Tales From the Hotline

Faculty: Eric Zacharias, MD; Dan Rosenquist, MD

Activity Date: September 9, 2024

Activity Location: NE

Activity Time: 6:00-7:00 PM

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- Planner/Faculty: Eric Zacharias, MD
- Reviewer: Alan Lembitz, MD
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- Planner: Dennis Boyle, MD

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1. Read the Financial Disclosures.
2. Read the target audience, learning objectives, and financial disclosures.
3. Complete the LIVE educational activity.
4. Complete the activity evaluation/assessment on COPIC's LMS platform.

It is estimated that this activity will take approximately 1 hour to complete.

Levels of Evidence

All planners/reviewers must document the evidence for patient care recommendations made in any CME/CE activity.

COPIC has adopted the following American Academy of Family Physicians Rating:

Level B (Other Evidence):
A well-designed, nonrandomized clinical trial. A nonquantitative systematic review with appropriate search strategies and well-substantiated conclusions. Includes lower quality RCT's, clinical cohort studies and case-controlled studies with nonbiased selection of study participants and consistent findings. Other evidence, such as high-quality, historical, uncontrolled studies, or well-designed epidemiological studies with compelling findings, is also included.

Goals & Purpose

This activity describes the indications, technique, and best use of COPIC's Physician Hotline, and highlights the role of the interprofessional team in the management of their patients.

Target Audience

This **LIVE** activity is designed to meet the educational needs of healthcare professionals who diagnose and treat patients including nurses, residents, student nurses, and physicians' assistants.

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- Planner:

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1. Read the Financial Disclosures.
2. Read the target audience, learning objectives, and financial disclosures.
3. Complete the LIVE educational activity.
4. Complete the activity evaluation/assessment on COPIC's LMS platform and/or Survey Monkey

It is estimated that this activity will take approximately X hours to complete.

Course Learning Objectives

- Articulate opportunities to contact COPIC for clinical or medicolegal concerns.
- Anticipate high-risk clinical scenarios in different care settings and actions to prevent adverse outcomes.
- Describe clinical situations where management of unexpected outcomes may be considered.
- Analyze situations that may increase risk for systems failures that lead to patient risk.

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Hotline Origin Story

Busy providers sometimes are in very time-sensitive situations and need experienced PSRM physicians.

Office and Hospital Support staff and care team members may be tasked with questions, concerns, situations by providers or facility or other issues in complex systems and need experienced PSRM guidance.

We asked, “What would I, as a busy provider, find useful? Answer: COPIC’s hotline.

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Question: When Should I call?

Answer: Anytime you are not sure (*Don't document the call in the MR*)

CATEGORIES INCLUDE

- Legal
- Regulatory
- Clinical
- Confidentiality
- Cyber issues
- HR issues
- Anything you want to run by an experienced physician risk manager

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Missed Finding

- 48-year-old in severe MVA
- Trauma center work-up
- CXR report: Incidental 8 cm lung nodule with recommended follow-up
- Surgery → Rehab → Home
- 2 years later, PCP works up persistent cough
- 1.5 cm lung cancer metastatic to bone
- PCP goes into EMR and sees radiology report and recs from 2 years ago

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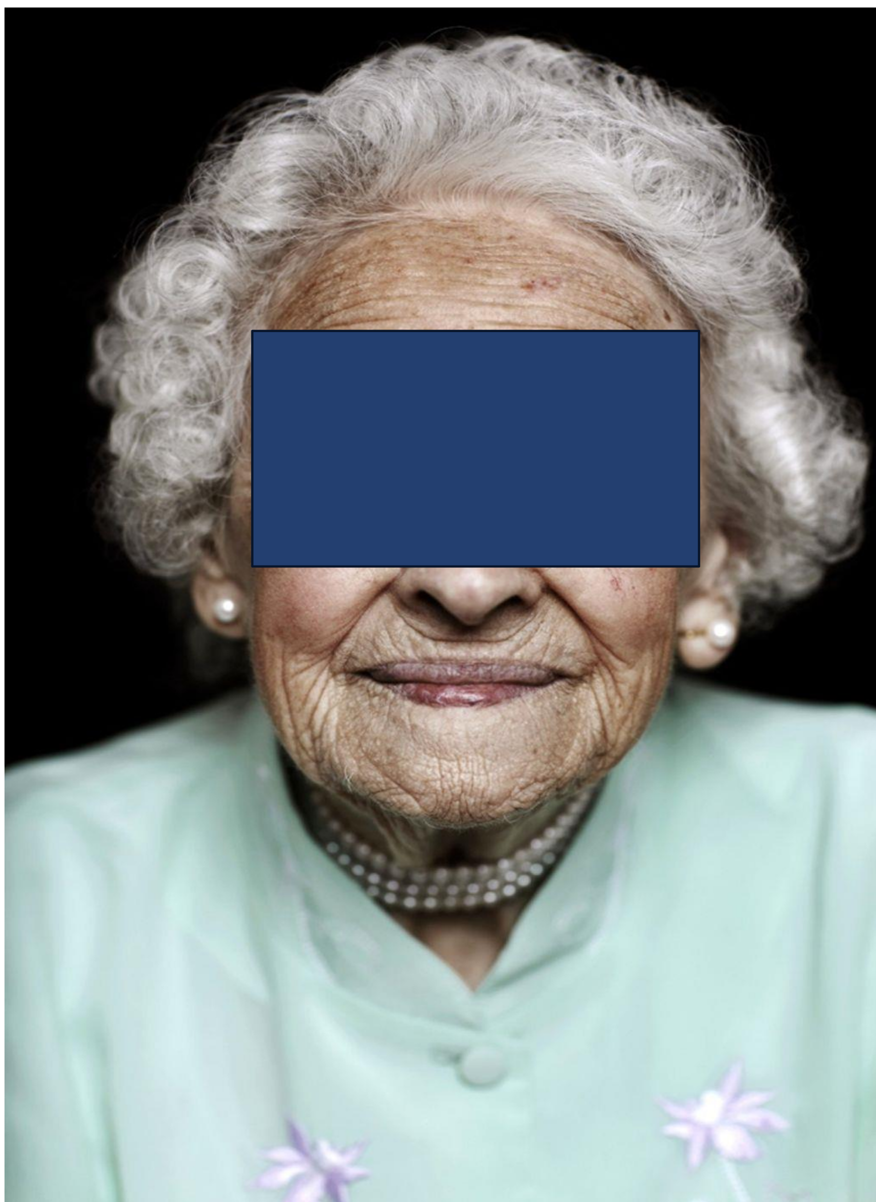
Now what?

Call COPIC and report the occurrence

Who’s “to blame”?

Disclosure: what do I tell the patient?

What if she “_______________”? (Fill in the blank)



CASE:

- Surg. Center nurse director calls: "help me"

- 82 y/o, very healthy, independent- (i) nasolacrimal duct surg., **that day added bilat. blepharoplasty**
  - local to gen anesthesia, :15 to 1:30
  - no informed consent (told nurse to add it)
  -"has a ride" (actually doesn't)

- Rules for center- must have ride, must have someone at home– doc made staff mark has-- no ride, home alone

- Nurse manager trying to cancel

- surgeon apoplectic, "I own this center!"

- pt confused

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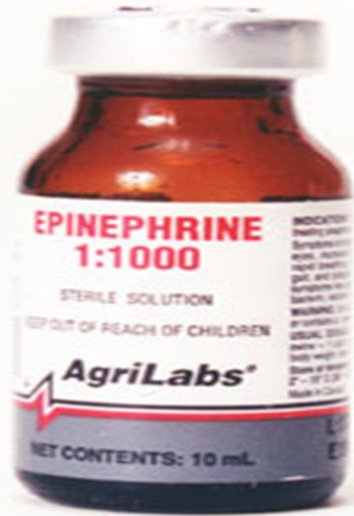
Will this be okay?

- Does that make it okay?
- Chart altering
- Improper consent
- Disruptive physician
- Outcome bias

Case:



- Nurse gives “3 of epi” (.3 was actual)
- 3 ml of the epi on the tray (1:1000!) IV
- Seafood allergy patient
- Tachy, HTN, Ischemia- + troponins
- Admitted
- How do we tell the patient?
- Would you be mad if the you were the patient? What if delay in being told?
- How prevent?
- What education resources do we have?

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The Neurologist

- Worked in for “new onset numbness in feet” and “viral syndrome” from PCP
- VS: 99.4, 105, 16, 105; back tender
- “I’m worried about SEA,…patient reluctant to get MRI or go to ER due to costs, what do I do?”

Informed Refusal

- Memorializes key points discussed in high-risk clinical scenarios
- May help maintain provider-patient relationship
- May serve as a "nudge device" and promote best care

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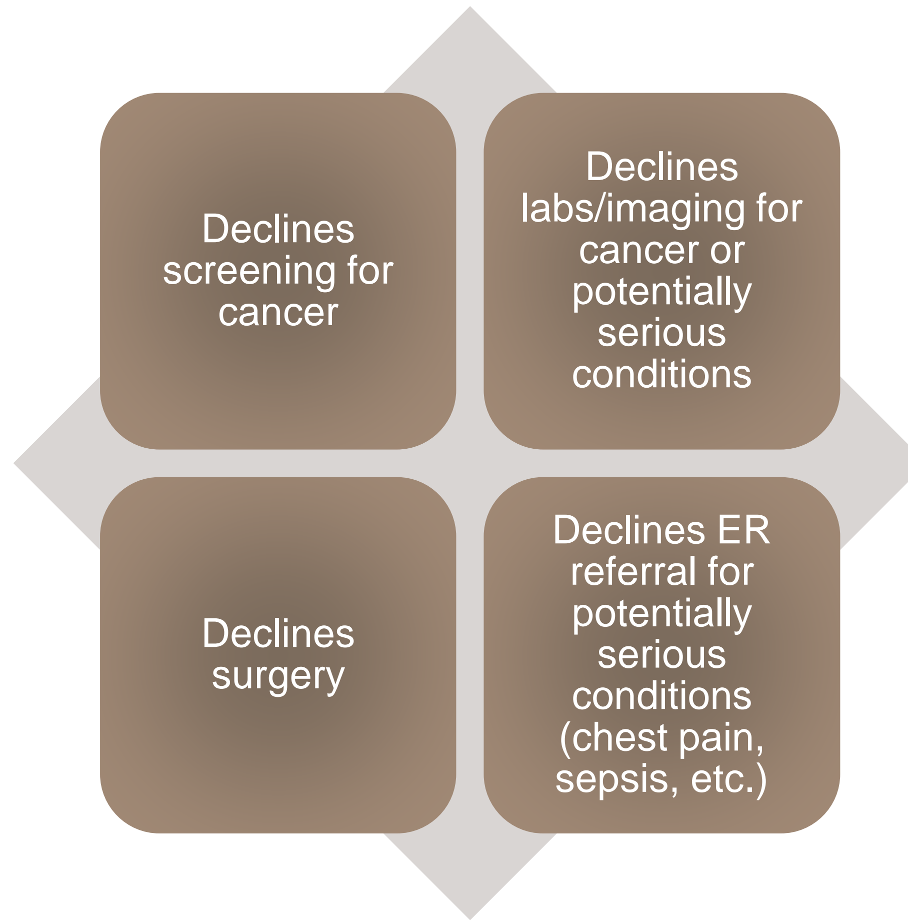
When to use Informed Refusal



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I want to care for a new patient out of state…

WITHIN YOUR STATE

1. Understand State telehealth rules
2. COPIC assumes you are doing telehealth- no need call
   - COPIC—You're already covered

ACROSS STATE LINES

1. Obtain required telehealth license for each State
2. Understand rules specific to each state
3. Check with your professional liability carrier

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From an Emergency Department: “We don’t do OB, what should we do?”

- Rural hospital no longer providing OB care
- Patient 32 weeks pregnant with “cramping”
- PCP suggested she “stop in” to ER for eval before 1.5-hour drive to OB
- “Do we need to see her?”
- “Do we let her drive to city? Ambulance?”
- “At what point do we admit? Deliver?”
- “What if complications?!?”

EMTALA

- Qualified individual **must** perform appropriate MSE to determine if medical emergency exists.
- If yes, stabilize ***or*** transfer (OB provider must certify benefits of transfer > risk **in writing**).
- Arrange for transfer with qualified personnel and equipment.
- Patient can decline transfer via consent or refusal.
- Appropriate medical screening cannot be delayed to inquire about insurance status or payment method.
- CMS deems emergency departments capable of delivering uncomplicated full-term deliveries and this is something they should be drilling.

Get Out in Front of This(*It is Going to be RSV Season Again*)

"…I only see kids, I only see adults..."

WHAT DOES COPIC SAY?

ASU Procedure- Airway Emergency

- 53 y/o male colonoscopy
- Rapid desaturation with sedation
- Difficult airway, ultimately intubated
- EMS called for transport
- Overnight ICU
- Complains about bills when GI and Anesth attempt disclosure

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	Traditional Response	CRP Response
Incident reporting by clinicians	Delayed	Immediate
Communication with patient/family	Deny/defend	Transparent, ongoing
Event analysis	Physician, nurse are root cause	Focus on Just Culture, system, human factors
Quality improvement	Provider training	Drive value through system solutions, disseminated learning
Financial resolution	Only if family prevails in a malpractice claim	Proactively address patient/family needs
Care for the Caregivers	None	Offered immediately
Patient/family involvement	Little to none	Extensive and ongoing

3Rs Payments

- Reimbursement, no provision for pain or suffering or permanent injury
- Not reportable to Medical Board
- Not reportable to NPDB
- No waiver or settlement

Allegations

- NP sees post-op patient in clinic
- Patient alleges assault in PACU
- Patient has reported to hospital, police, the Board
- Gives NP printed “timeline”
- How to document interaction?
- What to do with letter?

Documentation

Hospital records noted delirium in recovery room.

- *1. Brief note in chart regarding allegation (you listened).*
- *2. Law enforcement and authorities notified.*
- *3. Take care of her immediate needs (and then some)?*

Pro Tips from Defense Attorneys

- **Favorable:**
  - Clear
  - Timely
  - Outline thought process
  - “Tight ship”
- **Unfavorable:**
  - Inaccurate
  - Speculation or jousting
  - Template-based without clarity

Pro Tips from Defense Attorneys

- Foremost, **care for the patient**.
- Document in a **contemporaneous fashion your thought process**
  - engaged,
  - caring, and
  - following through
  - Template appropriate for clinical scenario and accurate
- Differential Dx:
  - many potential alternatives
  - care process is fluid and may be adjusted as more information becomes available over time.
- Document key conversations around important treatment decisions

YOU'RE LOOKING particularly GOOD TODAY

Late charting

- OK, stuff happens
- Transparency
- What occurred in the meantime?
    - The patient developed a complication
    - New data was delivered
    - The situation changed
    - You forgot something that was important at the time
- Information Blocking Rule…?
- Every hour increases the chance of intervening events

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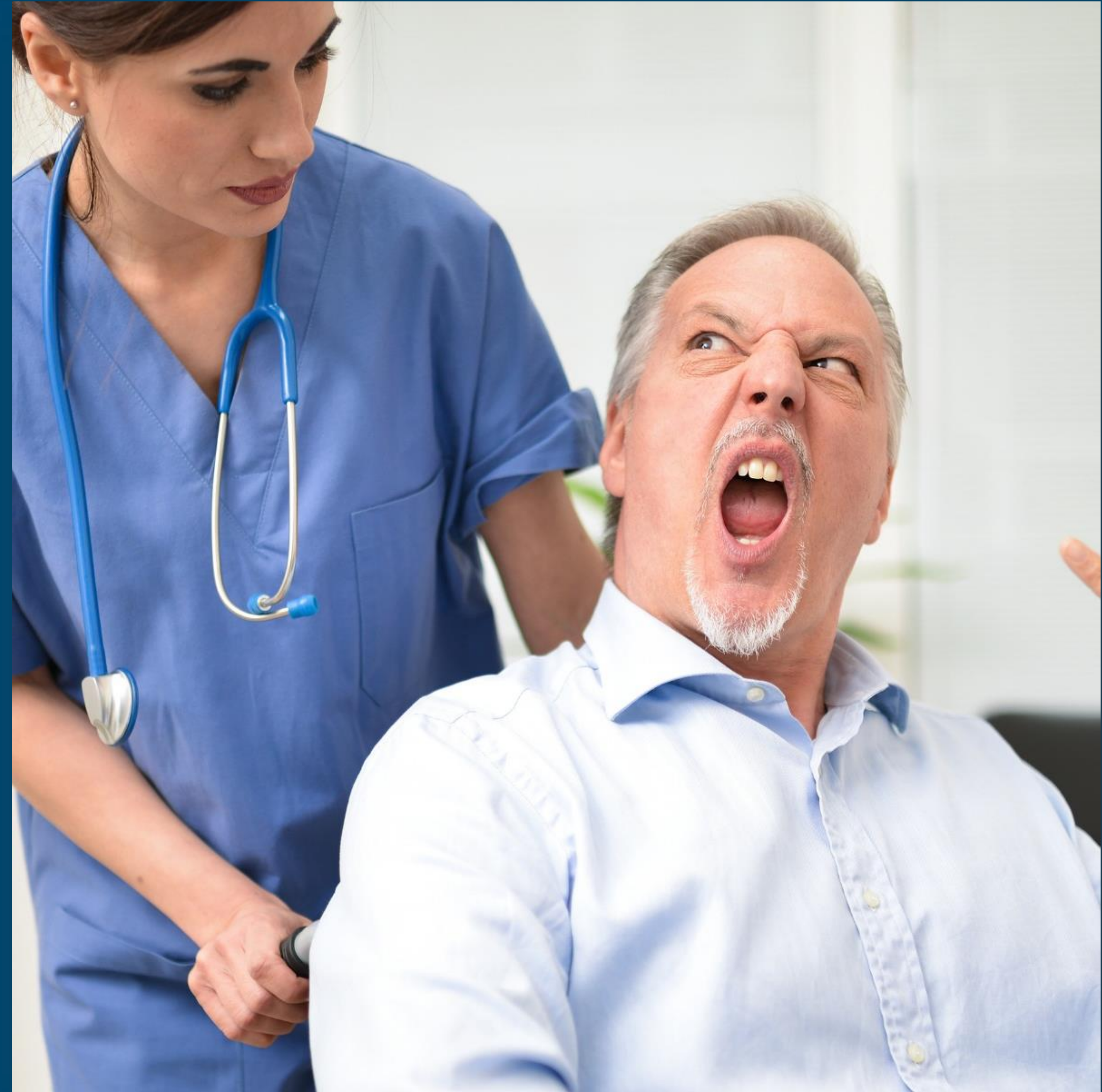
“Can I fire this guy?”

- 59-year-old 4 weeks post-op ankle surgery
- Patient “no show” for last 2 post op visits; meds had been renewed x 2
- Today’s visit, angry and aggressive to staff over wait time
- “He’s just using us for oxycodone refill”
- Can you dismiss the patient from practice?



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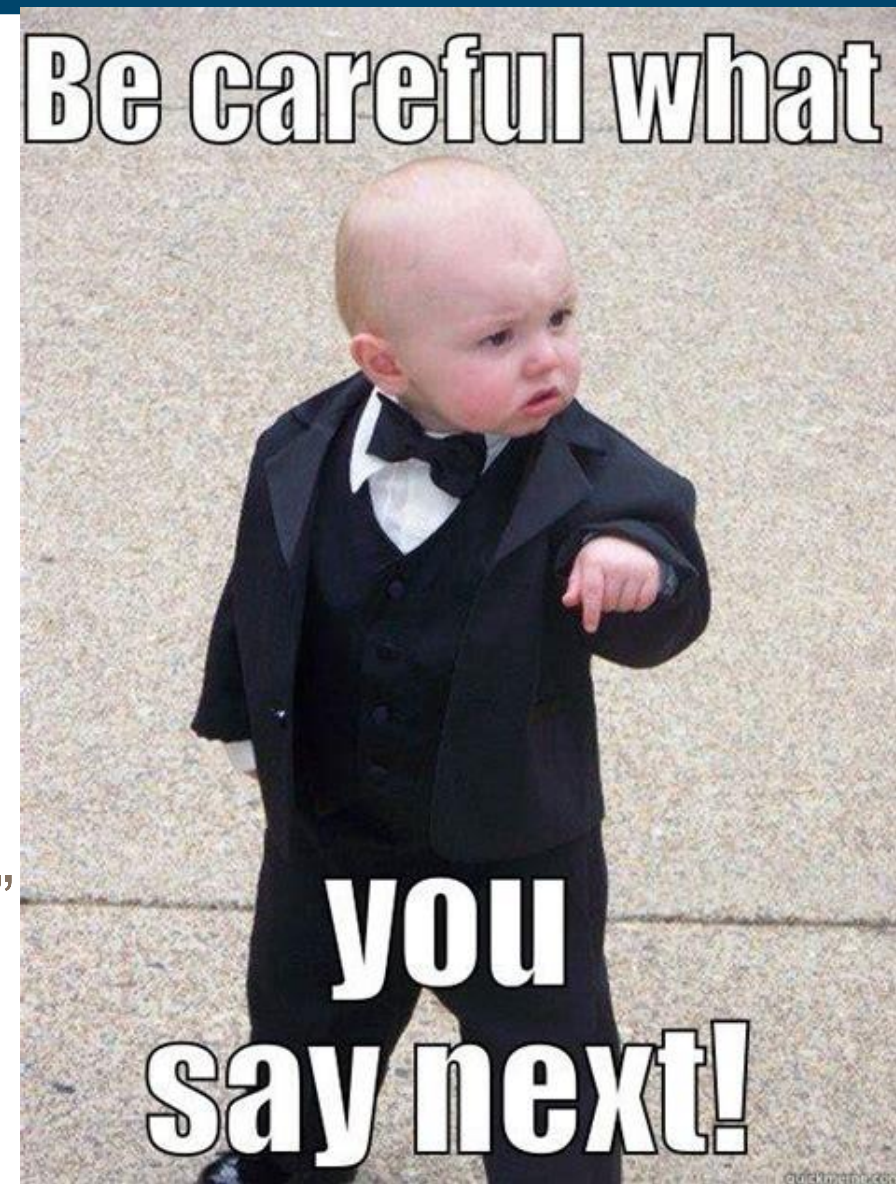
When you cannot/extremely risky terminate provider-patient relationship

- Immediate post-op period
- Involved in active work-up or treatment of problem
- Third trimester of pregnancy
- Geographic considerations
- Circumstances viewed "retaliatory"
  - Board complaint
  - Filed bankruptcy



ECRI Top 10 Concern

Top 10 Patient Safety Concerns 2023

This annual report from ECRI and our affiliate, the Institute for Safe Medication Practices (ISMP), identifies serious issues that threaten the safety of patients and healthcare workers when processes and systems are not aligned. The solutions to these challenges are usually complex and require a systems-based approach to eliminate them. The recommendations in this report will help healthcare organizations create organizational resilience to navigate these threats and strive for total systems safety.

The List for 2023

1. The pediatric mental health crisis
2. Physical and verbal violence against healthcare staff
3. Clinician needs in times of uncertainty surrounding maternal-fetal medicine
4. Impact on clinicians expected to work outside their scope of practice and competencies
5. Delayed identification and treatment of sepsis
6. Consequences of poor care coordination for patients with complex medical conditions
7. Risks of not looking beyond the "five rights" to achieve medication safety
8. Medication errors resulting from inaccurate patient medication lists
9. Accidental administration of neuromuscular blocking agents
10. Preventable harm due to omitted care or treatment

2. Physical and verbal violence against healthcare staff

vulnerable population.

In addition, staffing shortages—the number-one challenge on last year's list of Top 10 Patient Safety Concerns—continue to influence many of the concerns on this year's list. Such challenges include the pediatric mental health crisis, violence against healthcare staff, mismatches between assignments and competencies, and missed care or treatment, among others. The recommendations in this report reflect the collaborative, total-systems approach that all these problems demand.

Repeat Patient Safety Concerns

Over the years, several patient safety issues have made repeat appearances on ECRI's list of Top 10 Patient Safety Concerns. See Recurrent Patient Safety Challenges for a list of perennial patient safety issues.

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Termination Template

This letter should be typed on the healthcare provider's letterhead. One copy should be sent via certified and one by regular mail. A copy of the letter and the returned receipt should be kept in an administrative file separate from patient's chart.

[DATE]

Dear _______________,

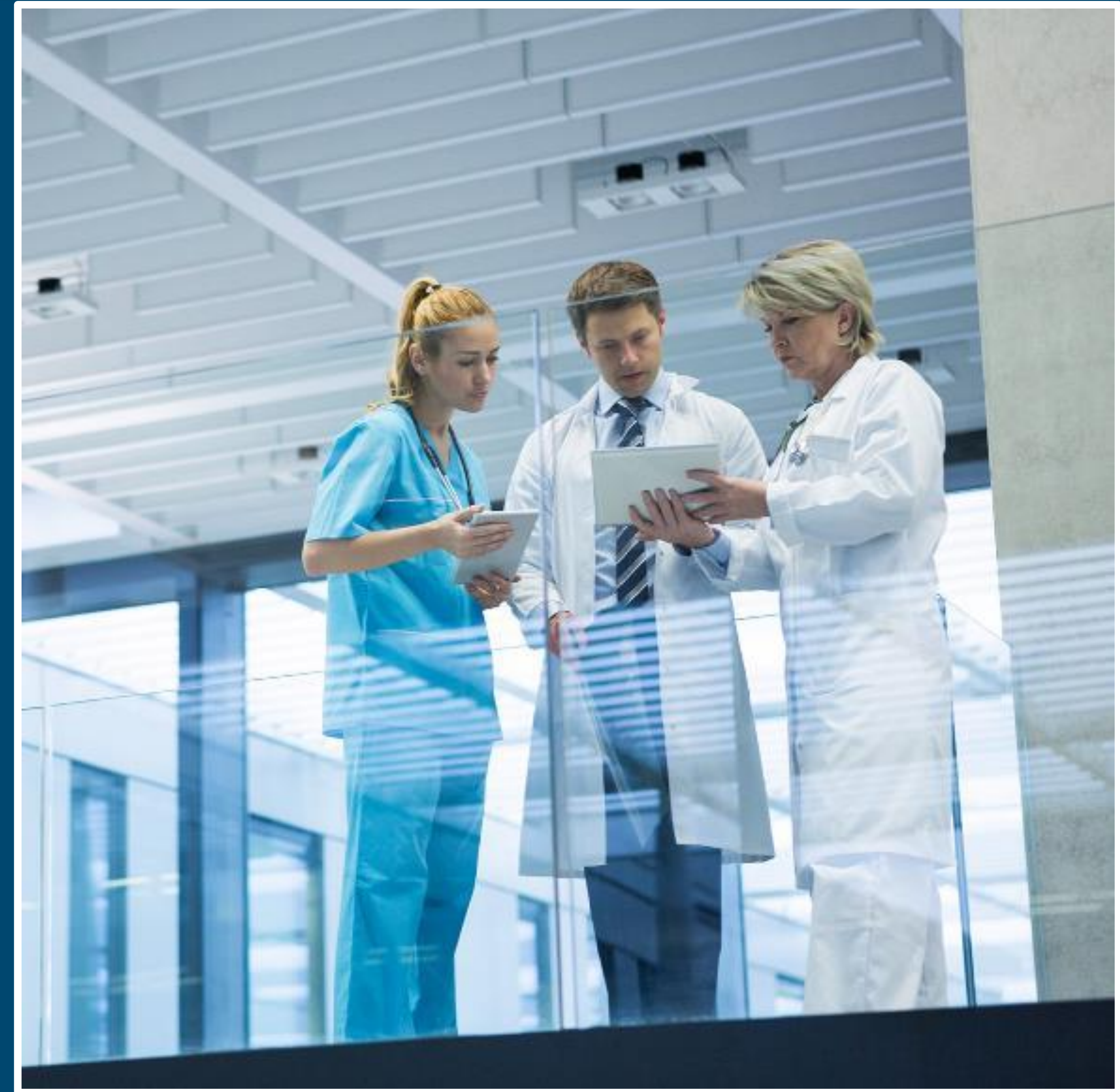
I [we] have decided not to continue as your___________ [TYPE OF] provider. Your local Medical Society [contact information] or insurance carrier may be able to assist you in finding another practitioner. I [we] will remain available to you for necessary care for 30 days following the date of this letter.

- To ensure continuity, please try to transfer to a new care provider as quickly as possible within this 30-day period. I [we] will provide a copy of your medical records to your new practitioner upon receipt of a written request from you, your personal representative or your new provider.
- [IF APPLICABLE] If you have access to your records through our office's electronic portal, I [we] will keep your account open for 30 days. Please follow the instructions for printing or downloading the material stored on the portal. After your portal account is closed, you will need to request copies of your records through our normal process. Please contact us if you need instructions.
- If you have access to our practice by email or other electronic messaging services (including secure messaging through our patient portal), this service will remain active for 30 days. After that, you will need to contact us by postal mail, telephone, fax, or through our general email account [IF THE PRACTICE PROVIDES ONE].
- I [we] will accept and save any copies of test results, clinical reports and other correspondence we receive for you. I [we] will notify you of information received according to my [our] usual policies.

Sincerely,

__________________ [TITLE]

By certified mail, return receipt requested, and regular mail
Mailed on ______________



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I’m Worried About Dr. Jones…
I’m Worried About Myself…

Some of the Most Common Scenarios

- Just served a lawsuit- what do I do?
- Attorney called "I am not named" they just want more information from me at this time…
- Minors and Risk- Custody and consenting; Different parent than usual is here with their child says they also have custody and MDM authority.
- I had an adverse outcome/complication- How do I talk to the patient/family?
- In general, I am stressed, burned out, I need support- CPHP.
- Pt declining ambulance- from office, from ER; EMC present; just concerned on how to handle and document.
- Firing a patient-I am concerned about a patient's behaviors- can we/how do we terminate the patient?

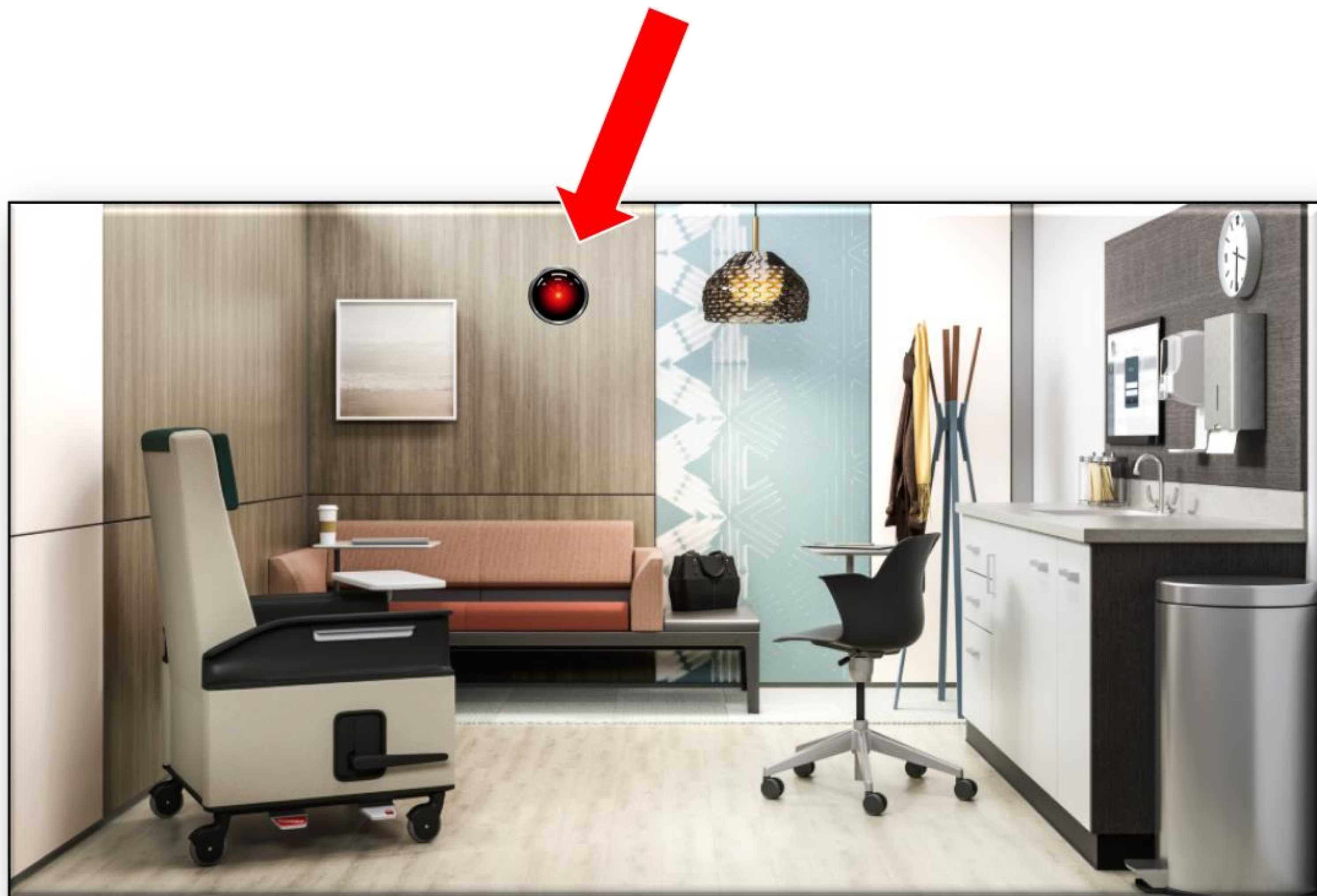
-Disruptive, Inappropriate, In Collections, Non-compliant with appointments/meds/referrals

Some of the Most Common Scenarios, cont'd.

- Opioids- Management of chronic opioid pain patients for partner's refills- do I have to fill these?
- Documentation -around adverse event: Immediate/recent event, relatively remote event.

  -realized charts not signed off on.
- Patient needs psych care- can't get in. I am managing meds. They want meds I don't prescribe. Can I fill a refill in this situation?
- My regular patient but patient is now out of state for vacation/permanent.

Where are we headed? Will AI fix everything?



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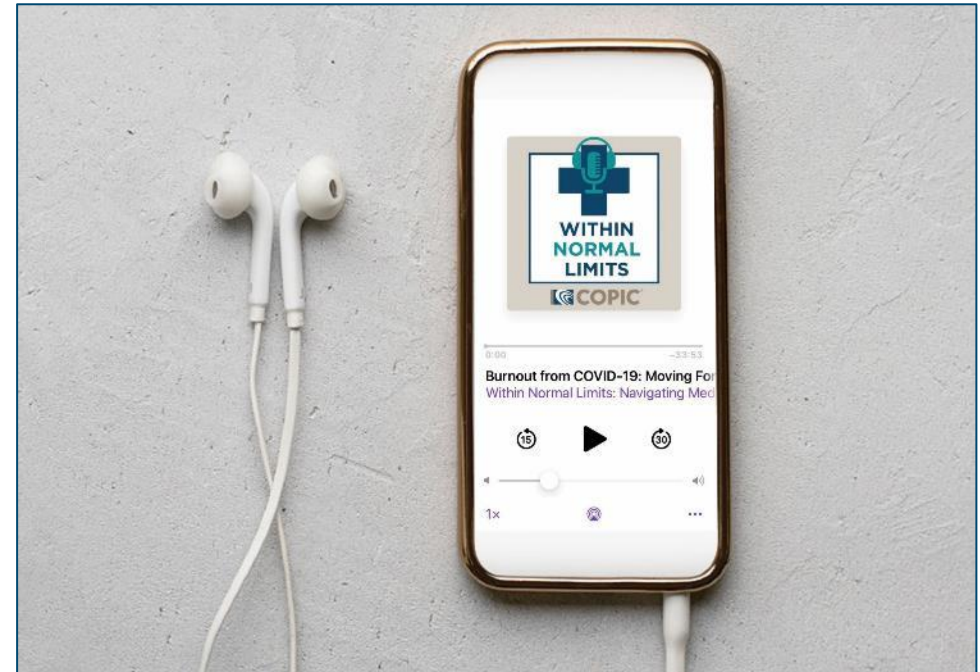

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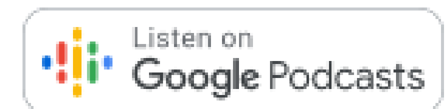

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Thank You for Attending!

Dan Rosenquist, MD

Eric Zacharias, MD

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