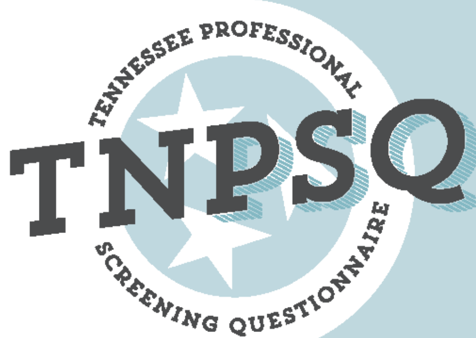
TN-PSQ: Two Years and 400+ Screenings Thus Far

LIFE CAN BE STRESSFUL AT TIMES.

Whatever you're struggling with—family pressures, work, relationship issues, grief, stress or financial concerns—it is easy to get overwhelmed without an idea of where to turn for support.



The TN PSQ is a **SAFE AND SECURE ONLINE TOOL** now available to health professionals in Tennessee, both licensed and in training: physicians, PAs, chiropractors, veterinarians, podiatrists, optometrists, x-ray technologists, clinical perfusionists. **It's as simple as:**

CLICK • CONNECT • CHAT

Visit the link below to take an anonymous mental health screening and find resources nearby.

Postcard funding provided by:

TN.PROVIDERWELLNESS.ORG

By Michael Baron, MD, MPH, FASAM

Two years of activity on the Tennessee Professional Screening Questionnaire (TN-PSQ) have shown the online mental health screening tool is helping to address the “parallel pandemic” affecting Tennessee health professionals in the era of COVID.

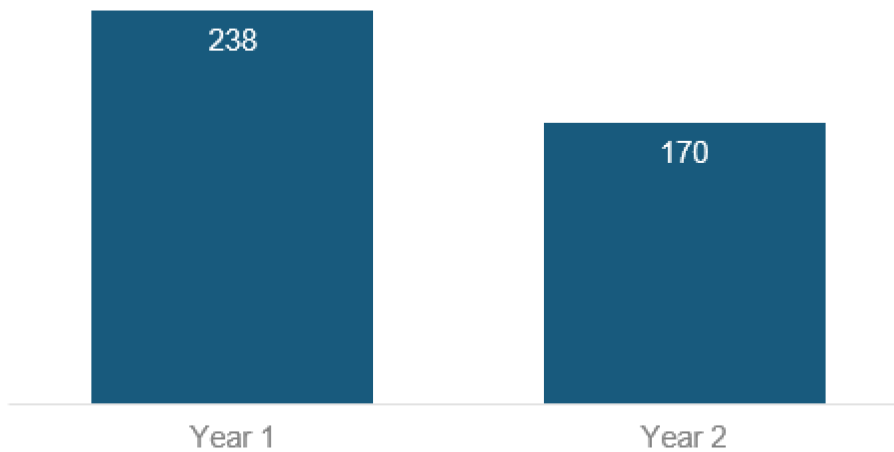
This is according to TMF Health Quality Institute leaders, who say data and user comments appear to confirm that the new resource is reaching its intended population and goals. More than 400 health professionals served by the TMF have utilized the site since it was launched in February 2020 as a proactive way to address rising mental health referrals to its Physician’s Health Program.

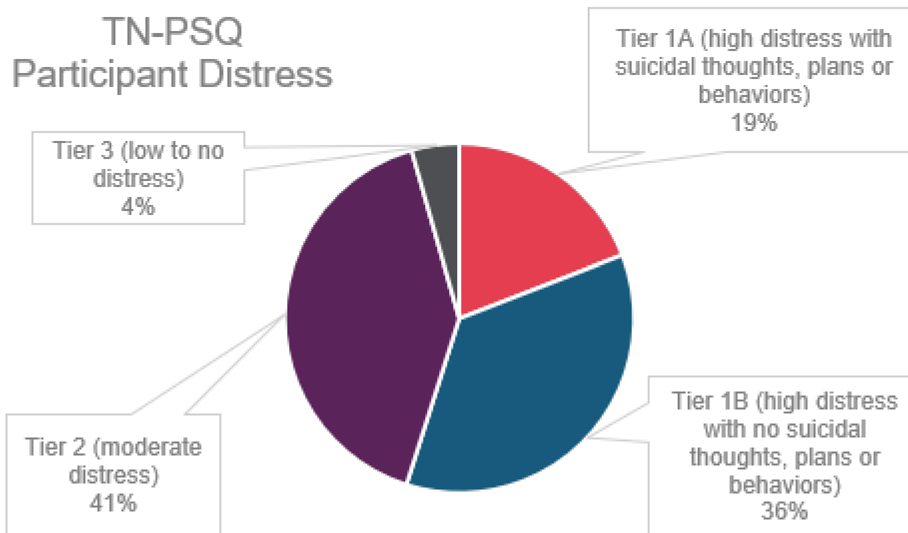
The TN-PSQ is a free, confidential, interactive online mental health screening tool based on the PHQ-9 questionnaire — a widely-accepted vehicle for self-assessment of common

mental disorders; it offers a response from, and optional anonymous interaction with, a licensed mental health professional for further assistance and connection to nearby mental health resources. The resource is separate and apart from the TMF, and its users are unknown to the TMF unless they contact the Foundation and reveal they have taken the screening.

Its target audience is health professionals who may not contact the TMF Physician's Health Program directly; the goal is to reach them before a mental health condition leads to more serious problems affecting patient safety and/or resulting in a referral to the TMF or action by an employer or state licensing board.

Results





- 85% were not already receiving treatment or therapy
- 74% reviewed counselor's response
- 32% dialogued anonymously with counselor
- 72% requested an appointment or referral

Feedback

- "Two things I like about the TN-PSQ is being able to keep my anonymity – I'm scared to be seen as unreliable or unfit for the field, and I'm extremely prideful – but more importantly, being able to talk through writing."
- "This is a great service to our state's health professionals."
- "I thank you so much for helping me in any way you can – and for reading my story. I truly appreciate the work and effort you put into your job and the services of TN-PSQ."
- "I'm feeling very burdened by work, family and other things and the weight of it feels crushing. Difficult for me to admit vulnerability and I'm exhausted by trying to fix this alone. There is definitely a fear of judgment by others given my profession. I appreciate any help or direction you can provide."

Learn More

Click here for more information about the TN-PSQ.

To take the screening, click here.

Risk Matters: Chaperones

By Jeffrey A. Woods, JD

There are often many questions regarding the use of a chaperone such as who, when, why, what (if the patient refuses/is the chaperones role) and how often? This article will attempt to answer these questions by examining the recommendations of SVMIC and the AMA. In the current environment, it is important that the provider understand the multiple purposes a chaperone serves as well as the need for gender identification when selecting the appropriate chaperone.

The use of chaperones during physical examinations has three benefits:

- it provides reassurance to patients of the professional character of the exam
- a witness is available to support the physician’s innocence should a misunderstanding or false accusation be made by the patient
- it offers advantages in convenience and time efficiency when authorized health professionals serve as chaperones and can assist with procedures such as gynecologic examinations.

Taking steps to help a patient feel comfortable during a physical examination is helpful in

building a solid and trusting relationship. It also allows the patient to assume ownership of his/her/their care. Equally important is providing the patient with information about the various types of examinations and the details of what to expect, which can alleviate anxiety and help prevent a misunderstanding as to the appropriateness of certain actions during the examination. Having this discussion may also increase the patient's comfort with the presence of a chaperone. Likewise, the chaperone must understand the purpose for being in the room during the examination and stand at a vantage point that would prevent later claims that he/she could not view what the provider was doing.

Historically, chaperones were offered when patients were of the opposite sex of the provider and most often when a male provider was performing a sensitive examination on a female patient. But that is no longer the case. Today, consideration must be given to the sexual orientation/identification of the patient and whether he/she/they are/have transitioned. The easiest way to avoid confusion is to ask the patient whether he/she/they would prefer a chaperone who is male or female?

The risks to the provider who chooses not to have a chaperone during a sensitive examination are significant. Providers can potentially face medical malpractice claims, assault/battery claims, and disciplinary actions by State Boards. Very often these types of salacious allegations "make the news" and can be detrimental to a provider's reputation even if the provider successfully prevails against the allegations. With no chaperone to support the provider, it becomes a "he said/she said" battle.

To evaluate the need for a chaperone, the Council on Ethical and Judicial Affairs (CEJA Report 10-A98), American Medical Association (AMA) suggests weighing the following considerations:

- The perceived intimate nature of the exam: "A sense of invasiveness towards different features of the physical exam can vary among individual patients. However, there is a general consensus that an examination of reproductive organs (i.e., a pelvic, testicular, or breast exam) or an examination of the rectum heightens the importance of a chaperone."
- The nature of the physician/patient relationship: "For a new visit or first-time examination, patients should be apprised of the availability of chaperones. Custom has dictated that chaperones are most commonly offered to patients of the opposite sex, and more frequently to female patients of male physicians. Whatever the social custom, it is important that patients from all demographic categories feel comfortable requesting a chaperone."
- The preferred type of chaperone: "Whenever possible, authorized health professionals should serve as chaperones rather than office clerks or family members. Unless specifically requested by the patient, family members should not be used as chaperones. Health professionals are held to standards for safeguarding patient privacy and confidentiality. Furthermore, their status affirms the formal nature of the examination."

The Council recommends the following guidelines:

- From the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations is recommended. A policy that patients are free to make a request for a chaperone should be established in each health care setting. This policy should be communicated to patients, either by means of a prominent notice or preferably through a conversation initiated by the intake nurse of the physician. The request by a patient to have a chaperone should be honored.
- An authorized health professional should serve as a chaperone whenever possible. Physicians should establish clear rules in their practices about respecting patient privacy and confidentiality to which all chaperones must adhere.
- If a chaperone is to be provided, a separate opportunity for private conversation between the patient and the physician should also be arranged. The physician should keep inquiries and history taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination.[1]

With these considerations in mind, SVMIC recommends:

1. Chaperones should be offered prior to all exams of an intimate and/or sensitive nature including, but not limited to pelvic/genital, genitourinary, rectal, and female breast examinations no matter the identified gender of the provider or patient. (Note: this list is not all-inclusive.)
2. A patient has the right to request a chaperone at any time throughout a consultation and examination, and to the extent possible, the patient's request must be honored.
3. A chaperone should be present even if the patient has a trusted companion or family member present as the secondary purpose of the chaperone is to protect the provider.
4. Special considerations for a chaperone may include: patients with severe anxiety, religious/cultural needs, communication obstacles, sexual identification/orientation, or memory deficits.
5. Each patient should be asked if he/she/they prefer a male or female chaperone assuming that the provider has both male and female staff members available. If not, this should be explained to the patient and permission to proceed with a specific gender chaperone should be obtained from the patient with documented consent.
6. Chaperone documentation in the patient's medical record should include the chaperone's name, title, and the portion of the examination for which the chaperone was present.
7. The chaperone should be a professional who understands his/her role and stands in a position that allows full view of the provider's activities.
8. In rare emergent/urgent circumstances, an appropriate chaperone may not be immediately available. In those unique situations:
    a. The provider may need to proceed with the examination without an

appropriate chaperone present based upon the clinical history, presentation, and risk to the patient of not performing the exam at the immediate time. The patient must agree to continue the examination without a chaperone. The provider should thoroughly document in the medical record the lack of a chaperone along with the rationale for proceeding without a chaperone present and the patient's consent to do so or;

b. After being fully informed of the risks, the patient may elect to decline the examination and reschedule the appointment. The provider shall thoroughly document in the patient's medical record the informed consent discussion including the risks and the examination delay due to unavailability of an appropriate chaperone.
   Either of these options is less than ideal and presents substantial risk to the provider.

9. If the patient declines a chaperone, the discussion and refusal should likewise be thoroughly documented.
10. Each practice should have a policy on chaperones that is consistently followed by all providers.

When in doubt, err on the side of caution and have an appropriate chaperone present. If there are any questions or concerns regarding the use of a chaperone, providers are strongly encouraged to contact an SVMIC Claims Attorney to discuss the specific situation.

[1] AMA CEJA Report 10-A98 Use of Chaperones During Physical Exams.

Keep It Flowing

By Elizabeth Woodcock, MBA, FACMPE, CPC

Simply getting through the day has been an incredible achievement over the past two years for anyone working in a medical practice. Off-the-charts staff turnover, heightened patient expectations, and the infusion of new technological tools have added to the operational pressures. Now patients are flooding in, seeking care that was delayed due to the pandemic. To avoid getting overwhelmed by the circumstances, here are some ideas to ensure that the core infrastructure of your operation remains efficient and effective:

Watch for bottlenecks.

There are so many pockets of time in the day that incorporate waits or delays; it's impossible to eradicate them all, but I urge you to pursue the reason for at least one challenge every day. Let's consider the moment you walk into the door: clinic starts at 8 a.m. Is the first patient ready to be examined by the physician? If not, where is the patient in the process? Is the patient still in the waiting room? On the scale? Being roomed? What does an "8 a.m. appointment" even mean? Break down the start-of-the-clinic into

individual components, making sure you have the people and tools in place. Establish the workflow, then hold your team accountable. There are often waits and delays that occur at the start of both the morning and afternoon clinic sessions. Examine those, and then move onto the smaller pockets of time that may be plaguing your practice. There's no magic bullet to make the practice flow perfectly; it's the little things that may equate to big opportunities.

Manage the slots.

Your practice's most important asset is time. Every minute of your physician's time, as well as that of your billable providers, is critical, and the delivery mechanism for that time is your schedule. Manage it obsessively; every slot is precious. Ensure that your scheduling horizon isn't too far out; your no-show rate rises as your time-to-next-available slot increases. If you are scheduling weeks to months out, make certain that your confirmation campaign is effective. Convert every cancellation when it arises, which means an electronic waitlist is a must. View your schedule at least twice a day, looking ahead to tomorrow – and next week - to watch for empty slots. Urge them to be filled, noting that it's human nature to do just the opposite because a filled slot means more work for everyone. Appoint a 'schedule optimizer' for your practice – a seasoned scheduler, or perhaps a member of your clinical team. Monitor your fill rate by doing a retrospective measure of arrived minutes as compared to available time on the schedule and then reward your practice for a high fill rate.

Make automation count.

Technology can offer an incredible advantage for your practice, but deploying it correctly is crucial. When a vendor sells you a solution, don't forget to ask about the integration into your current system, and the extent of the orientation, training, and service they offer for the product. Have a user – one of *your* employees – offer their input and test drive the tool *before* you buy it. After you purchase a tool, consider the changes in workflow that are required to gain the tool's full value. If you, for example, invest in an app to document hospital charges, then consider how and when the list of patients on whom you round will be uploaded to and managed in the tool. Also, how are nuances handled, like billing shared/split services? A critical step includes engaging the person(s) who keys your hospital charges, if only simply to ask the key questions about the "hows" and "whys." Too often, a practice will purchase a technological tool but fail to gain the promised return on investment. Don't fall into that trap.

Thank your team.

Despite all the equipment, supplies, and tools used by your practice, a medical practice is

really all about its people. You can have the finest electronic health record system on the planet, but it still requires support staff to keep a watchful eye on alerts about 'red flag' messages, critical test results, and so forth. Further, the service and experience your practice provides offers a safe, attentive, and healing environment that nurtures patients, as well as employees. It's been a challenging time for everyone; show your appreciation with a verbal, "I appreciate you," a written thank you note, or a gift of gratitude (e.g., a gift card from a gas retailer or a casserole that can be used for a family dinner). For a team that feels highly valued, getting through the busy days will feel satisfying instead of frustrating.

The operations of a medical practice have never been simple, but the challenges of the past two years have made efficiency and effectiveness even more difficult to achieve. Pause and reflect on the foundational elements that may have been tossed aside out of the necessity to survive. As normal operations resume, your practice will benefit from reconstructing a good footing.

You MUST Be Present to WIN

By William "Mike" J. Johnson, JD

The recently licensed resident physician was “moonlighting” at a rural emergency department when the patient, a young male in his twenties with several small children, presented in the early morning hours with complaints of cough, congestion, nausea, vomiting, weakness, headache, and abdominal pain. The patient indicated he had been experiencing these symptoms for three weeks. The patient had no fever, a normal oxygen saturation, somewhat low blood pressure, a pulse of 120, and respirations in the 20’s. He generally appeared weak and exhibited general tenderness in a non-distended abdomen. The physician assessed the lungs as normal. She did not order a chest x-ray because, based on her physical exam of the patient, she did not suspect pneumonia. She diagnosed the patient with an upper respiratory infection and ordered antibiotics plus medication for the patient’s cough. The patient was discharged. Two days later the patient presented to a different emergency department. His symptoms had worsened, and his condition deteriorated rapidly such that he died that day. An autopsy listed the cause of death as congestive heart failure due to dilated cardiomyopathy.

The patient’s spouse filed a lawsuit contending that the first physician failed to fully

evaluate the patient's vital signs, failed to order a chest x-ray, and failed to refer the patient to a cardiologist. According to the plaintiff, if a chest X-ray had been performed, the congestive heart failure would have been evident, which should have prompted a referral to a cardiologist for treatment. The plaintiff contended that such referral and treatment would have increased the patient's chances of survival. Stacked against the physician and the defense team were several risks and challenges. Commonly, defending a medical malpractice case means defending against "hindsight bias" which results when the plaintiff has the benefit of knowing the outcome and can "second guess" the physician's care. In this case, the physician did not order a chest X-ray which a plaintiff could argue, and a jury could likely perceive in hindsight, as a cheap, simple, and easy-to-obtain test. Another challenge was that the patient's condition worsened significantly after discharge. Defense counsel considered that a central difficulty in the case would be convincing a jury that a person ill enough to die from congestive heart failure would not have shown signs of that condition just two days prior. The potential for jury sympathy was also a big concern since the patient was very young, died a sudden and unexpected death, and was the father of young children. Finally, the physician was young and appeared even more youthful than her actual age. Would a jury think the physician was simply too young and inexperienced?

At trial, the defendant physician made a very good witness on her own behalf. She did an excellent job of explaining the thoroughness of her exam and used the medical record to back up her testimony such that everything she was telling the jury could be verified through the medical record. She explained that through her exam she was able to rule out more serious causes of the patient's condition, symptoms, and vital signs. She did not order additional tests, including an x-ray, because they would not have added to her treatment and diagnosis. The physician's tone with the jury was conversational, and she guided and instructed the jury on how an examination in the emergency department is conducted. The physician acknowledged that she was in fact recently licensed at the time she treated the patient. Nevertheless, her confident and empathetic testimony demonstrated to the jury that her examination of the patient was thorough and complete.

The defense's standard of care expert was a likeable "country doctor" who sparred with the plaintiff attorney and held his ground, but not to the extent that it was irritating. His support of the insured physician was backed up with 30 years of experience that complimented the insured physician's relative youth. He testified that the insured physician met the standard of care in all respects, and properly diagnosed the patient based on the presenting symptoms and her examination of the patient. Critically, he testified that no additional tests were required, and that the patient did not exhibit signs of congestive heart failure at the emergency department visit. The defense's causation witnesses, a cardiologist and pathologist, also testified well at trial. After seven days in trial, the jury rendered a unanimous defense verdict in approximately 2 and 1/2 hours.

What were the keys to the successful defense of this case? Foremost, the physician was very confident about the medical care she provided and had the will to go to trial and defend herself in a tragic and sympathetic case. She understood that going to trial meant accepting the risk of losing and that the risk of a plaintiff verdict could not be eliminated.

However, she also realized the power and benefit of thorough preparation and participating in her own defense. The defense team, who was very skilled and experienced, obtained good expert support from local physicians. Both the physician and the attorneys devoted a great deal of work to preparing for the trial; even so, they knew that trials are dynamic in nature and there are surprises, both good and bad. Thus, they were poised as best they could to defend against any unexpected challenges while also being ready to take full advantage of any opportunities that could benefit the defense. In one instance the plaintiff tried to introduce a “last minute witness,” but because of the way the defense handled the issue, the plaintiff decided not to present the witness. In another instance, the defense received a favorable evidentiary ruling that allowed them to present certain evidence that would have been excluded from the trial, but for the fact that the plaintiff “opened the door” to its admission. From a strategy standpoint good luck also came the defense’s way when the plaintiff chose to argue an alternate theory for the patient’s demise which weakened the plaintiff’s theory of liability. Above all, this story would not be told today, and the physician would not have been vindicated, had she not made the “gutsy” commitment to go to trial on a dangerous case ----“You must be present to win.”

The contents of The Sentinel are intended for educational/informational purposes only and do not constitute legal advice. Policyholders are urged to consult with their personal attorney for legal advice, as specific legal requirements may vary from state to state and/or change over time.