

ACEP ED Medical Directors Academy: Risk Management Phase 3



Daniel J. Sullivan MD, JD, FACEP

Emergency Department Structure

- Committee Structure - What meetings do you run? Which are most impactful in your department?
 - Describe the committees, include who attends (admin, nursing...)
 - Attendance requirements?
- Who has a peer review committee?
 - Which chart, complaint or event reviews are the most effective and impactful?

Group Discussion

- What is the most innovative and impactful structural/departmental program you created and can share with the group?
- What is the most significant risk/safety issue you have had recently, and what did you do about it?

Training, Competency, Orientation

- What is required for:
 - Medical Director or Assistant Directors
 - Physician practitioners
 - APPs
 - Ultrasound providers

Risk & Safety Administrative Scenarios



Scenario # 1

The hospital administration and the medical staff are up in arms regarding the hospital's door to balloon times in patients with acute coronary syndrome. Yours is THE go-to hospital for interventional care. The finger is pointing to the ED. The average door to ECG is over 30 minutes. The average 'time to order' of troponin is 45 minutes.

There is a chest pain protocol that allows nurses to initiate lab orders but most of the physicians will not allow them to initiate without seeing the patient.

There have been several poor outcomes, with related litigation.

The hospital, the physicians, and most importantly your patients are at risk. What steps will you take to address these issues?

Scenario # 2 (Consider this in non-COVID normalized times)

There have been three recent adverse outcomes in your ED waiting room over the last two months. A 14-year-old presented to the triage area complaining of a painful scrotum. The triage nurse did not recognize the importance of the presentation and the mother and teenager sat in the waiting room for 4 hours. The mother was irate and went to another hospital. At the second hospital the young man was in surgery within 30 minutes of arrival but lost the testicle.

A 65-year-old male presented with a complaint of slurred speech and weakness in the right arm that started approximately an hour and a half prior to presentation. His triage vital signs were normal, and the nurse did not detect weakness in the arm. He was asked to have a seat in the waiting room. After 55 minutes his wife knocked on the triage window after she noted that her husband was unable to move the right side of his body.

A 45-year-old patient with chest pain sat in a wheelchair holding his chest until he collapsed on the floor. This was all picked up on security videotape. The clock was running on the tape, he had been in the waiting room for 28 minutes before he collapsed.

The VP risk has contacted you, the medical director. She is asking for an action plan for resolution of the problem. She is looking at the possibility of three lawsuits and possibly worse. The states attorney brought a charge of homicide against the hospital related to the videotaped death of the chest pain patient.

Scenario # 3

The quality department has just brought an issue to your attention. The Medical Director and Assistant Director have been having patients return to the ED for continuing IV therapy in a special IV chair. Quality is concerned regarding possible over-utilization.

Case # 1 involves a patient who developed cellulitis after a cat scratch. The chart indicates cellulitis, patient was given Rocephin and discharged on Augmentin. She was asked to return for IV antibiotics the following day. In total, the patient returned for 17 days for various antibiotic regimens including Rocephin, Imipenim, and Vancomycin.

Case # 2 is a dog bite who was treated for a cellulitis on the leg for eight days with IV Rocephin in the emergency department.

Case # 3 is a patient who developed a skin infection following a laceration. The patient was initially treated with Keflex. The infection worsened. The patient was given a dose of Rocephin IV and discharged on Augmentin. He returned for 4 days and was treated with IV Rocephin. The patient became septic and was admitted to the hospital. He ultimately needed debridement of area around the initial laceration and has filed suit.

The quality department has asked you to investigate the issue. What steps will you take?

Scenario # 4

You are the medical director of an ED in a tertiary care hospital. Surrounding hospitals have been having serious problems with their on-call schedules. As a result, the number of transfers to your facility has been increasing dramatically. Transfer calls are typically routed to the on-call subspecialist who makes the decision about whether to accept the patient.

Two transfer cases were refused last weekend. In the first a neurosurgeon refused to take the case of a patient who had fallen off a horse and suffered an intracranial bleed. In the second, a cardiac fellow refused a transfer for a NSTEMI patient who required a cardiac cath. In both cases, the ED was extremely busy, but not on bypass and the hospital had the current capability to accept the transfers.

The hospital had to self report both cases to CMS. The state agency representing CMS will be visiting your hospital tomorrow. What immediate steps can you take? What additional steps can you take to resolve this potentially dangerous situation?

Scenario # 5

A charge nurse notifies you that 3 nurse are concerned because one of your physicians is administering narcotics to patients. She orders the meds, and then tells the nurse to give her the meds and she will administer to the patient. One nurse tells you directly that one of her patients told her the he only got one of the two pain meds ordered for him.

What do you do?

Post Intervention

You receive two more notes from nurses regarding your provider's continued request for narcotics to administer directly to patients.

Now what?

Scenario # 6

You have a 65-year-old physician on your team who is a wonderful individual and highly thought of by medical practitioners and nurses alike. In the last 3 years he has been seeing fewer patients per hour than the other practitioners. Your average is 2.3 and he has fallen under 1.5. When he works the waiting room routinely backs up. When you are on duty following this physician, you cringe at the thought of what awaits you. This comes up routinely in conversations with other physicians and the hospital is expressing concern about conditions in the ED when this doc is on duty.

What do you do?

Case Presentation

- A 25-year-old man presented to ED with low back pain.
- Based on his history of recently lifting furniture, **the emergency physician diagnosed musculoskeletal strain.**
- Patient discharged on Motrin 800 mg tid, PRN follow up with physical therapy.



Case Continued

- Patient returned (Bounceback) 2 days later with worsened pain.
- **Diagnosis: Spinal epidural abscess**
- Patient had a lengthy hospitalization. Ultimately no malpractice claim was filed.



Cognitive Autopsy

- ED Doc **never** asked about a history of fever.
- Fever on the patient track board was **not** seen by the ED Doc.
- Temp of 102 F was auto-entered into chart but **never** seen by the EP.
- ED Doc did **not** consider a predisposition for an epidural process – patients was an IV drug user.
- ED Doc did **not** modify his DDx based on multiple levels of back pain.



Malpractice Claims

- 99% of ED practitioners sued by age 65
- 7% of Emergency Physicians sued each year
- AON national benchmark HPL cost \$6.83 per ED patient

Medical Errors

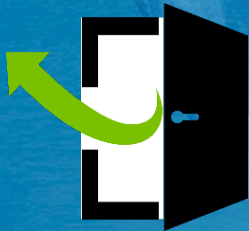


4th Leading Cause of Death in U.S.



Diagnostic Error Rate

SEA	AOD	Thrombosis	VTE/PE
62%	28%	24%	20%



9 Patients Die per 100K ED Discharges within 7 days from medical errors.



2.9% Bounceback Admit Rate many related to medical error

Key Points

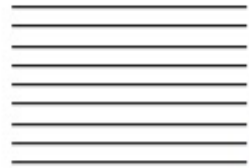
- The 'failure to diagnose' is overwhelmingly the single greatest risk issue in emergency medicine.
- Litigation is an issue, but the sheer volume of medical errors and patient safety is far more important.
- As ED leadership, our risk & safety focus should be squarely on reducing the frequency of 'failure to diagnose'.



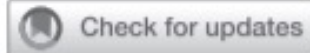


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0736-4679/\$ - see front matter

<https://doi.org/10.1016/j.jemermed.2018.06.035>



Clinical Reviews in Emergency Medicine



MALPRACTICE IN EMERGENCY MEDICINE—A REVIEW OF RISK AND MITIGATION PRACTICES FOR THE EMERGENCY MEDICINE PROVIDER

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Most Recent/Largest Analysis of Claims (20 years)

- 6,779 closed EM claims
 - 4000 (65.9%) were dropped, withdrawn, dismissed
 - 1546 (22.8%) settled for an average indemnity of \$297,709
 - 515 (7.6%) of cases went to trial
 - Verdict for the defense 92.6% of cases 477/515
 - 7.14% of cases 38/515 jury verdicts for the plaintiff. Average indemnity of \$816,909.

Rate of Diagnostic Errors

Diagnosis | Ahead of Print

Rate of diagnostic errors and serious misdiagnosis-related harms for major vascular events, infections, and cancers: toward a national incidence estimate using the “Big Three”

David E. Newman-Toker , Zheyu Wang, Yuxin Zhu, Najilla Nassery, Ali S. Saber Tehrani, Adam C. Schaffer, Chihwen Winnie Yu-Moe, Gwendolyn D. Clemens, Mehdi Fanai and Dana Siegal 

DOI: <https://doi.org/10.1515/dx-2019-0104> | Published online: 14 May 2020

“Big Three” Disease Diagnostic Error Rate

11.1%

CANCER

Lung Cancer	22.5%
Melanoma	13.6%
Colorectal Cancer	9.6%
Breast Cancer	8.9%
Prostate Cancer	2.4%

8.7%

VASCULAR EVENTS

Aortic Aneurysm / Dissection	27.9%
Arterial Thromboembolism	23.9%
VTE (Pulmonary Embolism)	19.9%
Stroke	8.7%
MI	2.2%

10.2%

INFECTIONS

Spinal Abscess	62.1%
Meningitis & Encephalitis	25.6%
Endocarditis	25.5%
Sepsis	9.5%
Pneumonia	9.5%

“Big Three” Disease Diagnostic Error Rate – 1st visit misses

8.7%

VASCULAR EVENTS

Aortic Aneurysm / Dissection	27.9%
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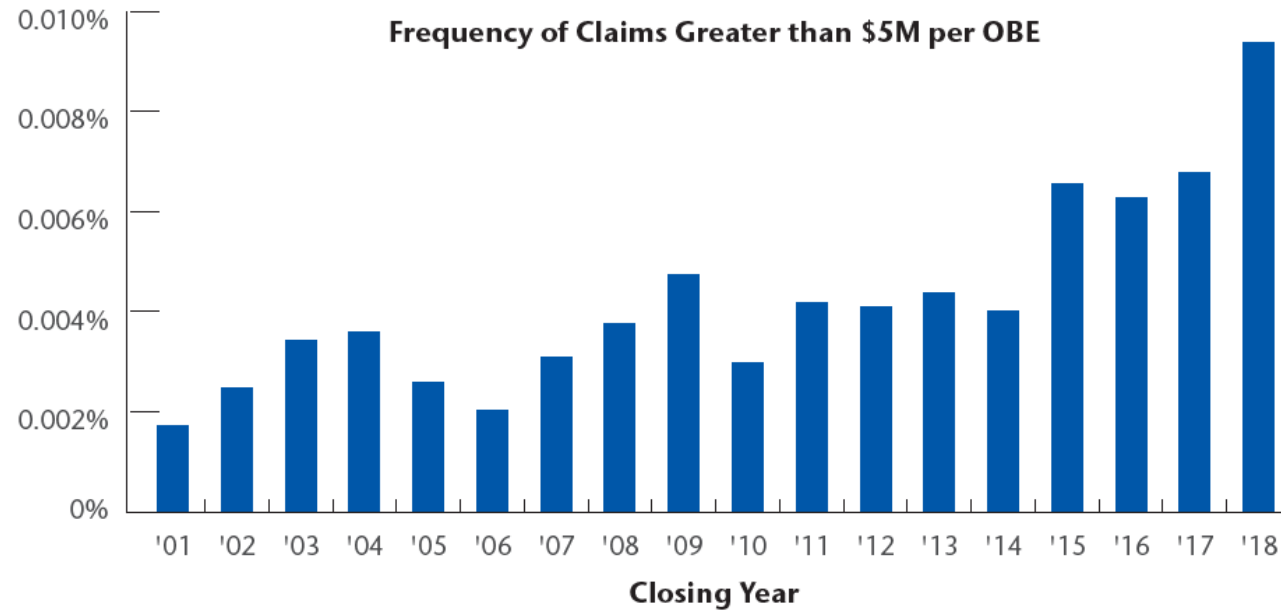
State of the Market 2020: Diagnostic Error is the Second Most Frequent Cause of Professional Liability Claims

Severity of Professional Liability Claims by Cause of Loss

Cause of Loss	Unlimited Average Claim Cost (Indemnity + Expense)	Unlimited Average Indemnity Cost	% of All Claims
Labor & Delivery Related Issue	456,000	1,121,000	6.4%
Diagnosis Error (Delay/Failure)	288,000	663,000	11.4%
Surgical Error	245,000	463,000	12.3%
Medication Related Issue	238,000	376,000	5.1%

Source: 2019 Aon/ASHRM Hospital and Physician Professional Liability Benchmark Analysis. All rights reserved.

State of the Market 2020: Malpractice Insurance Just Got Very Expensive

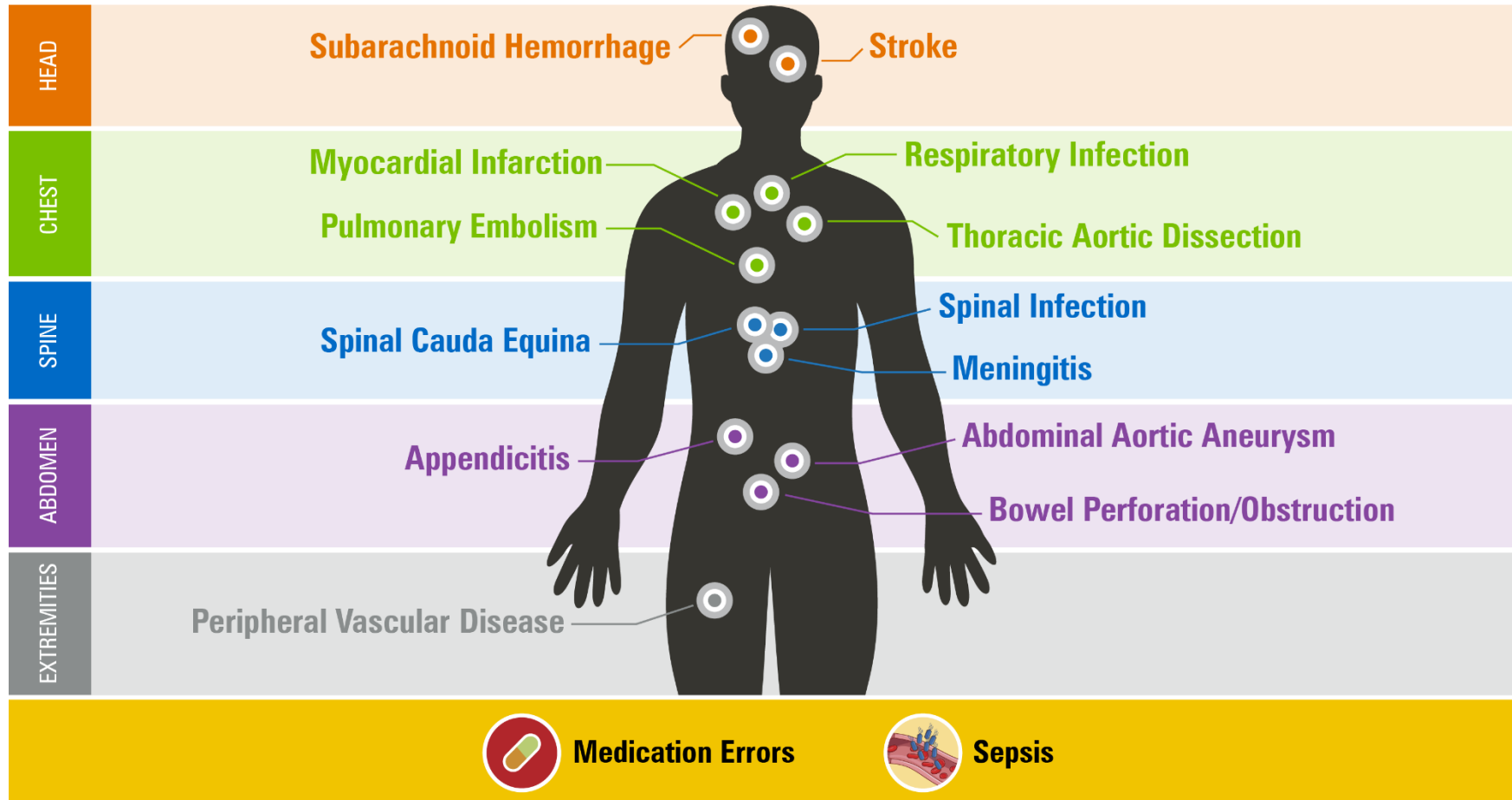


Credit: Slide created by Aon Healthcare Practice. Presented in webinar on 10/6/2020 by Andrew Azan & Erik Johnson

TSG Research Into the Root Cause of the Failure to Diagnose in EM



Strategy – Target the Highest Risks



Most Common & Costly Misdiagnosed Conditions (n = 7,211 claims)

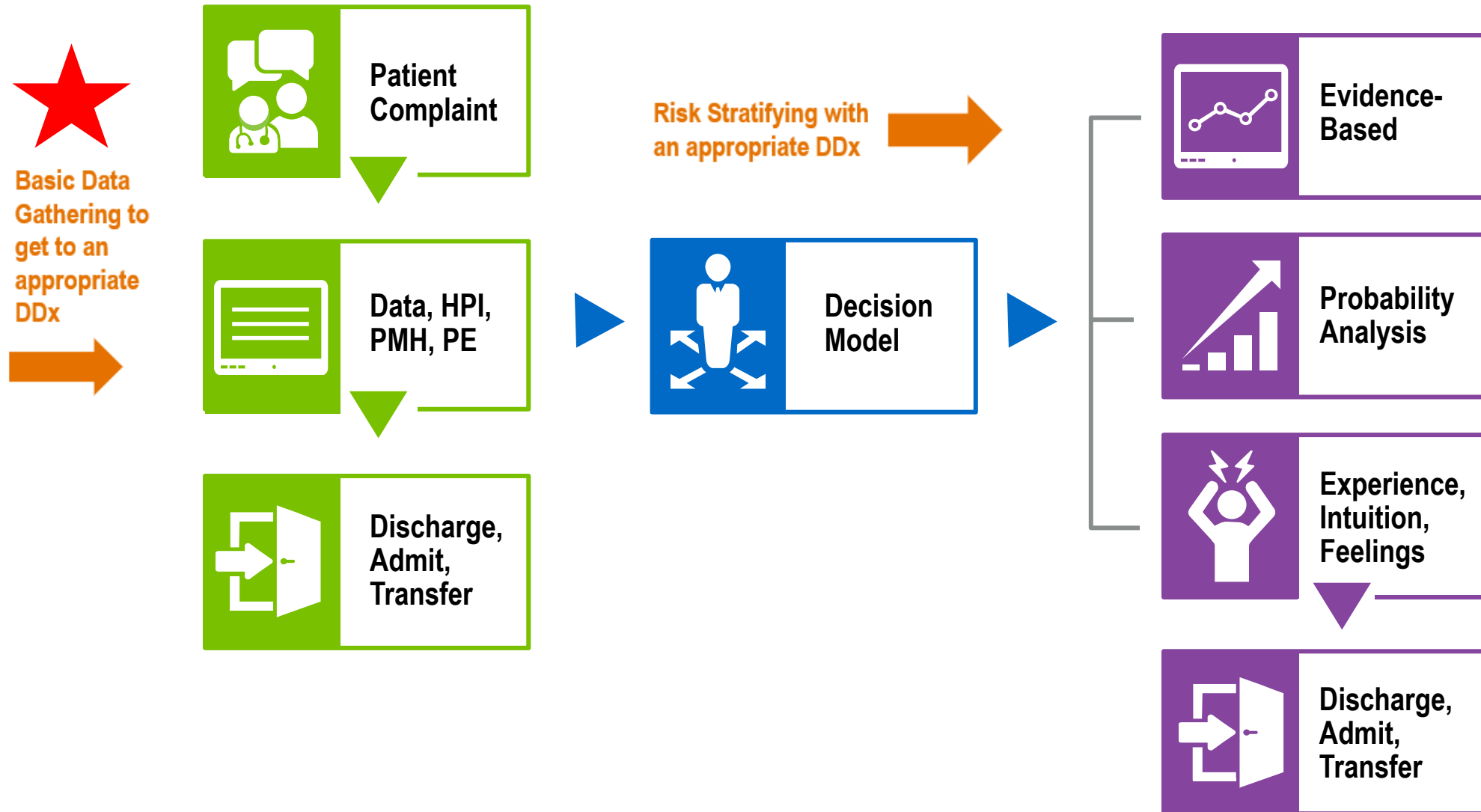
CLAIMS ANALYSIS TARGETS TOP 14

In our unpublished analysis of over 7,000 emergency physician liability claims, we found that 14 diagnoses accounted for the greatest frequency and severity of indemnity losses in acute care medicine. The common thread among these diseases is that they present as a patient chief complaint (e.g., chest pain) that requires a high-reliability diagnostic process to avoid misdiagnosis.



TOP 14 MISDIAGNOSED CONDITIONS IN ACUTE CARE MEDICINE

1. Acute MI
2. Stroke
3. Peripheral Vascular Disease
4. Sepsis
5. Intracranial / Subarachnoid Hemorrhage
6. Cauda Equina Syndrome
7. Intestinal Perforation / Obstruction
8. Respiratory Infection
9. Meningitis
10. Spinal Infection (Epidural Abscess)
11. Pulmonary Embolism
12. Acute Aortic Dissection
13. Abdominal Aortic Aneurysm
14. Appendicitis



Abdominal Pain (40 and older) and AAA – National Profile



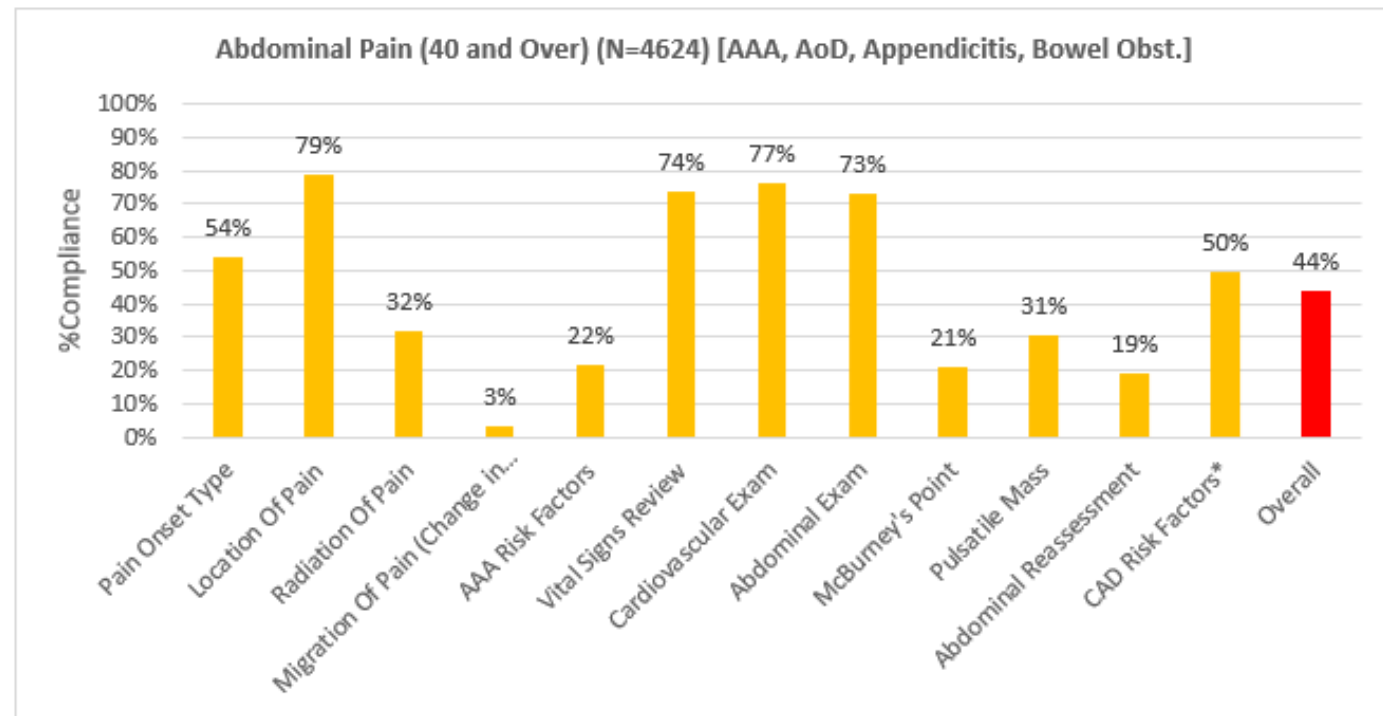
Appropriate H & P data set?

- Type of pain onset
- Location
- Radiation of pain
- Movement (e.g., chest to abdomen)
- AAA risk predisposition

Documentation Compliance From 21 EDs Across The Country*

< AP > 40

Abdominal Pain (40 and Over)				
ED Guidance	Documented			
	YES	NO	Total	%YES
Pain Onset Type	2,506	2,118	4,624	54%
Location Of Pain	3,659	965	4,624	79%
Radiation Of Pain	1,478	3,146	4,624	32%
Migration Of Pain (Change in Loca	153	4,471	4,624	3%
AAA Risk Factors	997	3,627	4,624	22%
Vital Signs Review	3,413	1,211	4,624	74%
Cardiovascular Exam	3,540	1,084	4,624	77%
Abdominal Exam	3,392	1,232	4,624	73%
McBurney's Point	981	3,643	4,624	21%
Pulsatile Mass	1,418	3,206	4,624	31%
Abdominal Reassessment	880	3,744	4,624	19%
CAD Risk Factors*	673	686	1,359	50%
Overall	23,090	29,133		44%



* From the last 18 months from EPIC, Cerner, Meditech EDs

Chest Pain (40 and older) and TAD, PE, AMI – National Profile



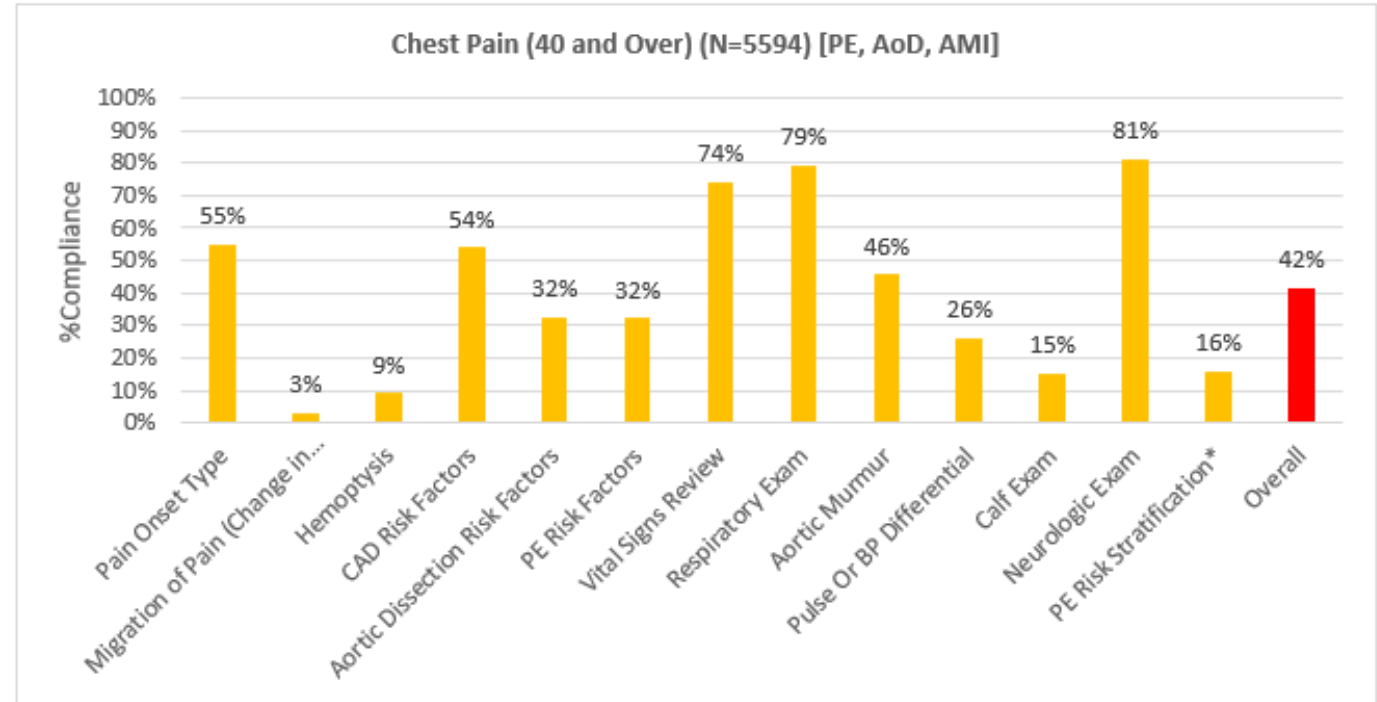
Appropriate H & P data set?

- Type of pain onset
- Movement (e.g., chest to abdomen...)
- Hemoptysis
- CAD, AoD, PE Risk Predisposition

Documentation Compliance From 21 EDs Across The Country*

< CP > 40y

Chest Pain (40 and Over)				
ED Guidance	Documented			
	YES	NO	Total	%YES
Pain Onset Type	3,077	2,517	5,594	55%
Migration of Pain (Change in Loca	166	5,428	5,594	3%
Hemoptysis	508	5,086	5,594	9%
CAD Risk Factors	3,020	2,574	5,594	54%
Aortic Dissection Risk Factors	1,818	3,776	5,594	32%
PE Risk Factors	1,801	3,793	5,594	32%
Vital Signs Review	4,155	1,439	5,594	74%
Respiratory Exam	4,439	1,155	5,594	79%
Aortic Murmur	2,554	3,040	5,594	46%
Pulse Or BP Differential	1,453	4,141	5,594	26%
Calf Exam	813	4,477	5,290	15%
Neurologic Exam	4,540	1,054	5,594	81%
PE Risk Stratification*	311	1,685	1,996	16%
Overall	28,655	40,165		42%

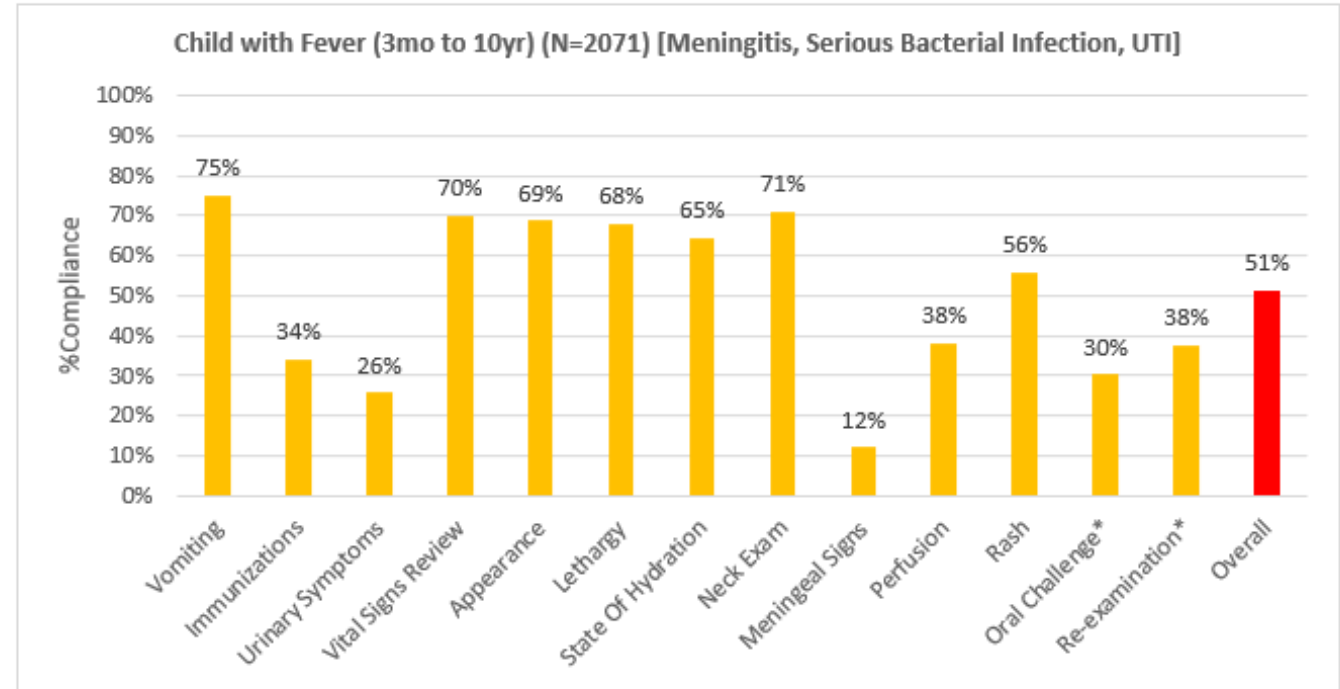


* From the last 18 months from EPIC, Cerner, Meditech EDs

Documentation Compliance From 21 EDs Across The Country*

: Fever 3m-10y

Child with Fever (3mo to 10yr)				
ED Guidance	Documented			
	YES	NO	Total	%YES
Vomiting	1,553	518	2,071	75%
Immunizations	709	1,362	2,071	34%
Urinary Symptoms	533	1,538	2,071	26%
Vital Signs Review	1,448	623	2,071	70%
Appearance	1,423	648	2,071	69%
Lethargy	1,410	661	2,071	68%
State Of Hydration	1,336	735	2,071	65%
Neck Exam	1,468	603	2,071	71%
Meningeal Signs	251	1,820	2,071	12%
Perfusion	788	1,283	2,071	38%
Rash	1,156	915	2,071	56%
Oral Challenge*	212	488	700	30%
Re-examination*	549	914	1,463	38%
Overall	12,836	12,108		51%



* From the last 18 months from EPIC, Cerner, Meditech EDs




Vital Signs Re-evaluation – National Profile



CHEST PAIN / EQUIVALENT

Time of Exam : _____

Level 1, 2, 3 Documentation 1 to 3 elements	Level 4 Documentation - 4 + elements	Level 5 Documentation - 4 + elements
CHIEF COMPLAINT & HPI: <input type="checkbox"/> Unable to fully assess due to altered LOC or patient condition		History Obtained From: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Police <input type="checkbox"/> EMS <input type="checkbox"/> Other
		Pain Grade 0 - 10: _____ ECG Completed <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> NA <input type="checkbox"/> Time of Interp. _____ <input type="checkbox"/> Nursing Notes Reviewed <input type="checkbox"/> Vital Signs Reviewed
Chest Pain: Y N SOB: Y N Nausea: Y N Vomiting: Y N Diaphoresis: Y N Radiation of Pain: Y N If Y, Where:		
Time Course: <input type="checkbox"/> NA <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Under 1 hour <input type="checkbox"/> Hours: _____ <input type="checkbox"/> Days: _____ <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Resolved		
Location: <input type="checkbox"/> NA <input type="checkbox"/> Substernal <input type="checkbox"/> Epigastric <input type="checkbox"/> Lt Chest <input type="checkbox"/> Rt Chest <input type="checkbox"/> Back <input type="checkbox"/> Neck <input type="checkbox"/> Other :		
Quality : <input type="checkbox"/> Pressure <input type="checkbox"/> Sharp <input type="checkbox"/> Aching <input type="checkbox"/> Stabbing <input type="checkbox"/> Dull <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Fullness <input type="checkbox"/> Same As Prior		
Associated With: Fever: Y N Cough: Y N Migration or Movement of Pain: Y N NA <input type="checkbox"/> Nothing <input type="checkbox"/> Trauma <input type="checkbox"/> Other :		
Severity Maximum is: <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Severe Severity Current is : <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Severe		
Exacerbated By: <input type="checkbox"/> Nothing <input type="checkbox"/> Exercise <input type="checkbox"/> Palpation of Chest <input type="checkbox"/> Movement <input type="checkbox"/> Cough / Deep Breath <input type="checkbox"/> Other :		
Relieved By: <input type="checkbox"/> Nothing <input type="checkbox"/> Nitroglycerin <input type="checkbox"/> X 1 <input type="checkbox"/> X 2 <input type="checkbox"/> X 3 <input type="checkbox"/> Oxygen <input type="checkbox"/> Sitting up <input type="checkbox"/> Supine <input type="checkbox"/> Remaining Still <input type="checkbox"/> Other :		
CAD Risk: <input type="checkbox"/> NA <input type="checkbox"/> None <input type="checkbox"/> Known CAD <input type="checkbox"/> Smoking <input type="checkbox"/> Cholesterol <input type="checkbox"/> HTN <input type="checkbox"/> Fam.Hx. <input type="checkbox"/> Diabetes <input type="checkbox"/> Cocaine		
TAD Risk: <input type="checkbox"/> NA <input type="checkbox"/> None <input type="checkbox"/> HTN <input type="checkbox"/> 1st Degree Relative <input type="checkbox"/> Turner's <input type="checkbox"/> Aortic Valve Disease <input type="checkbox"/> Connective Tissue Disease (Marfan's, Ehlers Danlos) <input type="checkbox"/> Pregnancy <input type="checkbox"/> Others : _____		
PE Risk: <input type="checkbox"/> NA <input type="checkbox"/> None <input type="checkbox"/> Previous PE <input type="checkbox"/> Malignancy <input type="checkbox"/> Obesity <input type="checkbox"/> Trauma <input type="checkbox"/> Greenfield <input type="checkbox"/> Pregnancy / Postpartum <input type="checkbox"/> Smoking <input type="checkbox"/> Prior DVT <input type="checkbox"/> Immobilization (e.g. Leg Cast, Travel) <input type="checkbox"/> Surgery Last 60 days <input type="checkbox"/> Coagulation Disorder <input type="checkbox"/> Estrogen Medicine <input type="checkbox"/> Others _____		

HPI CHEST PAIN	
▼ TIME	
Time:	<input type="text"/> 
▼ CHIEF COMPLAINT	
<input checked="" type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> CHEST PAIN:	<input type="radio"/> AICD EVENT:
▼ HISTORIAN	
<input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Family <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Caregiver <input type="checkbox"/> NH <input type="checkbox"/> EMS <input type="checkbox"/> Police <input type="checkbox"/> Translator	
Other:	<input type="text"/>
▼ TIME COURSE	
<input type="checkbox"/> Sudden <input type="checkbox"/> Gradual <input type="checkbox"/> Unknown	
Onset was	<input type="text"/> 
<input type="checkbox"/> Just prior to presentation	
<input type="checkbox"/> Current symptomatic <input type="checkbox"/> Improved <input type="checkbox"/> Worse <input type="checkbox"/> Persistent <input type="checkbox"/> Resolved	
<input type="checkbox"/> Constant <input type="checkbox"/> Intermittent	
Episodes last	<input type="text"/> and are <input type="text"/> apart
▼ LOCATION	
<input checked="" type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> No Localizing Sx.	<input type="radio"/> MOST SEVERE IN
<input checked="" type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> ANY CHANGE IN LOCATION OF PAIN OVER TIME	<input type="radio"/>
	<input type="text"/> RADIATION
	None
	To Back 

ZZZTEST, CAREADMIN ARTHUR | DOB: 11/10/1979 | Age: 41 years | Sex: Male | Attending: TOUCHGLE, USER | james_flanagan | 7 minutes ago

Menu: Document Viewing, Documentation, Clinical Notes, FlowSheet, Intake and Output, PowerOrders, Problems and Diagnoses, Allergies, Procedures and Diagnoses, Form Browser, Patient Information, Intake and Output, Histories, MAR, Staging MPage, Intake and Output, PowerOrders, Oncology, DynDoc Workflow MPage

Subjective/History of Present Illness

Tahoma 9 | [Rich Text Editor] | Last Saved: JUN 14, 2020 10:53 | Save

Objective/Physical Exam

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Review of Systems

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Assessment and Plan

Tahoma 9 | [Rich Text Editor] | Ongoing | No qualifying data

S19BX | DOCPHYSICIAN1 | June 14, 2020 | 10:55 AM CDT

ZZTEST, IME ← List → Recent Name

ZZTEST, IME	DOB: 5/17/1944	Age: 77 years	Sex: Female	MRN: MX00006796
Allergies: Allergies Not Recorded	Dose Wt: Error	Advance Directive:	Code Status: Error	Isolation: Error
Care Team: View Details	HealthLife: No	Clinical Trial: Error	Loc: CT	Inpatient FIN: MX000015635 [Admit Dt: 10/29/2018 12:18:00 PM CDT Disch Dt: ...]

Documentation reid_conant_EDG Full screen 0 minutes ago

Admission H & P List

Tahoma 9 B I U S A

Chief Complaint

History of Present Illness
The patient is a 20-year-old male with a chief complaint of severe back pain and fever. The patient states that his onset of pain has been gradual over the last few days and it is aching in character. There is been no movement of the pain. It has been steady in the same location. The pain is located in the both the lumbar and thoracic areas. The mechanism of injury according the patient was lifting furniture over the weekend and he has never had a pain like this before. There is no associated incontinence. There has been no nausea no vomiting no shortness of breath or chest pain. The patient does indicate that he thinks he had a fever which was accompanied by shaking chills at night over the last 2 weeks.]

Review of Systems
Constitutional: Subjective fever
Eyes: No pain or loss of vision
ENT: No loss of hearing, denies sore throat
Respiratory: No shortness of breath or cough
Cardiovascular: Denies chest pain or palpitations
Gastrointestinal: No nausea, vomiting or diarrhea
Genitourinary: No trouble urinating or flank pain
Musculoskeletal: Back pain in the thoracic and lumbar regions
Integumentary: No skin changes, denies rash
Neurologic: Denies headache, dizziness or syncope
Psychiatric: Denies depression or anxiety

Physical Exam
Vitals & Measurements
Vital Signs: Have been reviewed and are within normal limits.
Constitutional Exam: Well nourished, well developed, appears stated age.
Appearance: Awake and alert but does appear to be in pain.
Eyes: PERRL, EOM normal
Neck: Supple with full range of motion
Respiratory: Lungs clear to auscultation, no rales rhonchi or wheezing
Cardiovascular: S1, S2 normal, no murmur. Peripheral circulation intact
Gastrointestinal: Abdomen soft, non-tender. No guarding or rebound, bowel sounds NA
Musculoskeletal: There is paraspinal muscular tenderness in the thoracic and lumbar regions
Neurologic Exam: No focal findings.

Assessment/Plan

Problem List/Past Medical History
Ongoing
No qualifying data
Historical
No qualifying data

Procedure/Surgical History

Medications
Inpatient
No active inpatient medications
Home
No active home medications

Allergies
No active allergies

Social History

Family History

Immunizations

Lab Results

Diagnostic Results

OW

ED1

Isolation: None

ALLERGIES
Sulfa (Sulfonamide Antibiotics)

CHIEF COMPLAINT
Chest Pain

BP	Temp	Pulse
143/65	99 °F	66
>1 day	>1 day	>1 day
Resp	SpO2	Wt
21	—	—
>1 day		

NEW RESULTS
No new results

MED STATUS (4)
 Done (3)
 In Progress (1)

DISPOSITION

6/20/2020 v...

Chart Complete

BestPractice Advisor
No advisories to address.

ED Provider Note Reminder
ATTENTION: When with a mid-level, p remember to open note before the pa discharged

ED Provider Notes
My Note See All Notes
No notes of this type filed. A new progress which has not yet been s

Sidebar Summary TIMI FLOWSHEETS Edit Note

My Note
ED Provider Notes

Tag Share w/ Patient Details

Service: Date of Service: 6/26/2020 03:18 PM

Cosign Required

Insert SmartText

Empty text area for note content.

Pend Share Sign Cancel

Hyperspace - KH 29 My Incomplete Charts 145 Hospital Chart Completion 28 My Incomplete Notes 98

Epic ED Manager ED Track Board In Basket UpToDate Elsevier ClinicalKey Provider My Dashboards ED Chart Hospital Chart Patient Lists

Eisa, Edith KHN TRAINING - PLY ATTENDING E. ASAP

6/20/2020 v... Chart Complete

BestPractice Advisor
No advisories to address.

ED Provider Note Reminder

ATTENTION: When with a mid-level, p remember to open note before the pa discharged

ED Provider Notes

My Note

ED Provider Notes

Service: Date of Service: 6/26/2020 03:18 PM

Cosign Required

temp

Abbrev	Expansion
☆ TEMPGENERAL	CHIEF COMPLAINT @RFV@ HPI @NAME@ is a @AGE@ @SEX@ who presents *
☆ TEMPGU	CHIEF COMPLAINT @RFV@ HPI @NAME@ is a @AGE@ @SEX@ who presents *...

Refresh (Ctrl+F11) Close (Esc)

Isolation: None

ALLERGIES
Sulfa (Sulfonamide Antibiotics)

CHIEF COMPLAINT
Chest Pain

BP	Temp	Pulse
143/65	99 °F	66
>1 day	>1 day	>1 day

Resp	SpO2	Wt
21	—	—
>1 day		

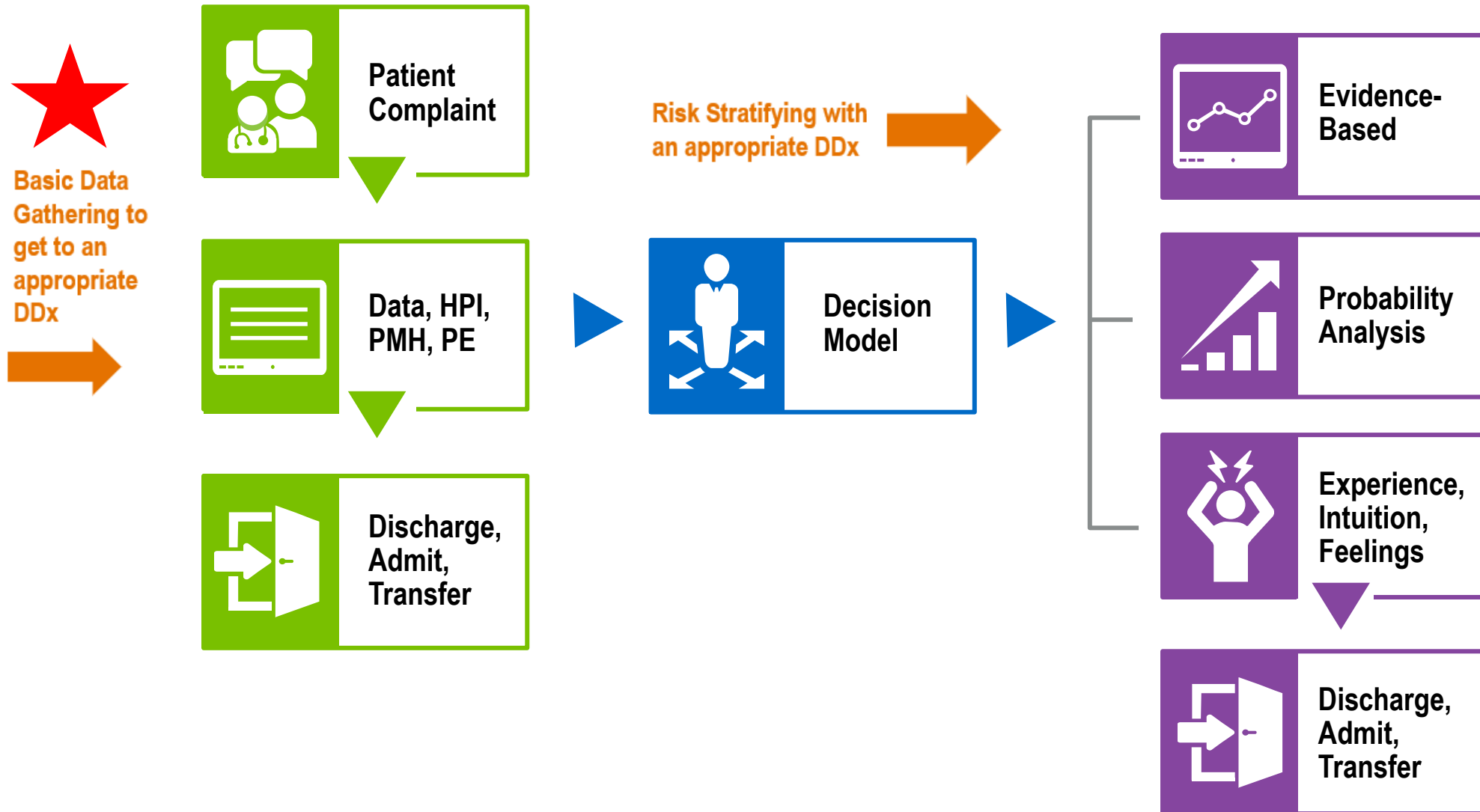
NEW RESULTS
No new results

MED STATUS (4)
 Done (3)
 In Progress (1)

DISPOSITION

Tag Share w/ Patient Details

Pend Share Sign Cancel



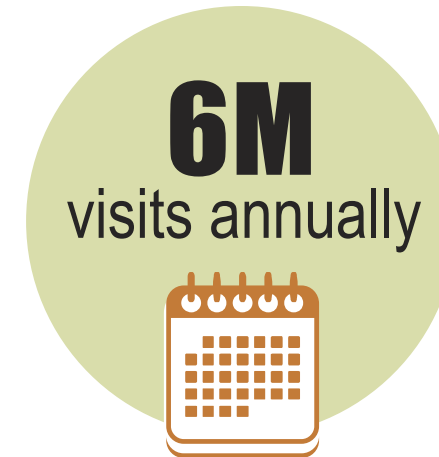
Driving Clinical Alignment Around Key Elements of Hx, PE, MDM Does That Work?



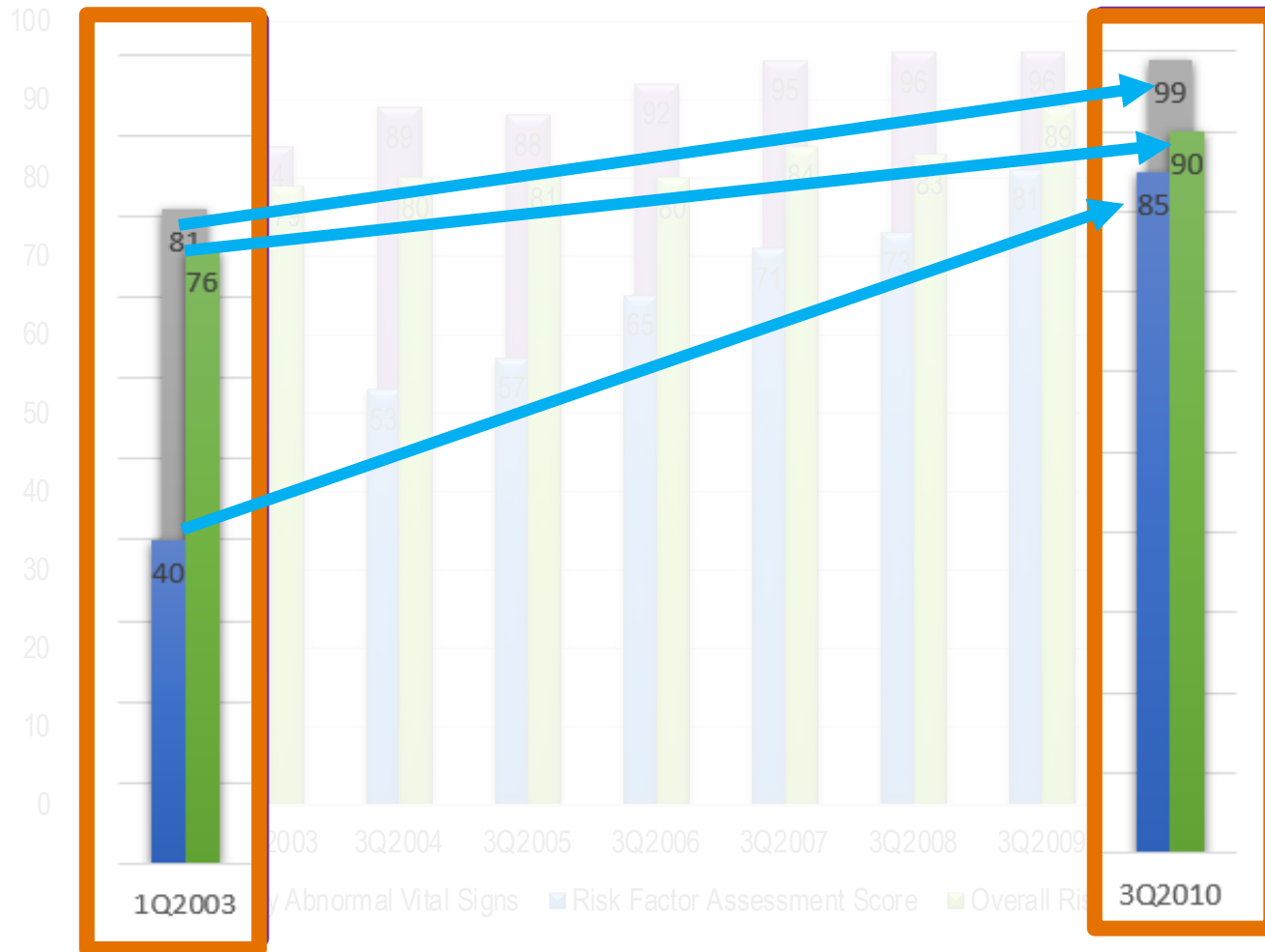
Does That Work?

- Data from a large U.S. healthcare provider

- Emergency Services



Large Hospital System: 190 EDs | >3000 practitioners | >6M Annual ED Visits

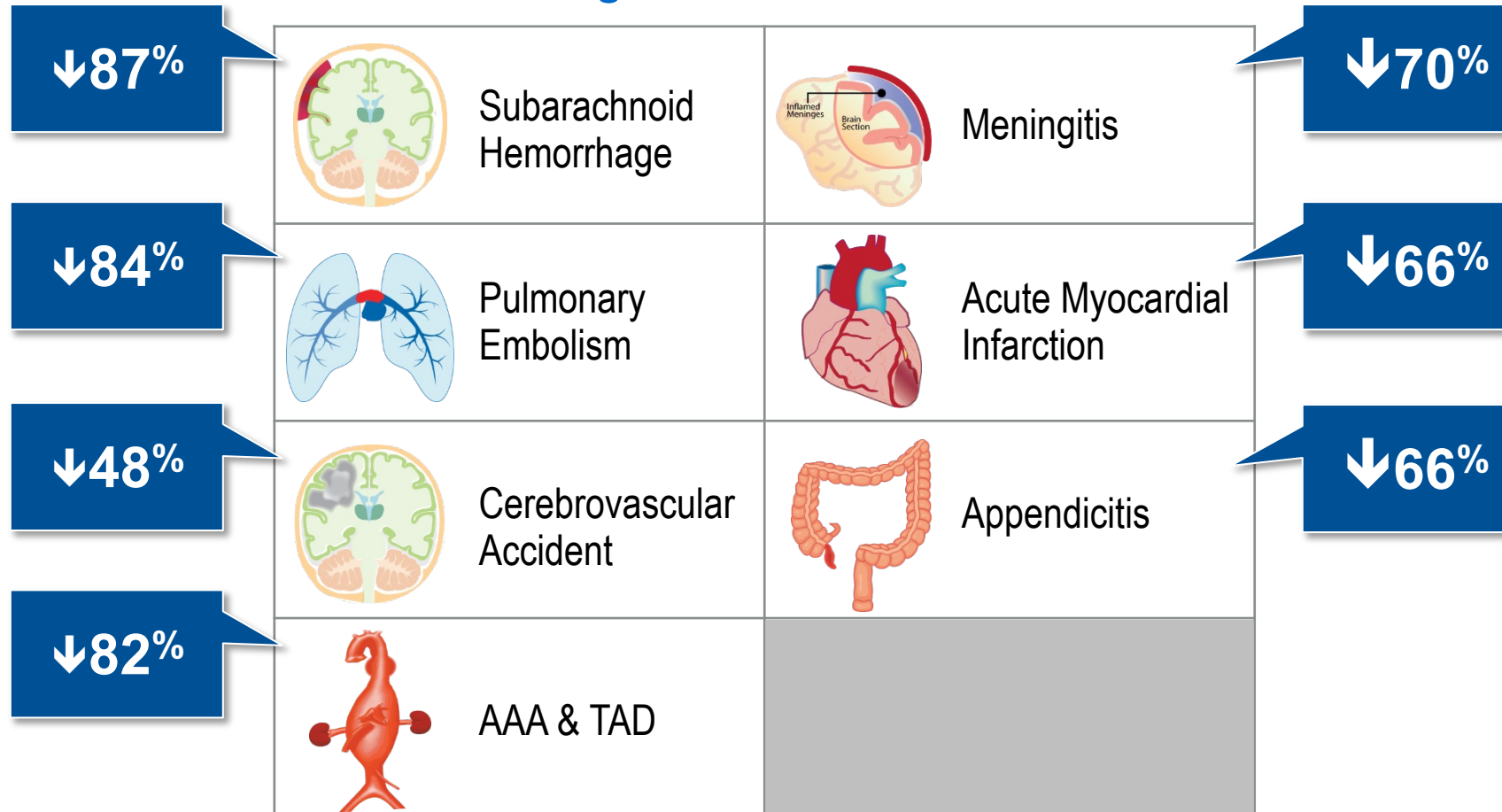


Clinical Alignment Over 7 Years

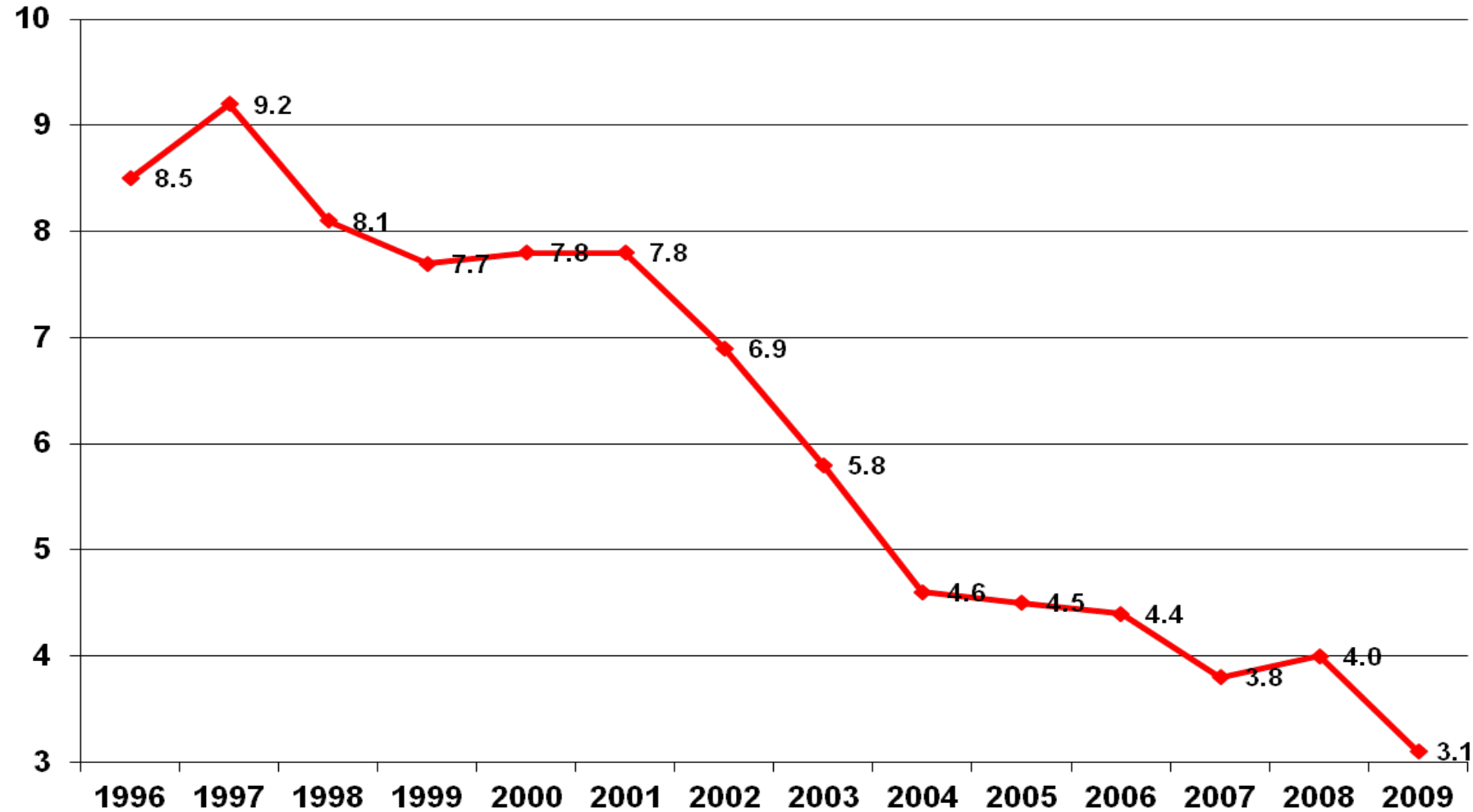
- Overall compliance with over 150 clinical drivers increased from **76%** to **90%**.
- The patients that presented with a very abnormal vital sign that was sent home with that same vital sign (no repeat) decreased from **19%** to **1%**.
- Overall compliance with risk factor analysis advanced from **40%** to **85%**.

Overall 74% Reduction in Dx-Related Claims

7 High-Risk Conditions



Claims Per 100,000 Visits



Solutions to Impact Dx-Related Errors Decision Making & Documentation

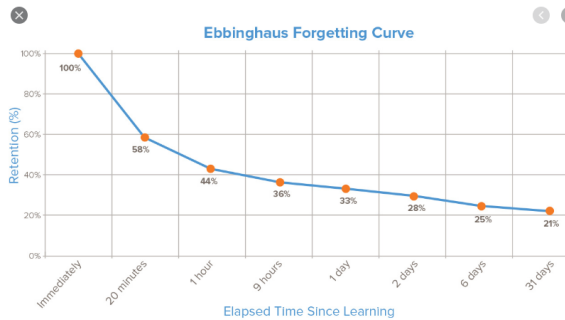


Current Risk & Safety Paradigm



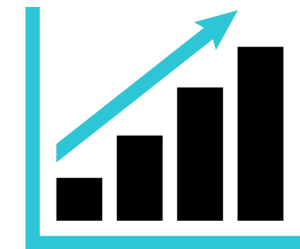
Current Approach

Books, lectures and on-line training.



Problem

The human forgetting curve, recall ability and memory loss. Key information is not front of mind at the bedside.



Impact

Over decades the frequency of errors and claims is steady to rising. The cost of claims is currently rising dramatically.

New EM Risk & Safety Paradigm



Using AI

provides **conditional algorithms, checklists & decision support, real-time** during the patient encounter.

It Must Be

visually available & comfortably in the practitioner's **workflow.**

6/20/2020 v... Chart Complete

BestPractice Advisor
No advisories to address.

ED Provider Note Reminder
ATTENTION: When with a mid-level, p remember to open note before the pa discharged

ED Provider Notes
My Note See All Notes
No notes of this type filed. A new progress which has not yet been s

Isolation: None

ALLERGIES
Sulfa (Sulfonamide Antibiotics)

CHIEF COMPLAINT
Chest Pain

BP	Temp	Pulse
143/65	99 °F	66
>1 day	>1 day	>1 day
Resp	SpO2	Wt
21	—	—
>1 day		

NEW RESULTS
No new results

MED STATUS (4)
Done (3)
In Progress (1)

DISPOSITION

My Note
ED Provider Notes Tag Share w/ Patient Details

Service: Date of Service: 6/26/2020 03:18 PM

Cosign Required

Rich Text Editor: B abc ↶ ↷ ? ? + Insert SmartText ↵ ↶ ↷ ↻ ↵ ↶ ↷

Buttons: Pend Share Sign Cancel



Christopher Ulrich

Male | 23 yrs | 15-Aug-1999

Account No.
v1583255

MRN
mrn1583256

Provider
—

dsullivan

View All Patients

- Allergies
- Problems
- Notes
- Vitals
- Labs
- Test Results
- Medications
- Orders
- Radiology
- Past Medical History
- Past Visits

Note

[Add new](#)

Note, 28-Sep-2022 11:55 AM
DanSullivan

Note, 28-Sep-2022 11:55 AM

Chief Complaint: The patient is a 23-year-old male with a chief complaint severe back pain.

History of Present Illness:

The patient states that his onset of pain has been gradual over the last few days, it is aching in character. There has been no movement of the pain; it has been steady in the same location.

Review of Systems:

[]

Physical Examination:

[]

Medical Decision Making:

[]

Impression: []

Pend

Sign

Ulrich, Christopher MRN: mrn1583256

1 ED Guidance CME 44.0

Back Pain (12 to 39) Resources

Mechanism Of Injury
Chronic Back Pain/Osteo | Lifting | MVA | Other | Other Known Cause | No Apparent Mechanism

Location Of Pain
Multiple Levels | Lumbar | Thoracic | Cervical | Other

Fever By History
No History of Fever | History of Fever

Bladder/Bowel Symptoms
No Incontinence | Recent Incontinence | Unable to Urinate | Other

Back Or Spinal Exam
<document back exam>

Neurologic Exam
<document neurologic exam (3 or more elements)> | Sensory | Motor | DTRs | Straight Leg Raise | Cauda Equina Eval

Document Considerations

Medical Decision Making
Risk of Morbidity / Mortality [Learn More](#)

Christopher Ulrich [Visit Id: v0304702]



MRN: mrn0304703 Sex: Male Blood Pressure: 95/60mmHg
DOB: 8/15/1999 Height: 150 cm Pulse: 68
Age: 20 Weight: 70 kg Temperature: 38.0° C

Note Patient Summary

Arial 10

B I U [Rich text editor icons]

Chief Complaint: The patient is a 20 year old male with back pain.

History of Present Illness:

The patient has had back pain for the last 2 days. He states the the onset of pain was gradual. There has been no movement or migration of the pain, it has remained in the same location. There has been no associated incontinence. The mechanism of injury according to the patient is lifting furniture over the weekend, but he has never had a pain like this before. The patient denies any history of fever.

Review of Systems:

[]

Physical Exam:

[]

Medical Decision Making:

[]

Impression: []

Advisor

Ulrich, Christopher

ED Guidance

CME 1.0

Back Pain 18 To 40

Location Of Pain

[Multiple Levels](#) | Lumbar | Thoracic | Cervical | Other

Vital Signs

<document review of vital signs>

Fever On Exam

No Fever | Fever in ED

Back Or Spinal Exam

<document back exam>

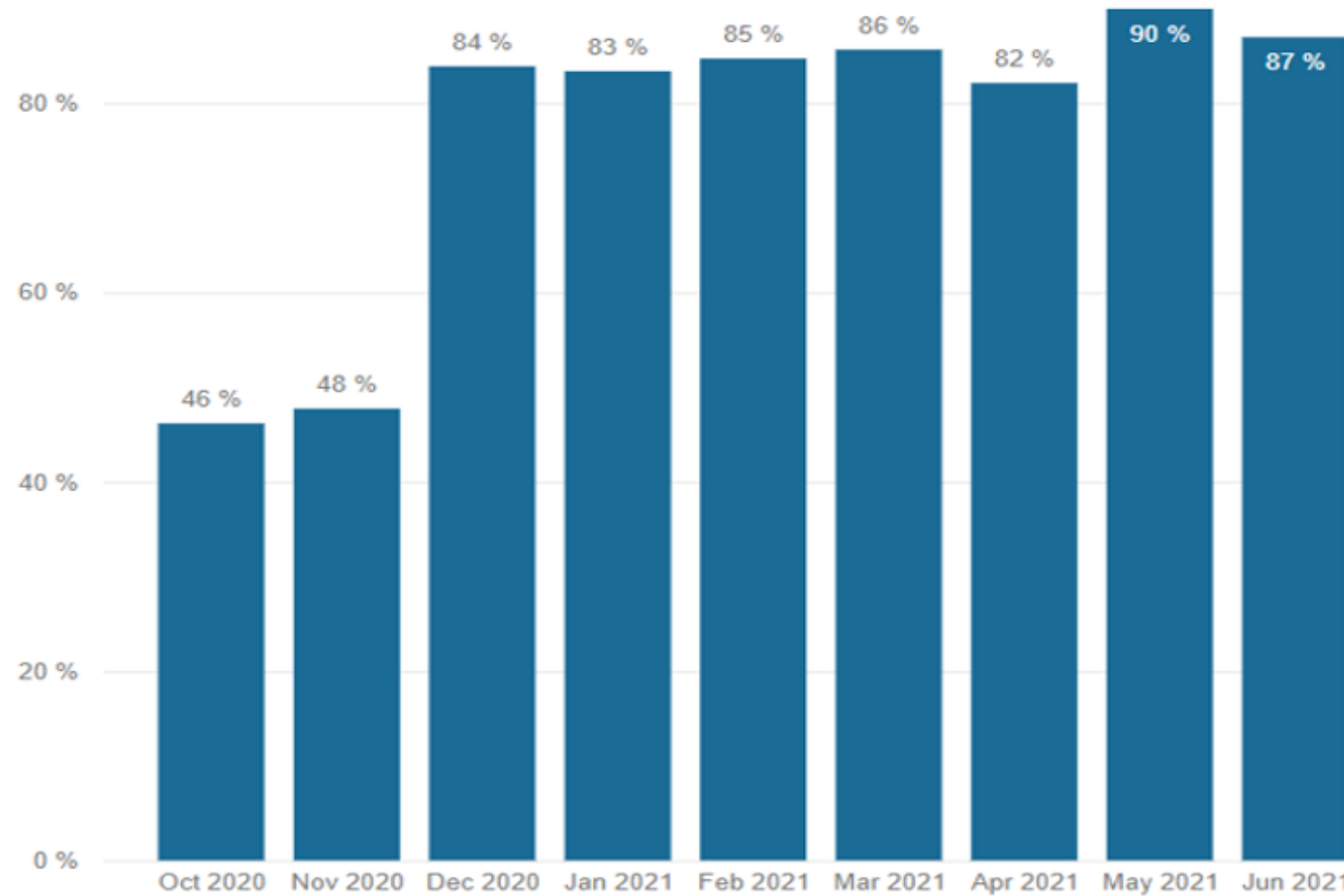
Neurological Exam

[Sensory](#) | [Motor](#) | [DTRs](#) | [Straight Leg Raise](#) | [Cauda Equina Eval](#)

ED Guidance Demo

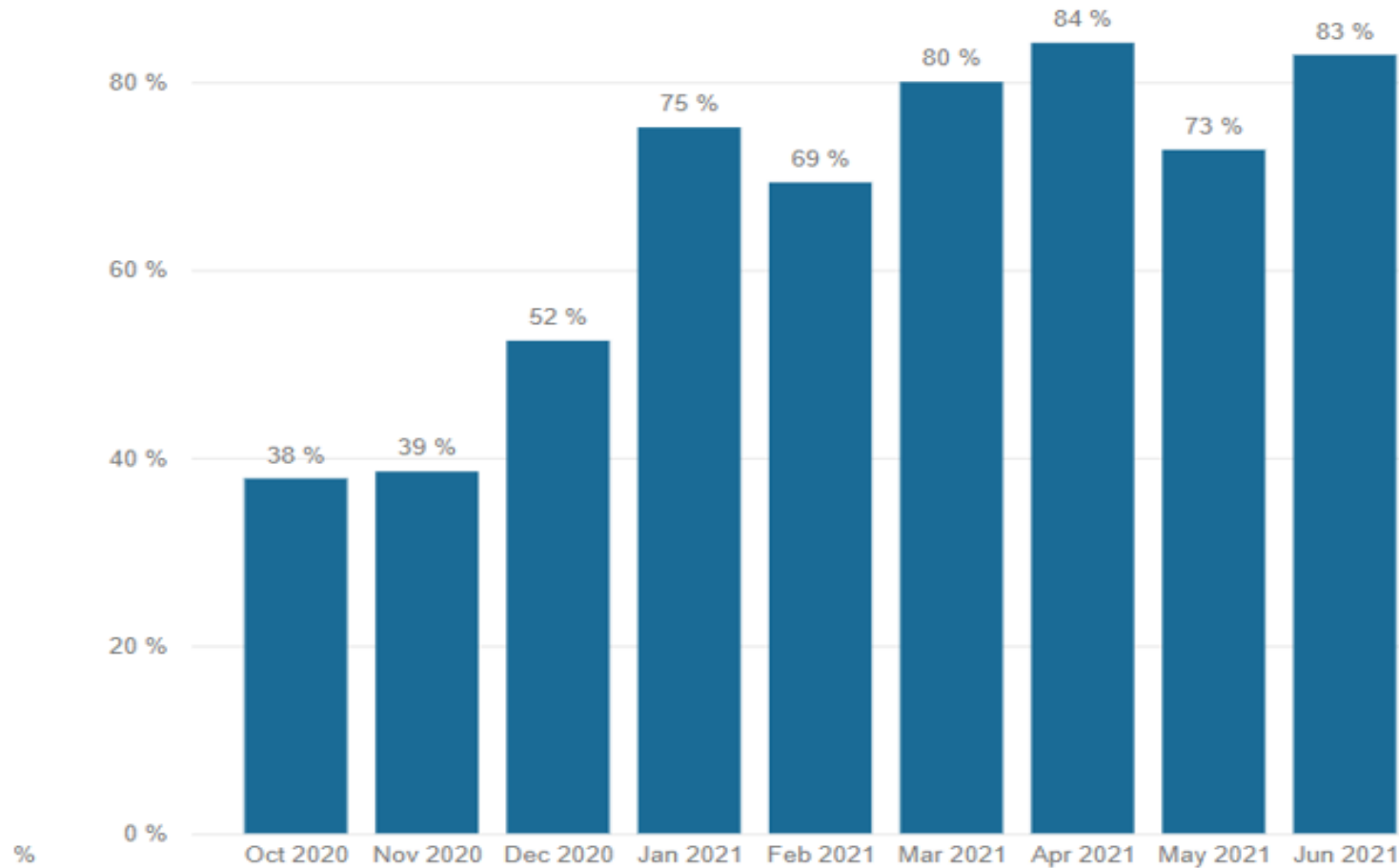
Abdominal Pain (12-39 years of age)

Risk & Safety Score Trend



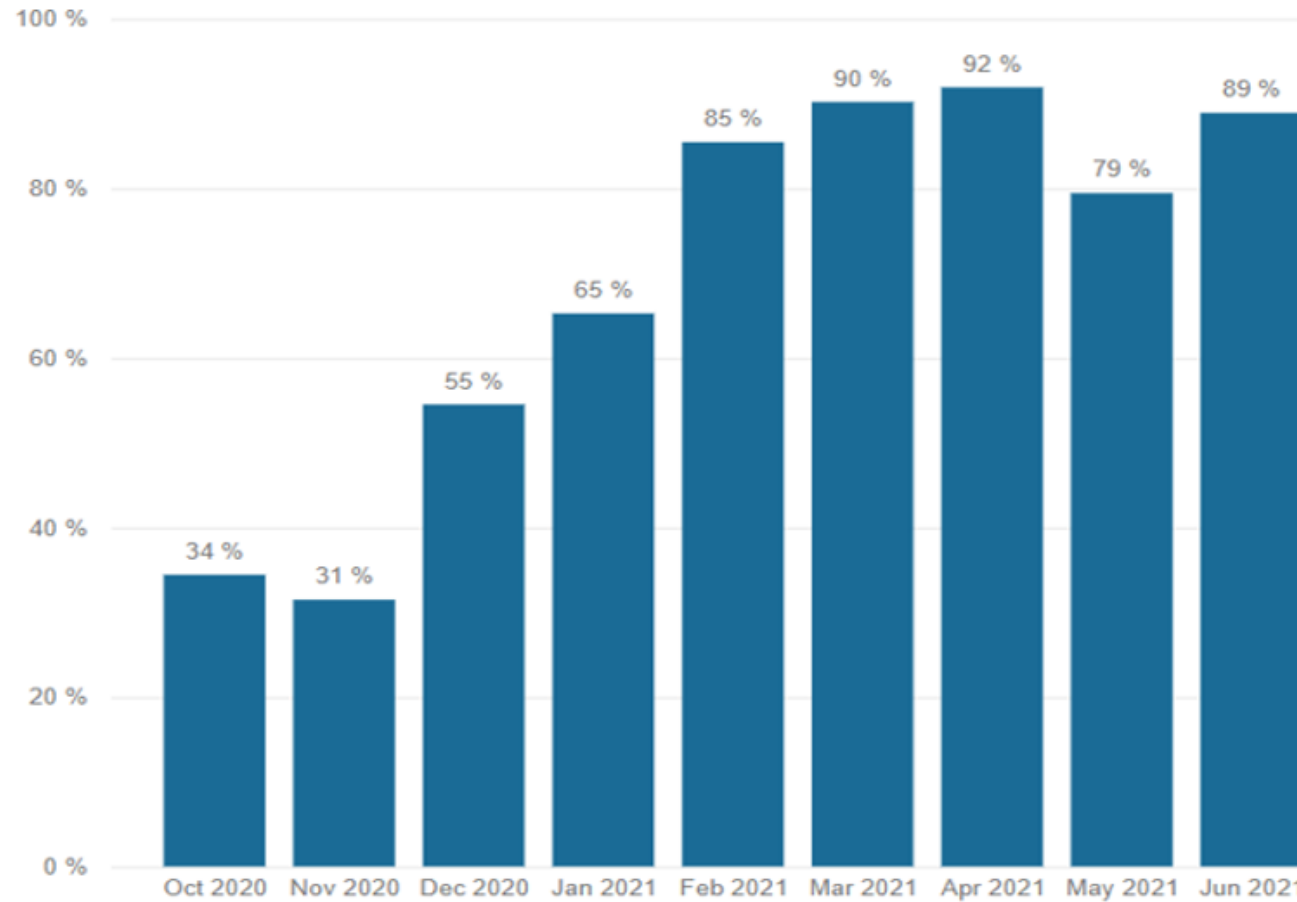
Abdominal Pain (40+ years of age)

Risk & Safety Score Trend

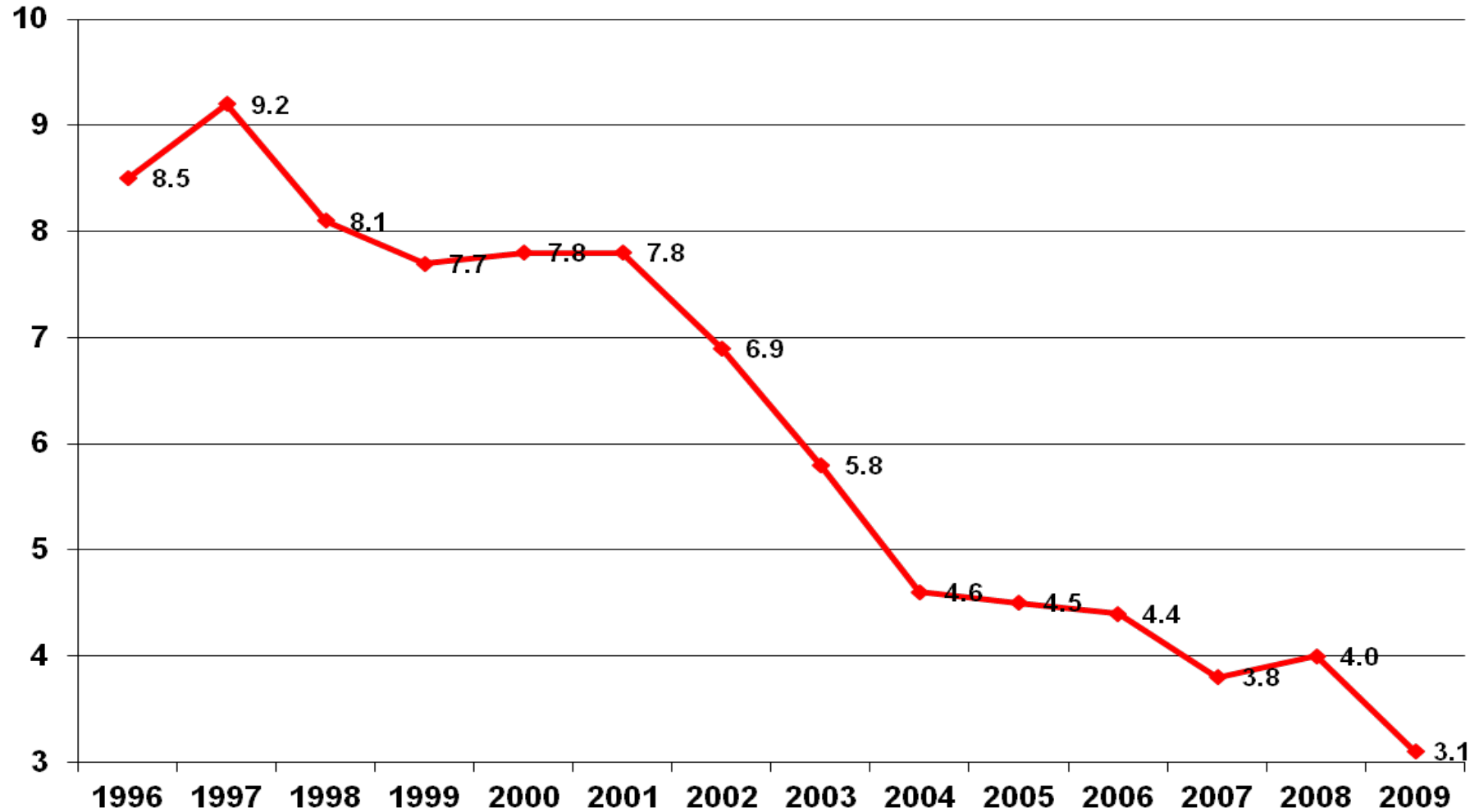


Chest Pain (40+ years of age)

Risk & Safety Score Trend



Claims Per 100,000 Visits



it's really
time that I sit

Can't we give you an injection
in your left knee a while ago?

I remember



Medical record interface for Alex Porter. The interface includes a patient photo, name, gender, age, date of birth, primary care physician (PCP), and medical record number (MRN). It also displays vital signs (P: 64, BP: 100 / 60, RR: 16) and sections for 'List' and 'Medications'.

Alex Porter
Gender: Female, 44 YO, 07/12/1974
PCP: Roberta Montanaro, M.D. MRN: 334129

P: 64 BP: 100 / 60 RR: 16

List Medications



The ED After Roe



Your Patient is Diagnosed With an IUP During the ED Visit

- Work with OB and your hospital admin/legal to create a list of referral options. Provide to all pregnant patients seeking pregnancy related care.
- Provide that approved list to the patient as a routine part of the discharge instruction process.
- If your state has criminalized abortion, don't engage in the conversation "Where can I get an abortion".

Your Patient Had a Self Managed Abortion (SMA) or is Miscarrying

- EDs are likely to see an increase in the number of patients post SMA.
- Post Roe state criminalization of abortion should have no zero impact in this scenario.
- In fact, evaluation and stabilization are required under EMTALA.
- There appears to be clarity on this issue from Health and Human Services. EMTALA preempts contradicting state law.

Your Patient Attempted an SMA but US shows a Fetal Heart-Beat

- Evaluate and stabilize as required (allowed) under EMTALA.
- Carefully document your findings.
- Consult with OB as needed, refer to the community resource list is appropriate.

When Abortion is Required to Stabilize Your Patient

From HHS: July 11th, 2022

Thus, if a physician believes that a pregnant patient presenting at an emergency department, including certain labor and delivery departments, is experiencing an emergency medical condition as defined by EMTALA, and that abortion is the stabilizing treatment necessary to resolve that condition, the physician must provide that treatment. And when a state law prohibits abortion and does not include an exception for the life and health of the pregnant person — or draws the exception more narrowly than EMTALA’s emergency medical condition definition — that state law is preempted.

Reinforcement of EMTALA Obligations specific to Patients who are Pregnant or are Experiencing Pregnancy Loss (QSO-21-22-Hospitals- UPDATED JULY 2022), available at

<https://www.cms.gov/medicareprovider-enrollment-and-certificationsurvey/certificationgeninfopolicy-and-memos-states-and/reinforcement-entala-obligations-specific-patients-who-are-pregnant-or-are-experiencing-pregnancy-0>

Legal Considerations

- Does the First Amendment protect your right to give medical and legal information about self-managed abortion? Probably – Maybe!
- Post-abortion care after fetal demise is no legally riskier than miscarriage management.
- At the moment, there are no mandatory reporting provisions regarding SMAs. Doing so is likely a HIPAA violation and possibly an invasion of privacy. If mandatory reporting provisions are created, leave that entirely to your administration.
- Post-stabilization care is required under EMTALA.
- Avoid patient criminalization. Don't document information in the chart not required by law nor clinically significant for subsequent providers.

EMTALA covers abortion in Idaho hospitals, judge rules

Molly Gamble (Twitter) - yesterday



A federal judge temporarily blocked a portion of an Idaho law that would criminalize medical professionals who performed abortions in medical emergencies.

U.S. District Judge B. Lynn Winmill ruled Aug. 24 the state law, set to take effect Aug. 25, violates the Emergency Medical Treatment and Labor Act. The federal law, enacted in 1986, requires that Medicare hospitals provide all patients appropriate emergency care — including medical screening, examination, stabilizing treatment and transfer, if necessary — irrespective of any state laws or mandates that apply to specific procedures.

HHS directed hospitals in July that if a hospital is in a state that prohibits abortion by law and does not make exceptions for the health or life of a pregnant person, EMTALA preempts that state law.

Idaho's abortion law was set to criminalize the performance of most abortions except for limited scenarios, including those where abortion is necessary to prevent the death of a pregnant

https://www.beckershospitalreview.com/legal-regulatory-issues/emtala-covers-abortion-in-idaho-hospitals-judge-rules.html?origin=BHRE&utm_source=BHRE&utm_medium=email&utm_content=newsletter&oly_enc_id=9107H5403578H0D

California Hospital Begins Medication Abortions in the ED -- A Possible First

— "Our job is to treat all comers no matter their medical issue," says researcher

by [Randy Dotinga](#), Contributing Writer, MedPage Today October 5, 2022

ADVERTISEMENT

SAN FRANCISCO -- A California hospital has initiated at least 50 elective, non-emergent medication abortions in the emergency department (ED) since February, a physician reported here.

Stanford University Medical Center may be the first in the nation both to facilitate non-emergent medication abortions within the ED -- patients are seen and discharged from there -- and have a protocol to do so, said Monica Saxena, MD, JD, of Stanford University School of Medicine in California, at the [American College of Emergency Physicians](#) [↗](#) (ACEP) annual meeting.

Failure to Diagnose Summary

- EM is one of the highest risk specialties for patients and practitioners.
- Our documentation of high-risk presentations is inadequate and probably reflects a high frequency of inadequate basic data gathering.
- The 30-year paradigm of the talking head has not significantly impacted medical error and the failure to diagnose in EM.
- The solution is part human and part tech and has to be focused at the point of care.
- The EHR companies do not have this on their roadmaps. Solutions will be coming from outside.

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RISK RESOURCES

CME Manager



The TSG Continuing Education Manager is a free service that TSG provides to all health care professionals. State Continuing Education requirements are stringent and we want to assist you with a user-friendly method of keeping track of all of your continuing education credits. This tool allows you to view your credit hours, print them as needed, and quickly locate your CME certificates.

EM Toolbox



The TSG Emergency Medicine Risk and Safety Toolbox is meant to provide emergency practitioners with forms, ideas, policies and anything else that we can think of to assist in improving patient safety and reducing practitioner risk. Check back periodically, we will update the toolbox on a regular basis. If you have any requests or recommendations please contact us at comments@thesullivangroup.com.



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Thank You

dsullivan@thesullivangroup.com
Mobile: 630.567.2344



Introduction: This study reviews malpractice, also called medical professional liability (MPL), claims involving adult patients cared for in emergency departments (ED) and urgent care settings.

Methods: We conducted a retrospective review of closed MPL claims of adults over 18 years, from the Medical Professional Liability Association's Data Sharing Project database from 2001–2015, identifying 6,779 closed claims. Data included the total amount, origin, top medical specialties named, chief medical factors, top medical conditions, severity of injury, resolution, average indemnity, and defense costs of closed claims.

Results: Of 6,779 closed claims, 65.9% were dropped, withdrawn, or dismissed. Another 22.8% of claims settled for an average indemnity of \$297,709. Of the 515 (7.6%) cases that went to trial, juries returned verdicts for the defendant in 92.6% of cases (477/515). The remaining 7.4% of cases (38/515) were jury verdicts for the plaintiff, with an average indemnity of \$816,909. The most common resulting medical condition cited in paid claims was cardiac or cardiorespiratory arrest (10.4%). Error in diagnosis was the most common chief medical error cited in closed claims. Death was the most common level of severity listed in closed (38.5%) and paid (42.8%) claims. Claims reporting major permanent injury had the highest paid-to-closed ratio, and those reporting grave injury had the highest average indemnity of \$686,239.

Conclusion: This retrospective review updates the body of knowledge surrounding medical professional liability and represents the most recent analysis of claims in emergency medicine. As the