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Risk Management and Patient Safety News

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Telemedicine Webside Manner: Putting Your Best Face Forward

by Amy McLain, BSN, RN

This past October, Dr. Neel Naik, the Director of Emergency Medicine Simulation Education and an Assistant Professor of Clinical Emergency Medicine at Weill Cornell Medicine in New York City, spoke at the American Society for Health Care Risk Management's (ASHRM) virtual annual conference. In his presentation on telemedicine, he made several interesting points:

- Physicians do not understand how to engage with the patient
- Physicians do not know how to present themselves to patients
- Physicians do not know how to conduct a virtual physical exam

Dr. Naik went on to say that "physicians must alter their 'bedside manner' from traditional in-person care to better accommodate patient needs during video-based telehealth visits." Yet, this important skill is often not taught.

If this is the case, then many CAP physicians must be struggling to conduct a telemedicine visit with their patients. Members may be at increased risk for patient complaints to insurance companies and/or the medical board. It's also important to know that telemedicine is a form of healthcare delivery and the standard of medical care provided to patients is the same whether you see them in person or not. Therefore, if an appropriate exam is not performed during a telemedicine visit, claims may arise from misdiagnosis and treatment errors.

To ensure your patients have an optimal virtual experience and best possible medical outcomes from their next telemedicine appointment with you, CAP recommends the following tips:

Prepare: You want your patient to have the utmost confidence in you. Know in advance why your patient is scheduled. Read the chart before your video encounter. Have a plan of action.

Time: Don't be in a rush. Your patient will feel unimportant and you're likely to miss important clinical details. Schedule the appropriate amount of time for

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each patient. Allow time for questions and be aware of "the doorknob phenomenon."

Location: Follow privacy and confidentiality rules. Choose a quiet, private location with a neutral professional background. Remove distracting or inappropriate items. Encourage your patients to find areas in their homes to interact privately with you.

Technology: Ensure that your technology works correctly. You don't want to delay or cancel your patient's appointment because your system is not functioning properly. Check your camera, your computer, your microphone, your speakers, and your internet connection. Then, check it again. Use healthcare-specific or end-to-end encryption platforms. Have IT on speed dial.

Lighting: Poor lighting conditions have an enormous effect on video quality. You want to look your best and allow your patient to see your face clearly. Use natural lighting. Face the window — never sit with your back to a window. If you do not have a window, find a soft light to put in front of you.

Camera: Avoid unflattering and awkward angles by framing the camera correctly. Place the webcam at eye-level and position yourself so that you are in the center of the patient's screen. Avoid embarrassing situations. Remember, the camera may still be *on*.

Sound: Most microphones pick up background noises that can be annoying or distracting. Use quality headphones/earbuds to improve hearing. Mute yourself when your patient speaks. Recognize that there is generally a slight delay between the time words are spoken and when they are received. Avoid talking over your patient. Caution: Hot mics!

Appearance: Present yourself as if you were in the office exam room with your patient. Introduce yourself and your role. Wear your white coat and badge or medical professional attire. Be mindful of your body language. Avoid distracting behaviors, such as excessive gesturing with your hands and facial expressions.

Engage: Confirm your patient's identity. Smile. Pay close attention to your patient and actively listen. Participate completely as if you were physically in the same room. Minimize distractions and avoid disruption, such as email/message notifications or phone calls. Look into the camera to maintain good eye contact. If you need to look away to take notes or consult a resource, tell them so they don't think you are doing other work.

Collaborate: Guide your patient through the visit. Have the patient adjust lighting and camera, if needed, for closer inspection. Demonstrate and coach your patients to assist you with their physical examinations. Have them use their thermometers, blood pressure cuffs, and other medical tools to gather additional clinical data.

Close the Loop: Document the telemedicine visit in the medical record. Send a visit summary along with written next-step instructions to the patient.

Resources: For more in-depth information about telemedicine and webside manner, please visit these websites:

- **www.CAPphysicians.com**
- **California Medical Association (CMA) www.cmadocs.org**
- **American Medical Association (AMA) www.ama-assn.org**
- **Medical Group Management Association (MGMA) www.mgma.org**

Addtional references are available upon request. If you would like to speak to a CAP risk manager, call 800-252-0555.

Amy McLain is Assistant Vice President, Risk Management and Patient Safety for CAP. Questions or comments related to this article should be directed to amclain@CAPphysicians.com.

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Employment Practices Liability Risks During COVID-19

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According to the COVID-19 employment law litigation tracker implemented by the Fisher Phillips law firm, smaller employers are in far greater danger of being the targets of COVID-19 workplace litigation, as are healthcare employers and other businesses requiring an in-person workforce. Employers with 50 or fewer employees have been sued at a far greater rate than larger employers, facing a staggering 38 percent of COVID-19-related lawsuits.

As a CAP member, you already receive up to $50,000 for legal defense costs associated with employment-related lawsuits[1]. While this benefit does help, this may not cover all claims costs.

Your practice may need to look into Employment Practices Liability Insurance (EPLI). This additional coverage protects you against employee claims alleging wrongful termination, sexual harassment, and discrimination. EPLI can be extended to cover claims made by third parties, such as vendors or employees at a hospital.

You may also add wage and hour coverage that will protect you from employees alleging they did not get breaks, time off, or overtime pay. The FP COVID-19 Employment Litigation Tracker reveals that the most common case type affecting smaller employers are remote work and leave law conflicts.

EPLI will easily pay for itself if you are sued even once. EPLI premiums will vary depending on a number of factors:

- The number of employees
- The amount of coverage purchased
- Whether your company has anti-discrimination and anti-harassment human resources policies in place
- Whether your company has had any EEOC complaints or lawsuits filed against it in the past

CAP Physicians Insurance Agency, Inc. (CAP Agency) offers our physician members highly competitive rates for EPLI coverage — provided by an A+-rated carrier. Contact us at 800-819-0061 or email us at CAPAgency@CAPphysicians.com for more information or to request a free, no-obligation quote.

[1]Various deductibles and/or exclusions may apply.

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Redistricting Woes Likely from Census Delays

by Gabriela Villanueva

Public Policy

Every 10 years, the U.S. Census Bureau undertakes the extraordinary task of counting the individuals residing in the United States and its island areas. Mandated by the U.S. Constitution, the primary use for the data collected by the decennial census is to determine the number of seats each state has in the 435-member U.S. House of Representatives — a process called apportionment. The census also provides social scientists with a fresh crop of demographic data and its data are also the basis for allocating $1.5 trillion per year in federal spending.

With 2020 being a census year, it is no surprise that this all-important and constitutionally mandated task would also be impacted by the current COVID-19 pandemic.

On April 13, 2020, the U.S. Census Bureau delayed its field operations by about 90 days because of the pandemic, and at the same time asked Congress for authority to delay the release of census data by 120 days. If granted, according to the National Congress of State Legislatures, the delay would be the first in at least 100 years.

The first results — used to reapportion congressional seats among states and reset the Electoral College map for the next decade — are legally due to the President by December 31, 2020. Under federal law, the president is required by January 10 to hand off those numbers to Congress for certification. But the 2020 census is facing some particular challenges to meet those dates; some related to COVID-19, while others have been created by changes in procedures taken by the current administration raising concerns over an undercount in the results.

Congress will need to decide whether to grant the request for these delays to release the data.

The requested delays stem from the delay in field operations and to two federally mandated deadlines:

- Under current law, data to be used for reapportioning districts in the U.S. House of Representatives are to be delivered to the president by December 31, 2020. This data determines how many congressional seats each state will have for the following 10 years. **The request would delay this deadline until April 30, 2021**.
- Under current law, data to be used by the states for redistricting legislative and congressional seats are due to the states no later than March 31, 2021. In previous decades, this data have been provided to the states on a rolling basis, starting at least six weeks prior to the deadline. **The request would delay this deadline until July 31, 2021**.

Such delays will reverberate in all states, as a delay in the release of data would compress the timeline for redistricting. For some states, the requested delays would be uncomfortable; for others, the delays would mean deadlines that are established in state constitutions or statutes will be impossible to meet.

Specifically to California, whenever census data are ultimately released and redrawing of districts begins, it is expected that the state will lose one congressional seat, shrinking the Californian congressional delegation from 53 members to 52 — the first time in its history to lose a seat.

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Case of the Month

by Gordon Ownby

Radiologist's Recommendation Puts Focus on Surgeon's Judgment

Consultants are not apt to directly tell the referring physician how he or she should treat the patient. But a radiologist's repeated recommendations to a surgeon for clinical follow-up can come very close.

A 45-year-old teacher and avid skateboarder visited the ER after crashing at a local skate park and landing in dirt. Dr. ER, the emergency room physician, noted a 4 cm laceration to the right suprapatellar region of the left leg. Dr. ER flushed the wound with sterile water and repaired the laceration with subcutaneous and superficial sutures. Dr. OS gave the patient aftercare instructions, advised him to return to the ER if things did not improve or got worse, and directed him follow-up with his primary care physician. Though Dr. ER took a history of a tetanus shot within five years, his chart also recited, twice, "NOT UTD WITH TETANUS SHOT." The patient claimed that Dr. ER told him that he did not need antibiotics.

The patient returned to Dr. ER three days later complaining of a diffuse, dull, and severe worsening of left knee pain. The knee was markedly swollen though the wound was healing well. An ultrasound was negative for DVT and an X-ray was "unremarkable," save for some tissue swelling. The temperature of the crutch-using patient was 98.7. Dr. ER prescribed Naproxen and Norco, but no antibiotics were applied or prescribed.

Three days hence, the patient visited his PCP, who took a history of the skateboarding accident. The patient complained of worsening pain, swelling, tingling, and numbness into his toes. The PCP noted the edema was progressing proximally and that the

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patient was still using crutches. The PCP counseled the patient extensively on wound care and advised the gentleman to look for potential signs of infection. The PCP told the patient that if tingling and numbness persist, he should remove his compression socks and to go to the ER again if there was no improvement. The PCP recommended an orthopedic consult and recommended a return in a week to remove sutures. No antibiotics were applied or prescribed.

Instead of returning to the PCP the next week, the patient visited Dr. OS, an orthopedic surgeon. Though the patient reported head sweating, Dr. OS' examination found no sweating and "extremities cool." Dr. OS found a healing laceration on the anterior surface of the patella, moderate to severe pre-patellar bursitis, and moderate bruising of the anterior knee. X-rays were normal.

Dr. OS assessed some form of internal knee derangement and ordered an MRI. According to the patient, he asked Dr. OS about draining the knee but was told that an aspiration would likely complicate his condition. No antibiotics were applied or prescribed.

When the patient returned two days later, the MRI results were available. Dr. OS incorporated the MRI findings into the "Comments" section of his chart that day, including: "(1) extensive anterior soft tissue edema with loculated 9.8 cm heterogeneous collection superficial to the extensor mechanism consistent with hematoma. Adjacent defect of the vastus medialis myotendinous junction is identified with propagation of collection deep to the muscle belly. Focal laceration/perforating injury is considered. The cutaneous defect is incompletely visualized at the limits of the study. Please correlate with clinical concern for infected collection/superimposed abscess. (2) Joint effusion/hemarthrosis with contained debris and/or blood degradation products as well as dissecting/ruptured popliteal cyst. Again, correlation with clinical concern for infected synovitis is recommended given history of laceration. . . . ."

The radiologist's recommendations notwithstanding, Dr OS' assessment included traumatic pre-patellar bursitis. The patient claimed that Dr. OS reported that everything was fine in the MRI. The sutures were removed and Dr. OS advised the patient to modify his activities and to return in two weeks. No antibiotics were applied or prescribed.

On his return to Dr. OS two week later, the patient reported some improvement but was still unable to bear weight on the left leg. His temperature was 99.3. Dr. OS aspirated the knee and sent 22cc of cloudy fluid to the lab. Though the patient's CBC white blood count was normal with a left shift, the WBC of the aspirate was 120,000. Dr. OS contacted the patient and told him that he needed surgery "tonight."

On his hospital admission, the patient was diagnosed with septic arthritis and underwent an emergent arthroscopic surgery, converted to an open I&D after findings of extensive infection. Cultures grew coagulase negative staph infection for which the patient received IV antibiotics. A hematologist on his care team opined that the patient's current anemia was multifactorial but included an untreated four-week infection. Acute renal failure was attributed to IV Vancomycin toxicity.

In the patient's subsequent lawsuit, he claimed Dr. OS failed to properly diagnose his condition or treat his infection, resulting in a stormy hospitalization and enduring damage to his knee. The dispute was resolved without going to trial. (The patient also sued Dr. ER.)

Discussing all the medical considerations involved in Dr. OS' care of the patent is beyond the scope of this column. From a litigation standpoint, however, Dr. OS' failure to document his thinking in light of the two – quite emphatic – recommendations from the radiologist regarding possible infection created a fact pattern that a jury would find compelling for the plaintiff.

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

Ask My Practice

by Andie Tena

California Anti-Harassment Training Deadline

Question: My practice has more than five employees, so I am already aware of the California requirements regarding anti-harassment training. While the training deadline of January 1, 2021 is looming, we have not been able to provide the requisite courses to our office staff. Due to the COVID-19 pandemic, we have cancelled any in-person events, including trainings. Do you think California will once again push back the deadline?

Answer: As of today, neither the California Legislature nor the Governor have indicated that the compliance deadline will be extended beyond January 1, 2021. As a California employer with five or more employees, your practice is required to provide sexual harassment prevention training to all employees by January 1, 2021.

While in-person training is not feasible during the ongoing pandemic, the California Department of Fair Employment and Housing allows for training to occur live in a classroom, online, or in "any other effective, interactive format."

As a benefit of membership, CAP provides free online courses for both supervisory and nonsupervisory employees that fulfill this compliance requirement. Receive access to these courses by completing the form on CAPphysicians.com/hrtraining. Upon completion of the program, each staff member will be able to save the certificate of completion as a PDF that can be printed or saved to prove compliance.

If you have additional questions regarding HR issues, contact Nancy Brusegaard Johnson, CAP's Senior Vice President of Human Resources and Operations, at 213-473-8664 during business hours, 8:30 a.m. to 5:30 p.m.

Andie Tena is CAP's Director of Practice Management Services. Questions or comments related to this column should be directed to atena@CAPphysicians.com.

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