother of two minor children with DM Type 2
  - Due to a scheduling conflict that came up for the patient, the procedure was rescheduled for six weeks later:
    - Medical clearance was not updated
    - Informed consent discussion was not documented
  - Seen by anesthesia:
    - No new physical exam notes or labs entered
    - Elected to use an epidural

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Case Study

Improper Surgical Performance and Management

- **The procedure began with four skin punctures:**
  - Liposuction was initiated and the anesthesiologist immediately noted the patient was becoming hypotensive:
    - Bradycardic with arrhythmias noted on the cardiac monitor
    - Plastic surgeon was asked to begin CPR
    - Anesthesiologist administered appropriate medications
    - Staff called 911

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Case Study

Improper Surgical Performance and Management

- **EMS were on scene within six minutes:**
  - Anesthesiologist did not immediately intubate patient:
    - Opting to "let her wake up"
    - Felt the OR was the safest place for the patient
  - Plastic surgeon deferred to anesthesia and EMT for direction
  - The patient remained unresponsive
  - EMS transported patient to nearby hospital:
    - Head CT done showed cerebral edema
    - EEG showed global brain injury
  - She remained comatose and intubated for several weeks:
    - Transferred to a rehab facility that took vented patients and remained there until she died

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Case Study

The Lawsuit Commenced

- **The experts opined:**
  - Critical of the care provided once deterioration was noted:
    - Specifically stated the lack of adequate documentation of the actions and care provided during resuscitation
    - Approximately fifty minutes had lapsed from the arrival of EMS on scene to arrival at ED of hospital
  - Prior to the rescheduled procedure, there were no new labs or medical clearance reviewed/updated
  - Informed consent discussion was not adequately documented
  - Credentialing issue with the plastic surgeon for the procedure he was performing
- **This case settled out of court for $2.6M:**
  - Expenses were $195K

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Case Study

The Lawsuit Commenced

- **Emergency Management:**
  - Once the patient began to deteriorate, they did the right things:
    - Plastic surgeon did CPR
    - Anesthesia gave appropriate medications
    - Staff called 911
  - Even after EMS arrived on scene, there was a failure by the providers to appreciate the rapid deterioration and respond aggressively to the patient's deteriorating clinical picture:
    - Failed to establish/protect an airway
    - Documentation of efforts were lacking
    - Lack of serial EKG and/or cardiac monitoring strips
  - Care was not immediately turned over to the EMTs

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Case Study
The Lawsuit Commenced

- **Care setting:**
  - The experts were concerned that this patient and procedure were being done:
    - In an ambulatory setting
    - Using epidural anesthesia
- **Credentialing process:**
  - Upon discovery, it was noted that the plastic surgeon was not specifically credentialed for the exact procedure he was performing
- **Informed consent process:**
  - While the plastic surgeon did speak to the consent discussion, the documentation for this was lacking on several counts

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Case Study
Informed Consent Process

- **Informed consent:**
  - A non-delegable duty that rests with the physician who will be performing the test/procedure
  - The discussion must include:
    - Risks and benefits
    - Alternatives to the proposed
    - Risks of the alternative options
    - Option of no treatment
    - Time for Q & A
    - Consent to proceed
  - This discussion needs to be fully documented in the EHR

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Case Study
Identified RM Opportunities

- **Patient selection:**
  - The patient needs to receive the right care at the right level of care
  - If an anesthetic is involved, there is no such thing as minor surgery
- **While ambulatory surgical centers offer patients options, the greatest consideration is that of appropriate patient selection:**
  - It is critical that criteria be developed and put into policy re: patient selection
  - Criteria needs to be evaluated in every patient situation
    - It is not a procedure-driven process
- **Staff should be competent to provide emergency rescue maneuvers should the need arise**

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The Jury's Still Out

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Risk Management Strategies
Legally Speaking in NYS

- **New York is #1:**
  - The highest medical liability payouts year over year
  - Lead in highest medical liability payouts on a per capita basis

Year	Per capita payment and Rank	Total medical liability payouts
2022 (so far)	$21.54, 1st	$434M
2021	No figures due to Covid and courts shutdown	No figures due to Covid and courts shutdown
2020	$34.01, 2nd	$661M
2019	No figures compiled this year	No figures compiled this year
2018	$31.13, 1st	$617M
2017	$35.49, 2nd	$700M
2016	$35.95, 1st	$711M

Source: Diederich Healthcare

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Risk Management Strategies
Legally Speaking in NYS

- **NYS and Nuclear Verdicts:**
  - Verdicts that greatly exceed longstanding verdicts of comparable or even more severe injuries:
    - New York's liability environment has seen a sharp increase in recent years:
      - Perez v. Live Nation, New York's 2nd Department
- **Improper anchoring:**
  - During summation, lawyers will suggest an unreasonably high reward to the jury
    - That number becomes the starting point in a juror's mind
    - Primary tactic used by the plaintiff's bar to secure nuclear verdicts:

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Risk Management Strategies
Legally Speaking in NYS

- **Expansion of NY's Wrongful Death cause of action:**
  - This bill would impose damages for noneconomic injuries, specifically grief and anguish, and any disorders they can cause
  - Those who can recover these newly expanded damages would be also be greatly increased and include:
    - "..any surviving close family members"; allow jurors to define them
- **Caps on pain and suffering awards:**
  - There are no caps on any damages that can be awarded to a successful plaintiff, including MPL cases:
    - As of 2021, twenty-nine states have laws in place that place a cap on medical malpractice damages that can be awarded https://www.ncsl.org/research/financial-services-and-commerce/medical-liability-medical-malpractice-laws.aspx

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Risk Management Strategies:
Closing Thoughts

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Risk Management Strategies
Final Thoughts: Diagnostic Error

- **Arriving at a clinical diagnosis is a process:**
  - Timeliness
  - Accuracy
  - Communication
- **Be aware that biases do exist**
- **Follow through on tests and results**
- **Communicate to all members of the team**
- **Document your differential thought processes:**
  - Check boxes may not be the best way to tell your patient's story
  - Consider using text boxes to fully record the clinical picture

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Risk Management Strategies
Final Thoughts: Improper Surgical Performance and Management

- **Patient selection for ambulatory settings:**
  - Ensure policy and procedure define the appropriate patients and procedures to be done in this setting
  - Review all documentation, including but not limited to medical and surgical history, family history, medications and medical clearance entries prior to the start of any procedure
- **Emergency management policy and protocols:**
  - Transfer agreements in place with nearby facility
  - Engage local EMS and law enforcement in policy development
  - Run table-top scenarios to keep staff informed and ready to act
- **Credentialing**
- **Informed consent process**

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Risk Management Strategies
Final Thoughts: Risk Management 101

- **The best defense is a good offense:**
  - Efforts to prioritize the **RM Trifecta** will mitigate the risk of an event becoming a significant malpractice claim
  - Effective **communication** is essential to developing and executing the best plan
  - The EHR is a legal **document** and primary means of communication among members of the team
  - **Follow-up** is critical as any missed action contributes to a potential liability exposure

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MLMIC Data

MLMIC is partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.
Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.
Using Candello's sophisticated coding taxonomy to code claims data, MLMIC is better able to highlight the critical intersection between quality and patient safety and providing insights into minimizing losses and improving outcomes.
Leveraging our extensive claims data, we help our insured stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insured minimize risk.

Candello
Safety in Numbers

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Tip #5: Follow-up of Missed or Cancelled Appointments

The Risk: A missed or cancelled appointment and the failure to follow up with or contact the patient may result in a serious delay in diagnosis or treatment. A well-defined process that includes provider notification and follow-up procedures in this situation will help ensure continuity of care and enhance patient safety.

Recommendations:

1. Develop a process for the follow-up of patients who have missed or cancelled appointments.

2. Physicians should be notified of all missed or cancelled appointments on a daily basis.

3. The physician should assess the clinical importance of the appointment, the severity of the patient's medical condition, and the risk(s) associated with the missed or cancelled appointment to determine appropriate follow up.

4. A reminder telephone call from the office staff may suffice for patients at minimal risk. The telephone call and the content of the message or conversation should be documented in the patient's record.

5. A telephone call from the physician may be indicated for patients at higher risk. The physician should emphasize the importance of follow-up care and the risks inherent in failing to comply. This conversation should also be documented in the medical record.

6. If there is no response from the patient or the patient develops a pattern of not keeping or missing appointments, a letter with a certificate of mailing should be sent to the patient to advise him/her of the risk of non-compliance. A copy of the letter should be maintained in the patient's medical record.

7. All efforts to contact the patient, either by telephone or in writing, should be documented in the medical record. This provides evidence that the patient was made aware of the importance of continuous medical care.

8. Educate your staff regarding patient follow-up processes in your practice. Consider conducting periodic record reviews to evaluate the effectiveness of the established processes for patient follow-up.

9. Continued failure of a patient to keep appointments may be deemed non-compliance with treatment. Consideration should be given to discharging the patient from your practice. The attorneys at Mercado May-Skinner* are available to assist you in determining how and when to properly discontinue a physician-patient relationship due to patient noncompliance.

*The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.

Tip #9: Effective Communication with Patients

The Risk: Effective communication is the cornerstone of the doctor-patient relationship. Patients' perceptions of physician communication skills may impact the potential for allegations of malpractice. The following are some suggestions that are designed to promote open communication and enhance your ability to reach an accurate diagnosis and develop an appropriate plan of care.

Recommendations:

1. Employ active listening techniques and allow the patient sufficient time to voice their concerns.

2. Sit at the level of the patient and maintain eye contact.

3. Assess the patient's literacy level. This may be as simple as asking what is the highest grade level the patient attained. (https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy/index.html)

4. Use lay terminology when communicating with patients and their families.

5. Develop plans for communicating with patients who are hearing impaired, deaf, or have limited English proficiency (https://www.ada.gov/effective-comm.htm).

6. Utilize the teach-back method when providing patients with instructions and information. This technique requires that patients repeat the information provided in their own words. The teach-back method is particularly useful in assessing patients' understanding of:
    - Informed consent discussions
    - Medication instructions including side effects and adverse reactions
    - Test preparation
    - Follow-up instructions

    If the patient is unable to convey the information, it should be restated in simpler terms, perhaps utilizing pictures and/or drawings.

7. Evaluate your educational tools and consent forms to determine the grade level at which they are written. This will allow you to provide written materials that will be understandable to the majority of your patient population. Techniques that determine the readability and comprehension levels of documents are available from numerous sources including:
    - http://www.cms.gov/Outreach-and-education/Outreach/writtenMaterialsToolkit/downloads/toolkitpart07.pdf
    - http://www.readabilityformulas.com/

8. At the conclusion of your patient encounter, ask the patient/family if they have any questions or concerns that have not been addressed.

9. Medical record documentation should reflect all aspects of patient interactions and comprehension. This will demonstrate the effectiveness of your communication skills and promote patient satisfaction, which may reduce your potential exposure to claims of malpractice.

Tip #12: Promoting Communication Between Referring and Consulting Physicians

The Risk: Lack of communication between providers may result in poor coordination of care. This may include a delay in diagnosis or treatment, the failure to order diagnostic testing or act upon abnormal test results, or the failure to prescribe appropriate medications. Clearly defining the roles and responsibilities of the referring and consulting physicians will promote safe and effective patient care.

Recommendations:

1. A tracking system should be in place to determine if the patient obtained the recommended consultation.

2. Referring physicians should develop a process for determining whether a report has been received from the consulting physician.

3. All consultation reports must be reviewed by the referring physician prior to being placed in the patient's medical record.

4. If a patient has been non-compliant in obtaining the recommended consultation, follow-up is necessary. Document all attempts to contact the patient and any discussions with the patient, including reinforcement of the necessity and reason for the consultation.

5. If a report is not received in a timely manner, contact the consultant to determine if the patient has been seen and whether a report has been generated.

6. Consultants should routinely send reports to referring physicians in a timely manner. These reports should include the:
    - findings;
    - recommendations including interventions; and
    - delineation of provider responsibility for treatment and follow-up of test results.

7. The consultant should contact the referring physician when a patient fails to keep an appointment. The medical record should reflect the missed appointment, as well as notification of the referring physician.

8. All telephone conversations between referring and consulting physicians should be documented. Timely communication must occur when an urgent or emergent clinical finding is identified.

Tip #23: Managing Patient Noncompliance

The Risk: Patient noncompliance is one of the most difficult challenges for healthcare providers. Noncompliance may include missed appointments and the failure to follow a plan of care, take medications as prescribed, or obtain recommended tests or consultations. The reasons given by patients for noncompliance vary from the denial that there is a health problem to the cost of treatment, the fear of the procedure or diagnosis, or not understanding the need for care. Physicians and other healthcare providers need to identify the reasons for noncompliance and document their efforts to resolve the underlying issues. Documentation of noncompliance helps to protect providers in the event of an untoward outcome and allegations of negligence in treating the patient.

Recommendations:

1. Establish an office policy to notify providers promptly of all missed and canceled appointments. We recommend that this be done on a daily basis.

2. Formalize a process for follow up with patients who have missed or cancelled appointments, tests, or procedures. This process should include recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow up should be.
    a. Consider having the physician make a telephone call to the patient as a first step when the patient's condition is serious.
    b. If the patient's clinical condition is stable or uncomplicated, staff should call the patient to ascertain the reason for the missed or canceled appointment.
    c. All attempts to contact the patient must be documented in the medical record.
    d. If no response or compliance results, send a letter by certificate of mailing outlining the ramifications of continued noncompliance.

3. During patient visits, emphasize the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations.

4. Seek the patient's input when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.

5. To reinforce patient education, provide simple written instructions regarding the plan of care. Use the teach-back method to confirm that patients understand the information and instructions provided.

6. With the patient's permission, include family members when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.

7. When there is continued noncompliance, patient discharge from the practice may be necessary. The attorneys at Mercado May-Skinner* are available to discuss patient noncompliance and the discharge of a patient.

*The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.

Visit our website at MLMIC.com

CASE STUDY NO. 1: DELAY IN DIAGNOSIS OF LUNG CANCER

A 63-year-old married female presented to the hospital emergency department (ED) on November 25, 2012, complaining of chest pain, shortness of breath and diaphoresis. The pain had been intermittent for one week, which she described as "boring through the back." The patient had a history of mitral valve prolapse and a weakened aorta. She was initially seen by the ED physician and was worked up for coronary artery disease. A portable AP chest x-ray was ordered, and the ED physician's impression of the study was negative. The physical examination was unremarkable, and her serial cardiac enzymes were normal.

The patient was admitted to the cardiac unit by her attending physician (an internist) and was seen by a cardiology consultant. She had a cardiac catheterization with normal left ventricular function and normal coronary arteries.

The following day, November 26, 2012, the patient's chest x-ray was interpreted by a radiologist who noted a vague nodular density overlying the left scapula. She suggested an erect PA view of the chest when clinically feasible and a CT scan if clinically indicated. The radiologist later testified that she did not review the prior reading from the ED, which was available in the hospital's information system, because the patient had been admitted. There was no indication in the report that the finding was communicated to the attending physician or anyone else. It was the radiologist's understanding that once her record was dictated and she approved it, it automatically was printed on the floor. It then went into the record and was available to any physician in the hospital's electronic health record system.

On November 27, 2012, the patient was discharged from the hospital by her attending physician, who did not prepare a discharge summary, which apparently wasn't required by the hospital because she was admitted less than 48 hours. The attending physician later testified that he did not review the radiologist's report but relied on the ED physician's reading of the chest x-ray, as documented in the record. He also testified that it was usual to receive a telephone call when further testing was suggested.

In the spring and early summer of 2013, the patient required orthopedic surgery on her knee, which was scheduled for September. On pre-surgical testing, a chest x-ray was performed which revealed a 2.5 cm mass in the left lung. Following a PET CT scan and a mediastinoscopy in early October 2013, she was determined to have stage IIIB nonresectable lung cancer. The patient received chemotherapy in conjunction with radiation therapy but died approximately one year later.

Prior to her death, the patient and her husband initiated a lawsuit against the attending physician, the ED physician, the radiologist, and the hospital alleging negligent care and treatment and a failure to diagnose lung cancer, which had metastasized.

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Module 5

High Exposure Liability Case Study Analyses – Part 1

Presented by:
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High Exposure Liability – Part 1

Objectives

At the end of this presentation, participants will be able to:

- Describe ways to effectively communicate the results of diagnostic imaging studies.
- Formulate strategies to ensure adequate tracking and follow-up of diagnostic tests that are ordered.
- Identify potential cognitive biases when establishing provisional diagnoses for patients.
- Discuss the negative impact of finger pointing between defendants in a malpractice case.

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Radiologist Issues

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Radiologist Issues

Delay in Diagnosis of Lung Cancer

- **The radiologist failed to:**
  - Compare the film reading to the reading in the ED.
  - Follow "Critical test and critical results reporting policy" in effect at the hospital.
- **Critical results are laboratory results with the following attributes:**
  - They are unexpected or unpredictable in a particular clinical setting.
  - They have the potential for serious adverse consequences to the patient or others if not dealt with promptly.
  - An appropriate action is indicated.
  - The reporting department must communicate critical values/results only to a licensed staff member caring for the patient within 10 minutes after the result has been confirmed.

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Radiologist Issues

Delay in Diagnosis of Lung Cancer

- **The radiologist took the position that her finding was not a "critical result".**
- **Hospital policies and procedures support the position that the radiologist had a further obligation to notify the attending and/or ED of the discrepancy as well as follow the ACR guidelines (DIRECTLY COMMUNICATE unexpected, significant positive findings.)**
- **Problem is not one of interpretation, but of communication.**

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Attending Internist Issues

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Attending Internist Issues

Delay in Diagnosis of Lung Cancer

- **Was it the attending internist's responsibility to ensure the patient's ED x-ray report was received and acknowledged prior to her discharge from the hospital?**
  - The attending physician testified that the finalized diagnostic report was not in the chart at the time of the patient's discharge on November 27, and that he would usually get a telephone call from the radiologist if the finalized report differed from the preliminary one rendered in the ED or if follow-up imaging was needed for a significant finding.

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Attending Internist Issues

Delay in Diagnosis of Lung Cancer

- **Failure to prepare a discharge summary may have contributed to the lack of follow-up.**
  - The hospital did NOT require one, but the attending still failed to retrieve and review the radiology report in the hospital electronic system before the patient's discharge.
- **All diagnostic test results should be reviewed prior to discharge.**

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Attending Internist Issues

Delay in Diagnosis of Lung Cancer

- **The attending physician initially testified that the finalized diagnostic report was not in the chart at the time of the patient's discharge on November 27.**
- **It was established at the deposition that the radiology report in question was transcribed at 2:20 p.m. on November 26, 2012, and was in the electronic record system and available for the internist's review.**
  - The internist conceded to his defense attorney that it was available in the EHR system but he did not access same.

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Attending Internist Issues

Delay in Diagnosis of Lung Cancer

- **The internist claimed he relied on the ED physician's preliminary reading of the chest x-ray as documented in the ED record.**
  - The ED report was not an official report and should not have been relied on. It was the internist's responsibility to ensure that this patient's chest x-ray report was received and acknowledged prior to discharging her from the hospital.

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Attending Internist Issues

Delay in Diagnosis of Lung Cancer

- **Chest pain was the primary focus due to the patient's previous cardiac issues**
  - Was this cognitive bias?
- **Chest pain was described as "boring through the back" which is classic in cases of lung cancer**
  - The patient underwent a cardiac catheterization that was reportedly negative. The serial cardiac enzymes were negative and the physical examination was unremarkable requiring further work-up to explain the cause of her chest pain.
- **After admission, a routine PA and lateral view chest x-ray should have been ordered.**
  - Had a routine chest x-ray been ordered as per usual follow-up, the decedent's lung lesion would more likely than not been diagnosed.

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Finger Pointing Issues

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Finger Pointing Issues

Delay in Diagnosis of Lung Cancer

- **Experts were concerned with the "finger pointing" testimony**
  - The attending internist claimed that in terms of the radiology report, it is "usual to receive a telephone call when further testing was suggested."
- **"Finger pointing" makes it easier for the plaintiff's attorney to prove the case**
  - Leaves jurors with the impression that there is liability associated with the patient's care.

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Causation and Outcome

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Causation

Delay in Diagnosis of Lung Cancer

- **Causation in this case**
  - 10-month delay in diagnosis.
    - The oncology expert for the defense stated he would feel comfortable arguing that the patient had fairly extensive disease at time of diagnosis (stage IIIa lung cancer).
    - Plaintiff's expert will likely argue that the patient had stage I lung cancer in November and if all the right things were done, including surgical excision with the patient doing well after surgery, her five-year survival would have been 75% for a tumor measuring this size.
    - Most lung cancers of this size are not curable. However, it would be difficult to assert at trial that the 10-month delay didn't matter.

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Outcome

Delay in Diagnosis of Lung Cancer

- **Patient was primary caretaker of her two grandchildren after her son was divorced.**
- **This case settled for $1.3 Million**
  - Radiologist – 50%
  - Attending Internist – 50%

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Risk Management Recommendations

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Risk Management Recommendations

Delay in Diagnosis of Lung Cancer

- **Follow the American College of Radiology Parameters for Communication of Diagnostic Imaging Findings when there are discrepant or significant and unexpected findings.**
- **Follow hospital policies and protocols for communicating significant abnormal test results to the patient's healthcare provider.**
- **Follow-up on diagnostic tests in a timely fashion, especially prior to a patient's discharge from the hospital.**
- **Consider the role of subtle cognitive biases when establishing a provisional diagnosis.**

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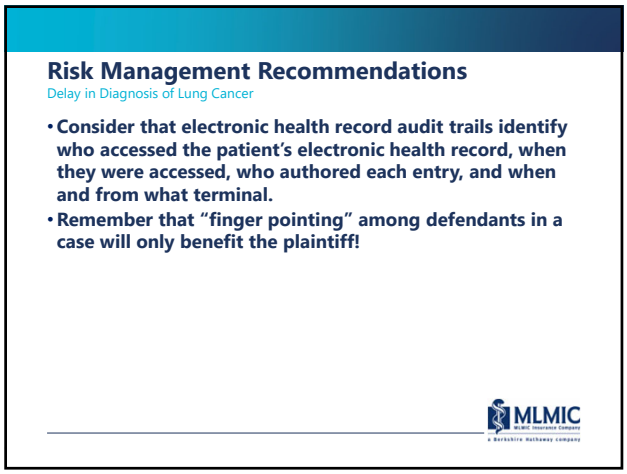
Risk Management Recommendations
Delay in Diagnosis of Lung Cancer
• Consider that electronic health record audit trails identify who accessed the patient's electronic health record, when they were accessed, who authored each entry, and when and from what terminal.
• Remember that "finger pointing" among defendants in a case will only benefit the plaintiff!
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Tip #15: Communicating and Following-Up Critical Test Results

The Risk: The communication of test results is an important part of providing care and may involve various healthcare professionals. Test results may be over-looked, lost, scanned into the wrong record, etc. Abnormal test results requiring follow-up present an additional risk if they are not received, reviewed, or communicated to the patient. This may result in missed or delayed diagnoses, patient injuries, and subsequent claims of malpractice. If a physician orders a test, he or she is responsible for ensuring that the results have been received and reviewed. Physician practices should have policies and procedures in place for the management of test results.

Recommendations:

1. All ordered tests must be documented in the patient's medical record.

2. A process should be in place to confirm and document the receipt of test results. Many electronic health record systems allow practices to efficiently track pending laboratory/diagnostic studies.

3. All incoming laboratory reports and diagnostic tests must be reviewed and authenticated by the provider.

4. The provider must document communication of the test results to the patient. Any recommendations or interventions must also be documented.

5. Providers should have a system in place for the follow-up of pending laboratory/diagnostic test results for their patients who have been discharged from the hospital or emergency department. Receipt and review of these results should be documented in the patient's medical record. Communication of the results to the patient should also be documented.

6. It is important for physicians to clearly establish who is responsible for follow-up when tests are ordered for a patient by another specialist or consultant.

7. Patients should be advised of all test results, normal or abnormal. This communication should be documented in the medical record.

CASE STUDY NO. 2: FAILURE TO DIAGNOSE CEREBRAL ANEURYSM FOLLOWING GALLBLADDER SURGERY RESULTING IN NEUROLOGICAL IMPAIRMENT

A 48-year-old female presented to the hospital emergency department (ED) complaining of right upper quadrant pain on 12/2/06, after consuming a meal of pizza and chicken wings. She was seen in consultation by a general surgeon and her work-up was consistent with cholecystitis. She underwent a laparoscopic cholecystectomy on 12/5/06, under general anesthetic. The procedure was uncomplicated. The general surgeon was assisted by his physician assistant (PA).

On 12/6/06, at about 1:00 A.M., the patient complained to the nurse of a headache. She complained of a small amount of emesis and feeling dizzy. She was complaining of pain 10 out of 10. The headache was not described in any detail. She was given a cold compress for her head and Dilaudid.

By 8:00 A.M. in the morning, the patient continued to complain of a headache and had her menses. There was no documentation that she had headaches with her menses. Of note, her blood pressure ranged between 168/102 and 144/92 on 12/6/06. By 12/7/06, she was ambulatory and tolerating a liquid diet and was discharged. Her blood pressure was 148/97.

The PA dictated the discharge summary on 12/6/06 (a day prior to her discharge). He did note that the patient was complaining of a headache, but which she attributed to her menstrual cycle. In the documentation in the record, there was no mention of neurological findings. There was no description of an intolerable headache or "the worst" headache the patient had ever had.

The patient called the surgeon's office on 12/8/06, at 7:50 A.M., complaining of a headache not responsive to Motrin or Tylenol. She was advised by the PA to call her primary care physician (PCP) or get back to the surgeon if she was unable to reach her PCP or her symptoms worsened. (Of note, the surgeon later added his signature to the progress note. A copy of the original note was forwarded to the plaintiff's attorney and the surgeon's signature was not present at that time.)

The patient presented at the hospital ED on 12/8/06, at approximately 10:30 A.M., and a CT scan revealed an intracranial hemorrhage. She was transferred to the neurosurgical service at another facility.

She came under the care of a neurosurgeon who performed an angiogram, which demonstrated a fusiform aneurysm in the distal internal carotid on the right side. On the evening of 12/8/06, he took the patient to the operating room and attempted to perform an embolization or coil placement. Due to the wide neck of the aneurysm, the coil did not stay in place even with a balloon. He abandoned the endovascular approach.

On 12/9/06, the neurosurgeon took the patient to the operating room with the intention of reconstructing the internal carotid artery. During the dissection, the aneurysm ruptured with diffuse bleeding. The internal carotid was clipped proximally and distally. There was increased intracranial pressure requiring a ventricular drain and pressure monitor. A repeat angiogram revealed a patent middle cerebral artery and anterior communicating artery. A subsequent

CASE STUDY NO. 2: FAILURE TO DIAGNOSE CEREBRAL ANEURYSM FOLLOWING GALLBLADDER SURGERY RESULTING IN NEUROLOGICAL IMPAIRMENT (CONT.)

angiogram revealed complete occlusion of these vessels. The patient returned to the operating room on two different occasions for debridement of infarcted brain tissue. Weeks after surgery when the patient awoke from a coma, she was left with left hemiplegia, incontinence of stool and urine, and significant cognitive deficits.

Subsequently, a lawsuit was initiated against the general surgeon, his PA, and the original treating hospital alleging negligent treatment of headaches prior to discharge, resulting in a failure to timely diagnose a cerebral aneurysm resulting in neurological impairment.

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Module 6

High Exposure Liability
Case Study Analyses – Part 2

Presented by:
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High Exposure Liability – Part 2
Objectives

At the end of this presentation, participants will be able to:
- **Explain the importance of addressing and documenting new, significant patient complaints.**
- **Recognize and address the negative effects of gender bias in clinical decision making and healthcare.**
- **Discuss the concept of "causation" and its significance in claims related to diagnostic error.**
- **Describe vicarious liability for attending physicians that are supervising advanced practice providers.**

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General Surgeon and Physician Assistant Issues

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General Surgeon and Physician Assistant Issues
Failure to Diagnose Cerebral Aneurysm

- **Most of the outside physician experts that initially reviewed the case opined it was defensible on the issue of negligence and causation.**
  - The care and treatment provided was reasonable and within the standard of care.
  - No question the patient had gallbladder disease and surgery was indicated.
  - No evidence the patient had a headache prior to surgery.
  - There was no indication that the patient had neurological findings or a headache out of proportion to what would be considered her normal and, therefore, no clear indication to pursue evaluation of the headache prior to discharge.

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General Surgeon and Physician Assistant Issues
Failure to Diagnose Cerebral Aneurysm

- **Most of the outside physician experts that initially reviewed the case opined it was defensible on the issue of negligence and causation.**
  - There are clearly many causes for headache in a postop patient, including the use of analgesics and post anesthetic.
  - There was no indication that the patient's headache required additional workup, such as a CT scan prior to discharge.

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General Surgeon and Physician Assistant Issues
Failure to Diagnose Cerebral Aneurysm

- **One expert neurologist who later reviewed the case had serious concerns about prevailing at trial.**
  - This expert indicated that the patient had a "sentinel bleed" while hospitalized following her laparoscopic gallbladder surgery.
  - It was mistaken for a "menstrual headache" and simply treated symptomatically with no investigation.

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **The expert neurologist felt the patient should have been asked about the headache, this inquiry should have been documented and additional evaluation performed**
  - The PA did not discuss or provide any details regarding the patient's headache.
    - Were her "menstrual headaches" 10 out of 10? She wasn't asked and nothing was recorded.
  - The headache in question was accompanied by dizziness.
    - Were her "menstrual headaches" usually accompanied by dizziness? She wasn't asked and nothing was recorded.

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **The patient was discharged on 12/7/2006.**
- **The only indication in the chart that the patient ever discussed her "menstrual headache" was in the discharge summary by the surgical PA.**
  - No details were provided.
  - There was no contemporaneously written note describing any discussion of her headache history.
  - The admission and triage forms did not indicate any history of headache.
  - The headache was described as "10 out of 10," which implies that this was as bad a headache that she had ever experienced.

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **The patient was given Dilaudid for the headache.**
- **Cold compresses were applied.**
- **Did the patient require that type of strong narcotic medication for her "menstrual headaches"?**
  - She wasn't asked and nothing was recorded.
- **She was given several doses of Ketorolac.**
- **The headache never went away, although it responded somewhat to the medications.**
- **Both Motrin and Tylenol were ordered on the day of discharge.**

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **The headache and dizziness were never investigated.**
- **A neurologic evaluation was not performed.**
- **A neurology consultation was not requested.**
- **A CT scan of the head was not performed.**
- **Details of her prior headache history were never obtained.**
- **There was no mention of headaches in the admission history and physical.**

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **The expert cardiovascular/vascular surgeon who reviewed the case also identified some issues.**
- **The primary issue identified had been that the PA dictated the discharge summary on the day before the actual discharge.**
  - He did note the patient was complaining of headaches, but which the patient attributed to her menstrual cycle.
  - The PA made no other reference to the severity of the headaches or their locations in his discharge summary.
    - Apparently, the PA placed reliance on the patient's comment about her usual headaches.

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General Surgeon and Physician Assistant Issues

Failure to Diagnose Cerebral Aneurysm

- **Gender bias can lead to disparities in healthcare.**
- **Here the patient's headache was attributed to her menstrual cycle and not taken seriously.**
- **Women have been victims to bias in medical diagnosis and treatment which can impact physician liability.**

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Causation

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Causation

Failure to Diagnose Cerebral Aneurysm

- **Initially, most reviewers felt that there was a causation defense in this case.**
  - It was initially believed that the non-party neurosurgeon would state that an earlier diagnosis would have made no difference in the outcome of this case.

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Causation

Failure to Diagnose Cerebral Aneurysm

- **One defense expert stated that the acute rupture of the aneurysm was an inherent risk of the surgery upon which he described as a "very pathological vessel."**
  - This was a saccular aneurysm on angiogram, which then dissected during surgery. He stated that this aneurysm occurred in a very abnormal location and that had a very broad base.
  - He believed it had a very thin wall, creating a very dangerous situation, and that is why it ruptured intraoperatively giving rise to the need to clamp the middle cerebral artery.
    - He believed this would have happened even had this surgery been performed days earlier.

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Causation

Failure to Diagnose Cerebral Aneurysm

- **In the expert's opinion, the patient's deficits occurred because of the arterial occlusion which was necessitated during the surgery when the artery ripped open, not as a result of any delay in diagnosing or treating this aneurysm.**

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Causation

Failure to Diagnose Cerebral Aneurysm

- **Another surgery expert felt very strongly that the surgery was the cause of the injuries in this lawsuit.**
  - He was in no way critical of defendant neurosurgeon.
  - He believed that this surgery would have been required to save her life regardless of when it was performed and that the need to clamp the middle cerebral artery was a result of the nature of the aneurysm, not a result of any delay in diagnosis.

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Causation

Failure to Diagnose Cerebral Aneurysm

- **The subsequent treating neurosurgeon later testified in his non-party deposition that if he had been brought into the case earlier, he would have been able to do things differently.**
  - He claimed there would have been less swelling, less clot, less bleeding, and therefore, his surgery may have been technically easier.
  - That may have allowed him to use a stent/coil
    - He originally told defense counsel that a stent was out of the question because it would require Plavix and aspirin, something that he would not give because of recent gallbladder surgery.
- **In any case, the causation defense, could no longer prevail.**

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Causation

Failure to Diagnose Cerebral Aneurysm

- **At trial, the plaintiff's neurosurgery expert testified that things could have been different if the patient had gotten to the neurosurgeon sooner.**
  - He was of the opinion that had an earlier diagnosis been made, the patient would not be in her current condition.
- **Plaintiff's counsel played parts of the neurosurgeon's EBT, which the expert agreed with completely.**

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Other Weaknesses

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Other Weaknesses

Failure to Diagnose Cerebral Aneurysm

- **The cardiovascular and vascular surgery expert also indicated that the patient was hypertensive upon presentation to the hospital and had some relatively elevated blood pressures all the way through her admission, right up to discharge.**
  - This was never medically addressed.
- **However, one of the neurosurgery experts commented that her elevated blood pressures were consistent with a postoperative patient who was experiencing normal postoperative pain.**

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Other Weaknesses

Failure to Diagnose Cerebral Aneurysm

- **The surgeon added a signature at an unknown time to a progress note from his office**
- **This suggested an alteration of the record.**
  - A copy of the original note was forwarded to the plaintiff's attorney and the surgeon's signature was not present at that time.
- **A potentially altered record can have a significant impact on a malpractice claim**
  - Puts the credibility of both the record and the provider into question.
  - Can make an otherwise defensible claim indefensible.

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Advanced Practice Providers/Vicarious Liability

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Advanced Practice Providers/Vicarious Liability

Failure to Diagnose Cerebral Aneurysm

- **Vicarious liability exists for attending physicians supervising advanced practice providers.**
  - The plaintiff's attorney wanted to get the general surgeon to admit he was actively negligent in supervising the PA.
  - In this case, the surgeon signed the discharge note after the events of the subarachnoid hemorrhage played out.
  - He also did not see the patient prior to discharge.

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Outcome/Damages

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Outcome/Damages

Failure to Diagnose Cerebral Aneurysm

- The damages are severe, and our in-house neurology expert believed it was not worth the risk of an adverse verdict far exceeding the available coverage.
- The case was settled at trial for $2.2M on behalf of the PA and the surgeon, as his employer for vicarious liability.
- The claimant settled with the hospital prior to trial for $3.0M.

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Risk Management Recommendations

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Risk Management Recommendations

Failure to Diagnose Cerebral Aneurysm

- Perform and document a history and physical examination when a patient reports pertinent new symptoms/complaints.
- Recognize and address the negative effects of gender bias in clinical decision making.
- Be aware of supervisory responsibilities/vicarious liability when employing advanced practice providers.
- Never alter the medical record.

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Thank You!

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Tip #13: Handling Patients' Complaints Properly

The Risk: Patient satisfaction is an integral part of providing healthcare, regardless of the clinical setting. Dissatisfaction with medical care may be a harbinger of medical malpractice litigation. When you receive a complaint about care, how you handle the situation may directly impact the potential for any future litigation. All physician office practices should have a policy or protocol in place to address patient complaints.

Recommendations:

1. One individual should be identified and consistently used as the primary person to address patient complaints. This is often the office manager.

2. All staff should know to whom complaints should be addressed, as well as what information constitutes a complaint that requires attention or intervention by that person. This should, at a minimum, include:
    - written or verbal complaints regarding medical care;
    - billing or payment issues that involve concerns about the clinical care; and
    - letters of complaint from third party payors, IPRO, NYS Department of Health, or other regulatory entities. We recommend that you retain personal counsel for assistance in formulating written responses to such agencies.

3. Effective communication skills are essential when addressing a patient complaint.
    - Express concern for the patient's condition and wellbeing.
    - Never be adversarial or defensive.
    - Be an active listener and ask questions when appropriate.
    - Avoid judgmental comments about patients and their families, or negative remarks about staff, physicians, or other providers.
    - Investigate complaints and follow up as indicated.

4. Conversations with patients should be documented in the medical record. It is appropriate to quote the patient when documenting their concerns.

5. Keep letters of response to complaints concise and simple. A copy of the written response should be kept in the patient's medical record.

6. When complaints involve clinical issues or are complex, physicians or other providers should be involved in addressing the situation.

7. Attorneys' requests for records may be an indication of a patient's unhappiness. The patient's medical record should be reviewed in conjunction with these requests in an effort to assess the potential for medical malpractice litigation.

8. Consider seeking guidance when presented with unusual or difficult situations. MLMIC staff is available to assist insureds with handling complaints, formulating responses, and determining potential exposure to claims of malpractice.

9. Never document any contact with MLMIC or your attorneys in the patient's medical record.

Tip #23: Managing Patient Noncompliance

The Risk: Patient noncompliance is one of the most difficult challenges for healthcare providers. Noncompliance may include missed appointments and the failure to follow a plan of care, take medications as prescribed, or obtain recommended tests or consultations. The reasons given by patients for noncompliance vary from the denial that there is a health problem to the cost of treatment, the fear of the procedure or diagnosis, or not understanding the need for care. Physicians and other healthcare providers need to identify the reasons for noncompliance and document their efforts to resolve the underlying issues. Documentation of noncompliance helps to protect providers in the event of an untoward outcome and allegations of negligence in treating the patient.

Recommendations:

1. Establish an office policy to notify providers promptly of all missed and canceled appointments. We recommend that this be done on a daily basis.

2. Formalize a process for follow up with patients who have missed or cancelled appointments, tests, or procedures. This process should include recognition of the nature and severity of the patient's clinical condition to determine how vigorous follow up should be.
    a. Consider having the physician make a telephone call to the patient as a first step when the patient's condition is serious.
    b. If the patient's clinical condition is stable or uncomplicated, staff should call the patient to ascertain the reason for the missed or canceled appointment.
    c. All attempts to contact the patient must be documented in the medical record.
    d. If no response or compliance results, send a letter by certificate of mailing outlining the ramifications of continued noncompliance.

3. During patient visits, emphasize the importance of following the plan of care, taking medications as prescribed, and obtaining tests or consultations.

4. Seek the patient's input when establishing a plan of care and medication regimen. Socioeconomic factors may contribute to the patient's noncompliance.

5. To reinforce patient education, provide simple written instructions regarding the plan of care. Use the teach-back method to confirm that patients understand the information and instructions provided.

6. With the patient's permission, include family members when discussing the plan of care and subsequent patient education in order to reinforce the importance of compliance.

7. When there is continued noncompliance, patient discharge from the practice may be necessary. The attorneys at Mercado May-Skinner* are available to discuss patient noncompliance and the discharge of a patient.

*The attorneys of Mercado May-Skinner are employees of MLMIC Insurance Company.

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