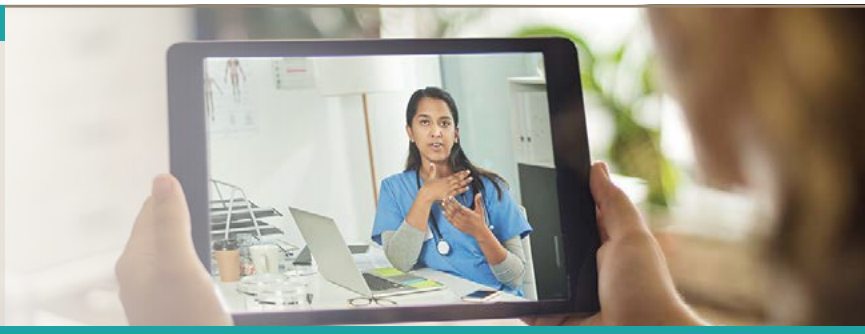
COPISCOPE

ISSUE 212
1ST QUARTER 2021

10 THINGS TO KNOW ABOUT TELEHEALTH



Among other things, 2020 will go down as The Year of Telemedicine. What began as a response to COVID-19 has emerged to become a more permanent shift in health care. A recent report[1] by the consulting firm, McKinsey and Company, estimated that 20% of U.S. health care will happen via telecare in 2021, and at least 76% of providers across all specialties and locations currently use telehealth or plan to use some aspect of it.

During the last year, the Centers for Medicare & Medicaid Services (CMS) relaxed restrictions and approved more than 80 new services, and commercial payers are following CMS's lead with mixed enthusiasm. HIPAA and DEA constraints have also been relaxed, and we've witnessed state licensing boards starting to modify rules to make interstate telecare easier and more straightforward.

Medical liability carriers (like COPIC) are taking steps to support providers in this new environment, while trying to foresee implications for patient safety/standards of care. It is possible that the regulatory and liability context for telemedicine will stabilize around a narrowing set of concerns in a few years. But, as we enter 2021, here are the key points from COPIC's perspective (we use the terms "telehealth," "telemedicine," and "telecare interchangeably):

1 Ready or not, telehealth is here

Your practice is going to be impacted by telecare. You may directly teleconference with patients or colleagues; or work indirectly through email, messaging, or data portals. If nothing else, you may be asked to advise patients whether to use telemedicine services in certain situations. We all need to understand the basics of telemedicine to make thoughtful judgments about its role in patient care. Ironically, while telehealth will provide better health care access for many, those without good connectivity and technology skills may find themselves disadvantaged.

2 Licensure

For regulators, telemedical services within one's state of primary licensure are considered today more or less "business as usual." Providers must be sure their telepractice is consistent with their usual scope of practice and privileges. Regulators will scrutinize services outside a provider's training or credentials. Some states also impose specific requirements regarding consent and documentation. But, for the most part, services a practitioner offers in the office will be acceptable via telehealth, when this is clinically justifiable.

3 Out-of-state practice

Outside the state where a practitioner is licensed, things are more complicated. Each state has a different tolerance for "extraterritorial" providers rendering care to patients physically located there. Some states explicitly do not allow this. Others accommodate practitioners not licensed in the remote state with various waivers and exceptions. Before COVID-19, telephone (audio only) care across state lines was often treated as "a violation not often enforced." However, the increased attention on remote video conferencing has made many medical boards realize that their state's legal definition of "telehealth/telemedicine" also fits phone calls. The prudent course looking forward is to expect the long standing, laissez-faire treatment of interstate phone calls to tighten in 2021.

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COPIC advises you to check the licensing rules in any state where you provide remote care, even by telephone. We understand this will represent a change in practice for many providers. A summary of requirements and waivers may be found at **www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf**.

4 Prescribing

Telephoning prescriptions across state lines has traditionally not been much of a problem. That doesn't mean every prescription will be accepted; it means you can usually rely on the pharmacist to know whether they are allowed to cooperate. Obviously, controlled substances invite greater scrutiny. But even these are not prohibited under DEA rules during COVID-19 (the DEA has suspended the requirement for an initial in-person visit). However, a controlled substance prescription must be consistent with guidelines, within the scope of the provider's usual practice, and accompanied by necessary due diligence. This may mean asking the pharmacist to do any required check of the state's prescription drug monitoring program.

5 Liability

The medical liability exposures for telemedicine are largely the same as for in-person care. Most of the slips, lapses, and hazards you guard against during hands-on care are not changed much by telecare. Normal guidelines for judgment, consent, and documentation apply. On the positive side, telehealth lends itself to a degree of "cherry-picking." Telepractitioners should be able to reduce the odds of adverse events through patient selection. The liability question for any telehealth service is, "Is it reasonable?" In some cases, the answer is altered by COVID-19. Some procedures may not be ideal choices in a perfect world, but during current conditions they may be acceptable—or even superior—options. As telehealth is the ultimate PPE during the COVID pandemic, one should consider adding the documentation that the visit was performed via telehealth as a "COVID countermeasure."

6 Hazards of electronic communication

Problems can arise during teleconferencing that are not concerns for in-person care. What if the signal is lost or degraded? What if the patient experiences a sudden emergency? How do you verify the identity of the person you're interacting with? Should you record your session? Is the patient recording it? All these need to be addressed in policies, procedures, and consents; discussed with patients; built into your privacy, security, and disaster recovery plans; and included in staff training.

7 Documentation

There are some unique aspects of telehealth documentation. First of all, it's important to know when a given encounter was a telehealth visit. A good practice is to note the medium (e.g., teleconference, phone, telemetry data review, etc.). If any technical issue prevented optimal communication, that should be noted (e.g., "Exam limited by capabilities of the patient's cell phone."). It's required by some states to record the fact that the patient was aware of the limits of the technology and that there was a backup plan if it failed. Extra steps need to be taken to document consent for recording or photography. You should note any additional parties at either end, such as assistants or relatives. If an in-person visit would have been preferable but was not possible or advisable due to circumstances (e.g., weather, COVID, etc.), this needs to be documented in the disclosure and consent.

8 The exam

Telecare obviously demands adjustments to the physical exam. Creative practitioners have posted online tips and tricks to accommodate the televideo environment. Devices are available for a variety of physiological measurements (e.g., weight, BP, glucose, etc.) and special exams (e.g., fetal doppler, video-capable otoscopes, spirometers, etc.). Many specialty societies have published guidelines for telehealth services and it behooves providers to be familiar with those in their own specialty.

9 Reimbursement

The disruption wrought by telehealth upon calculations of health care costs has been as great as COVID-19. Budget makers are struggling to project revenues and expenses for 2021 and beyond. Payers are adjusting coverage and reimbursement policies despite lack of data. There is justifiable concern about fraud and abuse. It is unsavory to mention, but the online world offers tremendous opportunities for criminals, both opportunistic and organized. Ethical providers need to be vigilant for signs of impersonation and other financial crimes—which may even be perpetrated under their own credentials.

10 Cyber risk

Finally, the cyber environment is inherently insecure. Health care is a prime target for cyber attacks. Despite improving safeguards, health information technology is so complex and fragile that it is frankly impossible to protect it from every intrusion by vandals, thieves, and particularly, nation-state hackers with military-sized resources and talents. As a COPIC policyholder, you already have embedded cyber liability coverage in your policy that provides access to robust resources through our website. Visit **www.callcopic.com/coverage-options/cyber-liability** for more details.

[1] **www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality#**

Diagnostic Errors:

THE "BIG THREE" THAT ACCOUNT FOR 75% OF ERRORS

In the world of medical liability, we know that diagnostic errors are an issue. However, the scope of the problem is uncertain, as national estimates about diagnostic errors that cause substantial harm can range from 40,000 to four million each year. When examining this topic, a good starting point is to define what constitutes this type of error.

A Johns Hopkins research team contributed important information on this topic that appeared in *Diagnosis*[1]. Utilizing a database from CRICO (the professional liability insurance company for Harvard medical institutions), they analyzed more than a quarter of all medical liability claims made in the U.S. over the span of a decade. Surprisingly, in a world where there is the theoretical diagnostic possibility of over 10,000 human illnesses, the research team found that a majority of cases where serious harm occurred (75% of diagnostic errors) were connected to only 15 diseases in these three categories:

1. **Vascular events** (e.g., stroke, heart attack, pulmonary embolus, etc.)
2. **Infections** (e.g., sepsis, meningitis, appendicitis, etc.)
3. **Cancers** (e.g., lung, colon, breast, etc.)

They called these areas the "Big Three." Approximately one half of these errors resulted in serious injury, and the other half caused death. It was noted that 71% of these occurred in either the ED setting or outpatient clinics. The Big Three are not evenly distributed across specialties or patients—missed vascular events are most common in emergency care, missed infections are most important among children, and missed cancer diagnoses lead the way in primary care.

Table 1: Proportion of serious harms attributed to "The Big Three" in frontline care settings[2]

Clinical Settings	Vascular Events	Infections	Cancers	Total
Emergency Medicine	~30%	~20%	~9%	~59%
Pediatrics	—	~40%	~13%	~53%
Adult Primary Care	~12%	~8%	~60%	~80%

These results are consistent with COPIC's historical claims data. For the last two decades, we have spoken and written on the "big risks" for primary care—heads, hearts, bellies, bugs, and cancer. We found that over two-thirds of claims against primary care fall into these categories. In addition, our data shows that misdiagnoses were the most common, catastrophic, and costly medical mistakes. This closely reflects the "Big Three" data. For example, their vascular is COPIC's "heads and hearts," and our "bellies" is encompassed in appendicitis (infection) and ischemic colitis (vascular).

The National Academy of Medicine outlined a broad range of research topics to help make progress on improving diagnostic accuracy, and it clearly emphasized that early wins may be achieved through an initial focus on "identifying the most common diagnostic errors, 'don't miss' health conditions that may result in patient harm, [and] diagnostic errors that are relatively easy to address."

Table 2: Exemplars from each "Big Three" category with diagnostic error causes and possible solutions[2]

Misdiagnosis	Principal Cause	Solution(s) in Need of Further Research
Stroke	No specialty expertise	Telemedicine and device-based decision support
Sepsis	Overwhelmed by data	Big data visual analytics & machine learning algorithms
Lung Cancer	Results not communicated	Direct-to-patient reports & EHR triggers to close loops

Diagnostic errors are common and a frequent cause of litigation. The human toll on both patients and physicians is substantial and underappreciated. The Big Three article is an important contribution to the diagnostic error literature, and at COPIC we have found that our experience is very similar. We continue to look at resources and tools that will help improve outcomes in this area and educate our insureds on ways to further improve patient safety.

[1] https://doi.org/10.1515/dx-2019-0019
[2] www.improvediagnosis.org/tackling-the-big-three/

THE IMPACT OF MEDICAL LIABILITY LAWSUITS ON MEDICAL RESIDENTS

How do we prepare young physicians to manage the various risks they will face in medicine?

Experienced physicians are well aware of the potential threat of medical liability lawsuits, but they may not know that their younger peers, medical residents, are named in up to 30% of all medical liability lawsuits.[1] This can be an overlooked concern with significant impact on physicians who are just starting their journey in medicine. Lawsuits generally last three to five years, but some last much longer and may overshadow the early portion of a physician's career. Additionally, being named in a lawsuit can be emotionally devastating for physicians and is directly and independently associated with burnout.

The following case study illustrates several common areas that we see in lawsuits involving medical residents:

CASE STUDY

A 78-year-old woman underwent a laparoscopic cholecystectomy performed by a third-year general surgery resident and the attending general surgeon. The procedure seemed to go well, and the resident rounded on the patient the following morning and informed her that she should plan on being discharged the next day. At approximately 11am that day, the patient alerted the nurse that she would like an extra dose of pain medication. The nurse called the surgery resident who approved the dose. Later that afternoon, the patient said her pain was worsening again. The nurse paged the surgical resident to report that "the patient's pain is increasing and not being well-controlled with the current pain medication regimen." Vital signs were normal and the resident ordered an extra dose of pain medication without coming to evaluate the patient.

At approximately 10pm, the resident was again paged and told that the patient's pain was keeping her from sleeping and the standing pain medication dosing was not adequate. The resident ordered another dose of pain medication and scheduled this to be repeated every two hours for the next 12 hours.

Around 5am, the nurse paged the resident to report that the patient "looks really sick." The resident came to evaluate her and noted a tense abdomen on exam along with tachycardia. The attending surgeon was called, and the patient was taken back to surgery and found to have a probable trocar injury and perforation of her intestine. The patient was hospitalized for over three weeks and had a complicated course including surgical intensive care and two additional surgeries to drain abdominal abscesses.

Six months after discharge, the patient sued the resident physician. The patient's attorney and an expert witness claimed the resident was negligent in failing to come do an in-person evaluation when she was complaining of excessive pain, and that this resulted in a delayed diagnosis of bowel injury, which lead to a complicated hospital course and recovery resulting in severe pain and suffering as well as chronic abdominal pain. Additionally, there were allegations that the resident was negligent in placement technique of the trocar that perforated her intestine. The attending physician was named for negligent supervision for all the resident's acts.

[1] **JAMA Surg. 2018 Jan; 153(1): 8–13.**

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IMPACT OF LAWSUITS ON MEDICAL RESIDENTS (FROM PAGE 4)

AREAS OF CONCERN

Residents who perform procedures may be accused of negligence in any of the components of procedural medicine. This includes the following:

- Patient selection
- Appropriateness of the specific procedure
- Informed consent
- Technical performance of the procedure
- Recognition and rescue of complications

An understanding of several major, recurring patterns in lawsuits involving residents in the above issues may help avoid these and may enhance patient safety:

- A lack of documentation of appropriate pre-surgical clearance and exam.
- An incomplete or not properly executed informed consent, including lack of information about the resident's participation.
- In the post-operative period, failure of a resident to see a patient in-person with complaints or when a nurse calls with concerns.
- Failure to notify the attending physician when there is a change in the status of a patient.

In addition to lawsuits involving procedures, residents may be named in cognitive fields. The main area is failure to diagnose or diagnostic errors. Most commonly, this occurs when potentially catastrophic conditions are early in their presentation. Broad diagnostic categories and commonly missed diagnoses to consider include:

- Neurologic symptoms
- Strokes (particularly posterior circulation), aneurysms, meningitis, encephalitis, and space occupying spinal cord lesions
- Cardiovascular and chest pain
- Pulmonary embolism, aortic dissection, myocardial infarction, and unstable angina
- Abdominal pain
- Testicular torsion, pelvic inflammatory disease, ischemic bowel, gastrointestinal tract bleed, viscera perforation, and intra-abdominal infections
- Infectious symptoms
- Necrotizing fasciitis, septic joint, spinal epidural abscess, meningitis, encephalitis, and sepsis

For these areas, the risk is that a severe problem can be potentially difficult to diagnose early on. When residents are seeing patients with any of these symptoms, they should make extra efforts to clearly document their thought process along with a follow-up plan and patient instructions, including a high alert for certain warning signs. A documented rational care plan and thought process, even in the face of a missed condition, makes the care far more defensible than if these are absent.

PRACTICAL GUIDANCE FOR FOLLOW UP

Another recurring area of risks for residents, in both cognitive and procedure-oriented fields, is failure to follow up on incidental findings seen on imaging or lab tests. When residents are aware of a clinically important incidental finding, including the following in their approach will be helpful:

1. Assume no other provider but yourself is aware of and responsible for taking care of the issue.
2. Inform the patient of the issue (e.g., "there was a small nodule in your lung we saw when looking for a pulmonary embolism; this might be a cancer and you need to follow up with your primary care provider regarding this after we discharge you from the hospital…") and document your conversation in the chart.
3. Call and speak directly with the provider who will be taking care of the patient to inform them of the incidental, important finding. This is in addition to putting the information in a note in the medical record as these can be missed by the next provider taking care of the patient.

COPIC'S RESIDENT ROTATION PROGRAM

Since 2004, COPIC has offered a program designed to educate medical residents about key medical liability issues. The program examines the integration of patient safety, communication, systems, disclosure, medicolegal aspects, and the review of in-progress and closed case studies. In addition, the program meets the Accreditation Council for Graduate Medical Education (ACGME) core competencies. To learn more, please visit:

www.callcopic.com/patient-safety-risk-management/resident-rotation

UPDATES ON MEDICAL GUIDELINES

COLORECTAL CANCER SCREENING

In October 2020, the United States Preventative Services Taskforce (USPSTF) officially recommended that colorectal cancer screening routinely begin at age 45, instead of age 50. This recommendation is in response to the sharp rise in the number of colorectal cancers in young adults. The USPSTF provides guidance on screenings and preventative care, and providers, insurance companies, and policymakers follow its recommendations.

Although the vast majority of colorectal cancers are still found in people age 50 and older, 12% of the 147,950 colorectal cancers that will be diagnosed this year, approximately 18,000 cases, will be found in adults under age 50. Notably, younger colorectal cancer patients say doctors often dismiss their complaints. According to a Colorectal Cancer Alliance report, 81 percent of young adults with colorectal cancer surveyed said that they experienced at least three symptoms of cancer before diagnosis. More than half were misdiagnosed, being told that they had hemorrhoids, anemia, irritable bowel syndrome or even mental health problems.

In summary, **the standard of care has changed: colorectal cancer screening should be offered to average risk adults at age 45**. Symptoms of colorectal cancer, namely bleeding, anemia, weight loss and abdominal pain cannot be dismissed without investigation in this age group. While colonoscopy is generally thought of as the definitive screening test for colorectal cancer, the task force has recommended both colonoscopy as well as tests that can identify signs of cancer based on stool samples.

For more information about colorectal cancer screening, please visit:

- **www.uspreventiveservicestaskforce.org/uspstf/draft-update-summary/colorectal-cancer-screening3**
- **www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html**

ACS RECOMMENDATIONS CONCERNING SURGERY AMID THE COVID-19 PANDEMIC

As COVID-19 has resurged nationally, the American College of Surgeons (ACS) updated its recommendations protecting essential medical services, including surgery. At the beginning of the pandemic, many state-issued moratoriums on "non-essential" surgical services led to significant delays in the provision of needed surgical services and a backlog of postponed procedures. The ACS points out that the provision of appropriate and needed surgical services can be performed safely when the following conditions are met:

- Patients have undergone appropriate risk assessment and testing;
- Providers have appropriate personal protective equipment;
- Providers are regularly tested for the virus;
- Providers have resources to support their emotional well being.

The ACS has previously published (and continues to update) recommendations for maintaining surgical services and for adjusting the number of procedures depending upon several important considerations. These include Regional Cooperation and supply chain flow. Regional Cooperation means that facilities should regionally address capacity and new patient needs to ensure facilities have the appropriate number of ICU and non-ICU beds, PPE, testing reagents and supplies, ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care. Supply chain flow refers to the availability of PPE, COVID-19 testing, case prioritization and various specific issues for perioperative care of COVID-19 patients.

The recommendations maintain that decisions to increase or decrease surgical services should occur at a local level driven by hospital leaders including surgeons and anesthesiologists in consultation with state government leaders. A multidisciplinary team should oversee guidelines for delivery of surgical services at each local care site with all previously learned lessons considered. The decisions should be based on local case incidence, ongoing testing of staff and patients, aggressive use of PPE, and physical distancing practices. Local selection of cases should be based on urgency of patient needs, staff availability and health, and hospital

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UPDATES ON MEDICAL GUIDELINES (FROM PAGE 6)

bed capacity, **not** by "wide-reaching regulation and blanket ordinances." In this manner, surgical capacity can be safely maintained and excessive backlogging of cases can be prevented.

Additional resources can be found in the following publications:

- American College of Surgeons, American Society of Anesthesiologists, Association of periOperative Registered Nurses, American Hospital Association. Joint Statement: Roadmap for Maintaining Essential Surgery during COVID-19 Pandemic. Available at: **www.facs.org/covid-19/clinical-guidance/roadmap-maintain-essential-surgery.**
- Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic; Journal of American College of Surgeons **https://pubmed.ncbi.nlm.nih.gov/32278725/**
- American College of Surgeons. COVID-19: Elective Case Triage Guidelines for Surgical Care. Available at: **www.facs.org/-/media/files/covid19/guidance_for_triage_of_nonemergent_surgical_procedures.ashxuspreventiveservicestaskforce.org/uspstf/draft-update-summary/colorectal-cancer-screening3**
- **www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/colorectal-cancer-screening-guidelines.html**

LISTEN TO COPIC'S NEW PODCAST "WITHIN NORMAL LIMITS"

COPIC recently launched a podcast, Within Normal Limits: Navigating Medical Risks, featuring host Eric Zacharias, MD, a COPIC risk manager and practicing internal medicine physician. The podcast focuses on a wide variety of patient care and safety topics and professional liability issues presented in a conversational format. Each episode is around 20 minutes and features experts engaged in insightful discussions with Dr. Zacharias. Here are some initial episodes we have released:

Episode 1: Med Mal 101—Heads, Hearts, Bellies, and Bugs

This episode draws upon decades of medical liability experience to distill the key areas where we consistently see malpractice lawsuits—heads (neurologic), hearts (chest pain), bellies (abdominal pain), and bugs (infections). We examine why physicians sometimes misdiagnose symptoms that seem obvious in hindsight, but in actual practice, are not so simple. Our guest is Dr. Dennis Boyle, a rheumatologist who also teaches at University of Colorado School of Medicine and is a physician risk manager with COPIC. Dr. Boyle and Dr. Zacharias walk through some sample scenarios and offer guidance on how to avoid common risks while enhancing patient safety.

BONUS CONTENT: Dr. Zacharias talks about how medical residents are named in up to 30% of medical liability lawsuits, what types of lawsuits these are, and the long-term impact these can have on residents. He also highlights COPIC's Resident Rotation Program that helps the next generation of physicians prepare for issues they will likely face during their careers.

Episode 2: Spinal Epidural Abscess—A Difficult Diagnosis

Dr. Zacharias switches places with his peer, Dr. Boyle, who asks questions about a classic case study that involves...you guessed it—spinal epidural abscess. The conversation gets deep into the clinical aspects surrounding a patient who visits the emergency room several times in an eight-day period with complaints of a subjective fever and severe back pain. As Dr. Zacharias notes, this is a difficult case and "the standard of care is to miss it." Using a step-by-step analysis, the two doctors offer guidance on where things can go wrong and the factors that should be examined to avoid a bad outcome.

You can access the *Within Normal Limits* podcast via popular platforms such as Apple Podcasts and Google Podcasts. You can also visit our website at **www.callcopic.com/wnlpodcast** for more information and a guide of the available episodes.

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ISSUE 212 • 1ST QUARTER 2021

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