NCC Pediatrics Continuity Clinic Curriculum:
Telephone Triage & Risk Management

Goals & Objectives:

To develop effective skills in telephone and e-mail management:

- Learn and practice the key elements and decisions needed to manage clinical problems on the telephone and via email/secure messaging.
- Appreciate the importance of telephone protocols in establishing a consistent approach to problem assessment and management.
- Become familiar with the 3 types of lawsuits brought against telephone triagers in order to improve upon your own telephone/email management skills.

Pre-Meeting Preparation:

- "Structured Format for Telephone Management"
- "Quality Improvement: An ACQIP Exercise on Telephone Advice" *(PIR, 1997)*
  - *Answer key for Telephone Advice Exercise at the end of article.* ***Test yourselves!***
- "Telephone Triage Liability: Protecting Your Patients and Your Practice from Harm" *(Advances in Pediatrics, 2008)*
- *Excerpts* "AMA Guidelines for Physician-Patient Electronic Communications"

Conference Agenda:

- Complete Telephone Management Quiz
- Complete Telephone Management Cases/Role-Plays
  - *5 min/role-play, followed by 5-10 min debrief & discussion*
- Critique sample "After-Hours Clinic" notes *(to be provided)*
  - *Separate into teams of 2. Critique notes in terms of (1) advice given; and (2) documentation. Present your findings to the entire group.*

Extra Credit:

- **"User's Guide for the Telephone Triager"** *(Barton Schmitt; 2018—WR-B nurses' guide)*
- **Implementing Telephone Care** *(AAP website)*
- **Telehealth FAQ's** *(GA Chapter AAP)*
- **Telemedicine in Pediatrics: Possibilities and Pitfalls** *(PIR, July 2020)*
- **Pediatric Residents' Telephone Triage Experience: Do Parents Really Follow Telephone Advice?** *(Arch Pediatr Adol Med, 2000)*
- **Does Telephone Triage Delay Significant Medical Treatment?** *(Arch Ped Adol Med, 2003)*
- **E-mail Communication between Physicians and their Patients** *(Pediatrics, 2004)*
- **The quality, safety and governance of telephone triage and advice services – an overview of evidence from systematic reviews** *(BMC Health Services Research, 2017)*

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Structured Format for Telephone Management

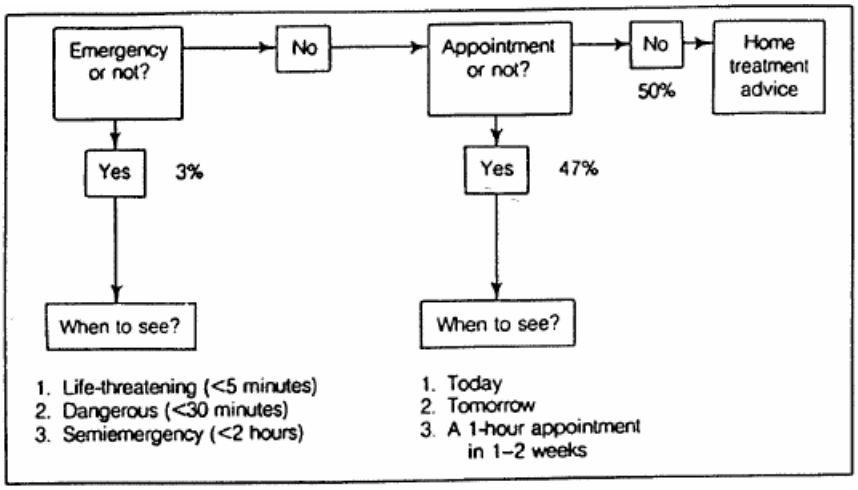

Figure 1. A model for telephone triage.

Purpose:

- Determine whether/when the child should be seen.
- Give instructions/ reassure
- Use telephone efficiently and effectively (i.e. if child should be seen NOW, don't waste time taking long HPI)

Step 1: Introduce Self

Step 2: General Info (age/gender/telephone #)

Step 3: HPI

- Duration of sxs, fever? (Taken how?), associated s/s, home management (meds, remedies)

Step 4: "Physical Exam"—assess overall condition of child

- *Open-ended questions*
- Questions about **chief complaint**, **vegetative functions** (e.g. eating, sleeping, activity level)
- **General appearance** (e.g. "Are you frightened by the way your child looks?" "Does he look sicker than he has in the past with similar illnesses?" "How does she look when she is up and about?" "What has she been doing in the past few hours?"

Step 5: PMHx—other health problems, meds

Step 6: Assessment – tentative diagnosis ("Although I can't be absolutely sure by talking with you on the phone, I think that this sounds like a cold . . .").

Step 7: Plan—management

- Emergent/Urgent: Come in **now**—confirm that they are able to come in or activate EMS, if appropriate
- Non-urgent: Come in **within 24/72 hrs**—make appointment or home care
- **Home management**:
    * Specific directions for medications, treatment
    * Expected duration of symptoms/ course of illness
    * Warning signs/ symptoms
    * Follow-up: when to call or come in . . . "Call if you become more concerned"
    * Assess understanding . . . "Are you comfortable with home management?"

Step 8: Document

- Overnight Calls: Create T-con. Send to appropriate ward or clinic attending.
- Other patient f/u: Create T-con in assigned PCMH Team and send to original preceptor.

Quality Improvement: An ACQIP Exercise on Telephone Advice

As part of *Pediatrics in Review*'s ongoing focus on quality improvement, we present a self-assessment exercise taken from the American Academy of Pediatrics' Ambulatory Quality Improvement Program (ACQIP). Readers are encouraged to participate in the ongoing ACQIP program. Additional information can be obtained by calling or writing to the Division of Quality Care, American Academy of Pediatrics, Box 927, Elk Grove Village, IL 60009-0927.

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Educational Objectives

When physicians and staff complete this exercise, review the accompanying material, and discuss their responses together, they will be able to create or improve office telephone protocols that will enhance patient care in the context of a mutual learning experience.

Instructions

1. Duplicate the questions and have both physicians and office staff who answer the telephone complete the exercise.
2. Choose only one answer to each question. These questions have not been designed to trick you in any way. The correct answer for one practice may not be appropriate for others.
3. Review the quality pointers that follow the exercise.
4. Physicians and staff should discuss each question and their answers, using that discussion to develop or modify appropriate telephone protocols for the office.
5. This exercise has been completed by ACQIP subscribers in the past. The most common responses and the percentage of offices in which physicians and staff are in agreement on each question are presented at the end of the article.

Telephone Advice

1. **A parent calls in saying that her 6-month-old child feels warm and has been sleeping a lot in the past 2 days. When asked a series of questions about the availability of a thermometer, appetite, etc, it becomes apparent that the parent is either confused, inebriated, or not in control. (Circle one response)**
   A. Advise the parent to bring the child in as soon as possible.
   B. Transfer the call to the physician immediately.
   C. Ask the parent for the name and telephone number of another adult who could visit the home and call the office back with more information. Contact this individual immediately.
   D. Our office has a different policy for handling this situation.

2. **A parent, whose 6-year-old child has known moderate asthma, calls in because the child has been up during the night wheezing. The parent reports that there is no dyspnea or cyanosis and that all medicines have been taken as prescribed. (Circle one response)**
   A. Advise the parent to bring the child in immediately to see the physician.
   B. Schedule a same-day appointment for the child to see the physician.
   C. Instruct the parent on home management and advise him or her to bring the child in if things don't improve over the next 4 hours.
   D. Our office has a different policy for handling this situation.

3. **The mother of a 21-month-old boy calls in and reports that her child has had a temperature of 38.8˚C (102˚F) rectally for 2 days, is crabby, and has had a cold for several days. When asked if she thinks the child may have an ear infection, the mother reports that she doesn't think so and that the child never has had an ear infection before. (Circle one response)**
   A. Schedule a same-day appointment for the child to see the physician.
   B. Instruct the mother on home management of fever and colds and advise her to call back if the child's fever increases or does not go away within 24 hours or if the child's general condition worsens.
   C. Our office has a different policy for handling this situation.

4. **A 17-year-old girl calls in because she suspects that she is pregnant. (Circle one response)**
   A. Call a laboratory for a pregnancy test.
   B. Urge the girl to come in with a parent to see the physician within 1 to 3 days.
   C. Refer the girl to a local obstetrician/gynecologist.
   D. Our office has a different policy for handling this situation.

5. **A mother calls in after her 4-year-old son has fallen. One of his front teeth is grossly discolored and the gum area is bleeding. (Circle one response)**
   A. Refer the mother to her dentist for an immediate or same-day appointment.
   B. Refer the mother to a dentist for a future appointment.

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C. Advise the mother to bring the child in to see the physician immediately.
D. Advise the mother on home management.
E. Our office has a different policy for handling this situation.

6. A new mother has a 5-day-old infant who has not been seen since discharge from the hospital. The mother calls in with several questions about breastfeeding, stools, colic, and sleep. She also is concerned about possible umbilical cord problems. (Circle one response)
A. Discuss the concerns, and if the mother seems satisfied, make an appointment for 2 weeks.
B. Discuss concerns by phone and advise the mother to bring the baby in if she still is concerned later in the day or the next day.
C. Advise the mother to bring the baby in the same day.
D. Our office has a different policy for handling this situation.

7. A very distraught mother calls because her 2-year-old child is running a fever of 40.0˚C (104˚F), having respiratory problems, and drooling excessively. (Circle one response)
A. Advise the mother to bring the child in immediately.
B. Advise the mother to bring the child to the appropriate hospital emergency department immediately.
C. Call 911 or a transport service that has pediatric emergency medical service capabilities.
D. Our office has a different policy for handling this situation.

8. A mother reports over the telephone that her 16-month-old, who was seen 2 days ago for otitis and given a course of amoxicillin, has broken out in hives shortly after taking the last two doses of the medication. (Circle one response)
A. Order an alternative antibiotic without an office visit.
B. Schedule a same-day appointment for the child to see the physician.
C. Advise the mother to bring the child in immediately to see the physician.
D. Our office has a different policy for handling this situation.

9. A mother calls in because her 4-year-old boy has spots that look like little sores on his wrist and face. She has heard that chicken pox is going around the nursery school, but she doesn't know personally of any children who have it. She also reports that her son has a fever and is complaining of a sore throat. (Circle one response)
A. Advise the mother on home management and tell her to bring the child in the next day if she still is unsure about whether it is chicken pox.
B. Schedule a same-day appointment for the child to see the physician.
C. Tell the mother to withhold the child from nursery school. Contact the public health, school, or home health nurse to visit and verify findings.
D. Our office has a different policy for handling this situation.

10. A mother calls, afraid that her child has been sexually abused during a weekend visit with her ex-husband, the child's father. (Circle one response)
A. Notify child protective services and immediately refer to a child protection team.
B. Advise the mother to bring the child in immediately to see the physician.
C. Schedule a same-day appointment for the child to see the physician.
D. Our office has a different policy for handling this situation.

11. A very angry father calls the office complaining about the amount the family has been billed for a health supervision visit and immunizations. (Circle one response)
A. Direct the call to business office personnel to explain charges and answer questions. Route the call back to the physician only if the father is not satisfied.
B. Give the message to the physician along with other telephone messages.
C. Transfer the call to the physician if possible; if not, give the message to the physician as soon as possible.
D. Our office has a different policy for handling this situation.

12. The mother of a 3-year-old boy calls in because her son appears a little sick, is limping, and has blood in his urine. (Circle one response)
A. Advise the mother to take the child to the hospital emergency department immediately.
B. Advise the mother to bring the child in to see the physician immediately.
C. Schedule a same-day appointment for the child to see the physician.
D. Our office has a different policy for handling this situation.

13. The mother of a 16-month-old girl calls because she has run out of the ointment prescribed for eye discharge 3 days ago. She reports that the child's eye is better, but still is oozing some, and she wants more medication. (Circle one response)
A. Advise the mother on aggressive home management, but do not refill the prescription.

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B. Call the pharmacy to refill the prescription.
C. Schedule a same-day appointment for the child to see the physician.
D. Order alternative antibacterial topical medication and have parents report back in 2 to 3 days.
E. Our office has a different policy for handling this situation.

14. The mother of a 2-week-old baby calls because she notices that the infant's skin is a yellowish color. She doesn't have a clear recollection of when the condition started or if it has worsened. (Circle one response)
A. Advise the mother to come into the office to see the physician immediately.
B. Schedule a same-day appointment for the child to see the physician.
C. Advise the mother on home management.
D. Our office has a different policy for handling this situation.

15. A mother calls because her 15-year-old daughter has been complaining about stomachaches for the past few weeks and as a result has missed several days of school. No vomiting, diarrhea, constipation, menstrual cramps, or disturbed sleep are reported. (Circle one response)
A. Schedule a brief same-day appointment for preliminary assessment. Arrange time for a comprehensive visit in the near future.
B. Schedule a future appointment with the physician.
C. Refer the child for a psychosocial evaluation.
D. Our office has a different policy for handling this situation.

Quality Pointers

Telephone protocols serve many functions that are crucial to a successful and well managed practice.

Telephone protocols contribute to the quality of care rendered to patients and families:
- If they are developed properly, they allow staff to give sound and thoughtful advice that is agreed upon throughout the practice.
- They ensure that patients receive information that has been thoroughly reviewed and approved.

The use of telephone protocols in a practice also contributes to patient satisfaction:
- Patients get immediate answers to their questions, instructions on what to do, or an appointment to see the physician. Worried parents appreciate having some immediate information leading toward the resolution of their problems.
- Patients receive confident answers to their questions, which is very comforting and promotes satisfaction.
- Patients who receive sound telephone advice are likely to feel more confident about the practice and the care given.

Telephone protocols enhance efficiency:
- The staff person answering the telephone knows what to do and does not waste time checking instructions with the physician.
- Staff can schedule appointments efficiently, ensuring that the most critical cases are seen in an appropriate time period and that less critical cases wait until later in the day or a future time.
- When telephone protocols are used, physicians see only necessary cases, with staff handling many cases using telephone advice only.

Telephone protocols have important implications for office risk management:
- Remember that the physician is liable for the actions of his or her staff members. Staff responsible for handling telephone calls should give only advice agreed upon by the physician.
- If a practice has clearly articulated telephone policies that fall within a reasonable standard of care, and liability does arise from telephone advice that has followed written protocol, the physician defense will be greatly helped.

Developing telephone protocols is time-consuming, but well worth the effort.

Telephone protocols can meet the practice's needs by following these preliminary steps:
- Analyze incoming calls to determine the most frequent issues and the level of sophistication of callers in describing symptoms and expressing complaints.
- Determine what aspects of the office telephone system work well and what areas cause problems. Ask patients for their opinions.
- Delineate the services that the practice offers.
- Identify services in the local medical community to which you can refer patients.

Consult references to begin developing telephone protocols for your practice. Two excellent sources of pediatric telephone protocols are offered by Harvey Katz and Barton Schmitt (see References).

Develop a few protocols and after key staff members have reached consensus on them, try them to see how calls are handled.
- Be sure to have all protocols available in written form. Some practices even have them computerized so that staff can type in symptoms as they speak with callers and refer to appropriate protocols.
- Periodically review how the telephone protocols are working. This should be done in office staff meetings, but it also can be done by reviewing the phone log and asking patients about the advice they receive when calling the office.
- Revise protocols, in writing, if they are not meeting patient and staff needs.
- Develop new protocols and revise existing ones as needed. The development of telephone protocols is a dynamic process.

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Telephone protocols serve little purpose if they are not implemented properly. This requires recruitment and training of responsible staff.

Recruit the right person for the job. Make sure to talk with potential candidates over the phone to get an idea of their telephone voice and skills.

Conduct formal training of new telephone staff. Refer to Katz and the second edition of the AAP's *Management of Pediatric Practice* (see References).

- Make sure newly hired staff review all protocols before using them with callers. Encourage new staff to ask questions about policies and procedures about which they are uncertain.
- Staff should study protocols carefully so that they are familiar with the advice they will be giving to callers.
- Role play some telephone calls with new staff to see how well they understand and implement the protocols.

It is essential to evaluate staff handling of telephone calls regularly:

- Periodically monitor calls. Both staff and patient *must* be informed that their conversations may be monitored.
- Review the phone log regularly to ensure that appropriate action is being taken on incoming calls.
- Keep this exercise and try it out with the staff to see the extent to which they agree with your answers. Develop some additional scenarios, or have staff develop them to assess your agreement.

The Quality Pointers do not reflect any policies or positions of the American Academy of Pediatrics. The Pointers are meant solely for the purpose of providing information and guidance that may be helpful in improving practice management

Summary of Responses

Subscribers to ACQIP who completed this exercise submitted their answers to the program. For each question, the most common response is listed by letter. In parentheses is the percentage of offices in which physicians and staff agreed on the same response.

1. A (46.7%)
2. B (57.2%)
3. A (70.2%)
4. B (48.4%)
5. A (71.5%)
6. B (49.5%)
7. A: staff, C: physician (44.9%)
8. B (51.8%)
9. B (53.8%)
10. C (58.0%)
11. A (79.3%)
12. B and C (51.8%)
13. B (36.4%)
14. B (70.8%)
15. A (56.9%)

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ADVANCES IN PEDIATRICS

Telephone Triage Liability: Protecting Your Patients and Your Practice from Harm

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Pediatricians receive more telephone calls than any other medical specialty. The American Academy of Pediatrics reports that 30% of office-hours pediatric care is provided over the telephone, as well as 80% of after-hours care [1]. Sometimes physicians are sued for the telephone advice they give. Pediatricians rank fourth in frequency of lawsuits after internal medicine, family medicine, and obstetricians. The purpose of this article is to help pediatricians prevent errors in telephone triage that could cause harmful outcomes for their patients, not to mention medical liability for their practice. After-hours calls (when the office is closed) account for most of the adverse outcomes. Therefore, preventive measures for these calls will be covered in more depth than office-hours calls.

Lawsuits against pediatricians have a better outcome than most specialties [2]. In 68% of cases, the claim was dropped, withdrawn, or dismissed. In 27%, a settlement was reached without going to court. Only 5% of cases go to trial, and of those, in 80% the verdict goes in favor of the physician. These data come from all pediatric lawsuits, not those just involving telephone care.

MALPRACTICE DEFINITION

To sustain a malpractice lawsuit, a plaintiff's attorney must prove the following: damage to the patient, duty to treat, direct cause (damage caused by our care), and deviation (departure) from standard of care. We will examine each of the 4 Ds in some depth.

Damage usually means permanent harm or injury to the patient. This can include death (eg, from shock), disability (eg, from kernicterus), disfigurement (eg, from necrotizing fasciitis), or unnecessary loss of all or part of an organ (eg, torsion of the testicle). In fact, the severity of the damage often determines the size of the malpractice award.

Of the total paid claims in pediatrics from 1985 to 2005, death accounted for 30%, major permanent injury for 29%, significant permanent injury for 12%,

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and minor permanent injury for 7% [2]. Damage is the essential element in the 4 Ds. If there is no injury, there should be no grounds for a successful lawsuit. However, of the total paid claims in pediatrics, major temporary injury accounted for 9%, minor temporary injury for 8%, and insignificant injury for 2%. Pain and suffering alone are not grounds for a lawsuit.

Duty to treat means the legal contract between the patient and health care provider has been established. The duty to treat begins when we start our telephone assessment or give any medical advice. It ends when the caller's medical problem is resolved, or at the time the duty is transferred to another health care provider. For our own patients, we are expected to be available or have a substitute health care provider available within a reasonable period of time. For patients who call us but are not in our practice, while we can decline to give advice, we accept the duty to treat as soon as we begin to help them. As for who is accountable and liable in these cases, it is the physician and the triage nurse. In an after-hours call center, the responsible people are the triage nurse and the call center supervising physician. The primary care physician (PCP) is not accountable unless he or she is consulted.

Direct cause means there is a causal link between the damage or harm to the patient and our performance. Usually, a life-threatening or serious medical condition is present that was not recognized or acted on by the triager. A delayed referral to medical care is a common denominator. Delayed referral leads to delayed diagnosis and delayed treatment. A direct or proximate cause means the damage occurs or progresses after the call is made. Over 95% of direct causes are from errors of omission or underreferral. Errors of commission are uncommon. An example would be recommending the application of a hot water bottle to the abdomen of a 1-month-old child with colic and causing a third-degree burn that leads to permanent scarring.

Deviation from standard of care means the urgency of the child's symptoms could have been recognized by a reasonable triage person at the time of the call. The standard of care is what a reasonable physician or nurse with similar training and experience would have done. Standard of care is defined by peers, experts, and guidelines. The standard of care is a range of reasonable responses, not optimal care [3]. Negligent care must fall below the lower limit of acceptable care.

TYPES OF LAWSUITS

In my view, there are three types of lawsuits brought against telephone triagers: true accusations (malpractice), false accusations, and imperfect call accusations. True accusations meet all the grounds for malpractice or negligent care. False accusations are ones in which the telephone care was reasonable, but the caller lies or distorts the facts and blames the triager for recommendations he or she did not make. The third type of accusation could be called the imperfect call accusation. It falls into the gray zone where the seriousness of the child's condition could not have been recognized at the time of the call and the damages or complications started after the call was finished.

TRUE ACCUSATIONS

True accusations mean the bad outcome and damage were directly caused by delayed referral to medical care. These are true malpractice errors. They are the worst-case scenarios that can teach all of us how to practice better telephone management. The delayed referral to medical care usually includes the following:

- Life-threatening emergency call can't get through
- Emergent call not returned promptly
- Triager doesn't refer a child with an emergent condition in immediately
- Triager sends child in by car rather than emergency medical services (EMS) or an ambulance [4]
- Triager sends child to office/clinic rather than emergency department (ED)

After-hours malpractice errors

Medical errors can occur at any step in the after-hours call process. The answering service's role is to receive calls, collect basic information, and then transfer this information to the nurse or physician on call [5]. The information is transmitted by fax, voice message, or pager to the call center or physician. During this process, the answering service can make an error (Box 1).

The charge nurse at the call center prioritizes the call. The telephone triage nurses then return the call. Most malpractice errors occur at this point in the call process because the decision making is by the triage nurse (Box 2). The physician, physician assistant, or nurse practitioner who provides backup to the call center nurse can also make an error (Box 3). Box 4 lists risk management rules that can prevent most of these medical errors if they are adhered to [6].

Office-hours malpractice errors

Generally office hours calls are very safe. The main reason for this is that there is no attempt to reduce access. If the caller wants his or her child seen, he or she is

Box 1: Answering service risk management

1. **Error:** Life-threatening emergency present and caller gets voice message machine or busy signal at answering service. They call again.

Example: 6-year-old with abrupt onset hives and stridor. Result: dies.

Risk Management Rule: Include EMS (911) on all intake messages. ''If this is an emergency, hang up and dial 911 NOW.''

2. **Error:** Answering service doesn't recognize life-threatening emergency and transfers call to call center by fax.

Example: 4-month-old with weak, slow breathing. Result: apnea and dies.

Risk Management Rule: Make sure your answering service has a brief list of life-threatening emergencies AND redirects these calls to 911 OR puts them through to the call center on a direct line.

Box 2: Telephone triage nurse risk management

1. **Error:** Delay in returning call regarding seriously ill child.

Example: 4-week-old with 102°F fever. Result: goes into septic shock.

Risk Management Rule: Have incoming faxes screened and prioritized into emergent, urgent and nonurgent categories. Attempt to return emergent calls within 5 minutes and urgent calls within 15 minutes.

2. **Error:** Child sent to ED by car rather than EMS.

Risk Management Rule: Use protocols with a 911 disposition and triage questions that recognize life-threatening symptoms.

3. **Error:** Transfer call to 911 without giving first-aid advice (eg, Heimlich maneuver).

Example: 2-year-old choking on foreign body. Result: arrests before reaching EMS.

Risk Management Rule: Before transferring a life-threatening call to 911, give 10 seconds of first-aid advice if advice could be life-saving.

4. **Error:** Nurse doesn't ask about complications of main symptom (eg, dehydration in child with diarrhea)

Risk Management Rule: Use triage protocols and ask all the questions.

5. **Error:** Nurse doesn't follow protocol.

Example: Dog bite to face and not referred to ED. Result: severe cellulitis, needs incision and drainage, leads to disfigurement.

Risk Management Rule: Follow and adhere to the protocol. Don't downgrade a disposition. If unsure, transfer call to PCP.

6. **Error:** Language barrier and child has serious condition

Example: Infant with severe diarrhea missed. Result: progresses to dehydration and hypovolemic shock.

Risk Management Rule: For language problems, transfer to a nurse who speaks that language OR to translation service.

7. **Error:** Triage nurse doesn't ask about chronic disease and caller doesn't mention.

Example: Child with Sickle Cell Disease and fever. Result: dies of pneumococcal sepsis.

Risk Management Rule: Always ask about chronic disease (eg, immunocompromised) to identify patients at special risk.

8. **Error:** Triage nurse assumes call doesn't need triage (advice only call).

Example: Breastfeeding question re: milk supply. Result: dehydration progresses to stroke.

Risk Management Rule: Require triaging of all newborn and sick child calls.

9. **Error:** Triage nurse allows parent to make diagnosis.

Example: Chickenpox. Result: actually meningococcal septic shock and DOA.

Risk Management Rule: Mainly triage by symptoms. Don't accept a caller's diagnosis unless it meets the protocol's diagnostic criteria.

10. **Error:** Nurse uses wrong triage protocol.

Example: Hives protocol instead of Rash, Widespread and Cause Unknown Protocol. Result: misses serious rash.

Risk Management Rule: All triage nurses are carefully trained and monitored to select the best protocol.

11. **Error:** Triage nurse accepts caller's story for injuries and doesn't consider child abuse.

Example: Infant with bruises from falling off sofa. Result: next injury is subdural hematomas from shaking injury. State Child Protective Services sues triage nurse and physician.

Risk Management Rule: Use protocols that include inflicted injuries (child abuse) in the differential diagnoses.

12. **Error:** Inexperienced nurse handles sick child call that doesn't have protocol.

Example: Buccal cellulitis not seen. Result: progresses to meningitis.

Risk Management Rule: When no protocol applies and child is sick, ask for consult from charge nurse or PCP.

13. **Error:** Protocols are inaccurate or incomplete.

Example: Herpes simplex of newborn not mentioned in newborn rashes. Result: progresses to herpes encephalitis.

Risk Management Rule: Use protocols that are tested, reviewed, and updated yearly.

14. **Error:** Nurse refers to ED now but caller doesn't have immediate access to transportation.

Risk Management Rule: Verify caller has available transportation to designated ED. If not, advise to call 911.

15. **Error:** Nurse tells caller to go to ED, but doesn't tell when to go.

Example: 3 year-old with testicular torsion. Nurse tells caller to go to ED, family goes 8 hours later. Result: testicle not viable.

Risk Management Rule: Nurse clarifies disposition site and timeline. Nurse checks caller's understanding and acceptance of disposition.

16. **Error:** Multiple calls regarding same child in one night.

Example: Child again triaged as mildly ill. Result: hidden agenda missed and social crisis escalates (eg, spouse abuse or child abuse).

Risk Management Rule: Have a policy that two calls about the same child in one night triggers a visit. (Exception: checking a drug dosage or care advice.) Repeated calls means the child needs an in-person evaluation.

17. **Error:** Nurse tells parents their child doesn't need to be seen in ED, but caller wants to be seen anyway. Nurse then implies that they can't be seen.

Example: Caller has fever phobia and nurse brings up ED co-payment issues.

Risk Management Rule: If the caller is still uncomfortable and can't be reassured *after* triage and advice, allow the caller to override the protocol. Have the child examined tonight or transfer the call to PCP.

18. **Error:** Nurse doesn't give call-back instructions.

Example: Newborn bleeding from circumcision. Result: hemorrhages and dies.

Risk Management Rule: Always give the caller indications for calling back (the contingency plan). If middle of night, ask parent to recheck child in reasonable time.

Box 3: Physician risk management

1. **Error:** Physician on call fails to answer page for over 1 hour or asks answering service to hold all calls for 1 hour.

Risk Management Rule: On-call physician also must be accessible and prioritize incoming calls.

2. **Error:** Physician switches antibiotics by telephone without examining child.

Example: Acute otitis media unresponsive to amoxicillin and high fever. Result: progresses to mastoiditis or meningitis.

Risk Management Rule: Don't switch antibiotics without examining the patient.

3. **Error:** Physician (doing second-level triage) downgrades triage nurse's disposition without talking directly to parent.

Example: Infant with fever and sounds listless to triage nurse. Physician not impressed. Result: misses septic child.

Risk Management Rule: Don't allow primary care physician (PCP) to overrule a triage nurse's referral to an ED without talking to the parent. The nurse should refuse to transfer the PCP's disposition to the caller if he or she disagrees with it and the result could be harmful to the child.

given an appointment. There are some exceptions, however, where delays lead to complications. The appointment scheduler may give a late-day appointment to a seriously ill child who then deteriorates. The scheduler may also give a next day appointment to a very sick child when it's a near closing time (late afternoon) call. The appointment scheduler may answer a simple question about a sick child instead of transferring the call to a nurse (eg, offering a Tylenol dosage for a 6-week-old with a fever). The physician who returns calls in bunches twice a day also runs the risk of delaying access. In addition, many of the preceding errors that occur with after-hours calls can happen during office hours.

The office-based physician may want to review the risk management rules for after-hours calls and reflect on whether they should be operational in their office. In addition, the following rules that are specific to office hours should be reviewed:

Box 4: Defense for false accusation calls

- Documentation of the call is key
- Disposition given is documented
- Protocol or resource used is documented
- Dosage of any recommended medication is documented
- Call-back instructions are documented
- Share this documentation with the accuser

- Never put a caller on hold until it's been confirmed that the call is not urgent.
- Have talking with a real person as one of the options on the automated attendant system.
- Require all sick child calls to go through nurse triage unless they can be worked into the appointment schedule within 2 hours. Also have the scheduler ask if there are any serious symptoms before giving an appointment.
- Don't allow nonclinical staff to give any medical advice over the telephone.
- Don't put emergent or urgent calls in the PCP's callback list. Either interrupt the PCP or have the triage nurse manage these calls.

FALSE ACCUSATIONS

A false accusation is one in which the triager arrives at and conveys an appropriate disposition, but later the caller claims that the triage nurse gave a different disposition and advice. An actual case example is a call about a 3-year-old who had chickenpox and bleeding into some of the lesions. The triage nurse sent the child to the emergency department immediately. The parent brought the child to another hospital several hours later. A diagnosis of chickenpox with aplastic anemia was made, and the child was admitted to the ward for a lengthy stay. The parent told a nurse on the ward that she had called a call center 3 consecutive days and each time was told that her child had chickenpox and didn't need to be seen. She said she was going to sue the hospital. This story eventually reached the private pediatrician who contacted our call center. There was no record in the answering service or in the call center of any preceding calls about this patient except for the call on the date the child was hospitalized. The private physician confronted the mother with this information and the mother backed down and stated she probably called some other nurse line but didn't remember which one it was.

What are the reasons a caller would lie or distort the interaction with a triage nurse? In our experience, false accusations usually involve a case where the parents delayed seeking care. They feel guilty about their actions, and shift their guilt to the nurse or physician who takes their call. If the physician who sees the child in the emergency department says something like, "you should have come in sooner," the parents may feel on the defensive and in turn blame somebody else for their delay in seeking medical care. In general, these parents seem to remember many more details about the call than we do and their selective memory usually favors them. Many times the parents have another family member who claims to have witnessed the call. In the final analysis, it's the parent's word against ours.

False accusations are usually one of four types:

- The caller claims we didn't refer the child in immediately.
- The caller claims we didn't tell them to call 911 or an ambulance.
- The caller claims we sent the child to the office instead of the emergency department.
- The caller claims we gave harmful advice or a wrong drug dosage.

The following is an example of a false accusation about a drug dosage. The triage nurse gives the caller the correct dosage of acetaminophen based on the

child's weight. She asks the caller to write it down and repeat it. The caller then proceeds to use a teaspoon to give acetaminophen from a bottle that has a dropper. The concentration per volume in the dropper solution is 3 times more than in the acetaminophen syrup. This dosage given over 2 days leads to acetaminophen poisoning and liver damage. While hospitalized, the parent blames the overdosage on the triage nurse. Fortunately the nurse has complete documentation of the dosage she recommended.

Adequate documentation is the only way to protect one's practice against false accusations. Documentation is our witness. In fact, it's important that physicians who don't document all their calls, do document any call that has an unexpected outcome such as hospitalization. It is acceptable medical practice to document that call in the patient's chart, even after the fact, as long as we record the correct date of entry. The nurse working in a call center has a lower risk than the primary physician taking calls at home for the following reasons: The nurse always documents the call. In fact, many call centers record all calls. This is the ultimate way to counteract false accusations and prevent them from moving on to a lawsuit. The nurse also has more time to address the call than the physician who may have other demands on his or her time, such as rounding on inpatients. In addition, the physician may have a conflict of interest, from the standpoint that if he or she is taking the call at night and is practicing in an area where an ED is not readily available, then he or she needs to get up and drive to the office and see the patient.

The amount of documentation necessary to defend against a false accusation is not extensive (see Box 4). The most important fact to document is the disposition that was given. The disposition is the decision reached following telephone triage as to where and when the caller was instructed to seek medical care. Was the caller told to call 911? Was the caller sent to the emergency department by car? Was the caller told to proceed immediately? The time frame for seeing the patient needs to be clearly documented, as does the fact that the caller agreed to it.

The minimal documentation needed for risk management also includes the following: If a nurse is taking the call, he or she must be using a protocol system and should document the specific protocol used for this call. Callback instructions, in case the child's condition deteriorates, should be given and documented. Any drug that is recommended should have the dosage documented. If one is using protocols, it is within the standard of care to write "advice given per protocol" or "triage per protocol." Then one only needs to document pertinent positives.

The documentation of the call must also be retrievable. Written records of telephone interactions can be kept in a file system or in a chart. In a call center, often the documentation is kept within a computer file on the hard drive. The ultimate defense is to have a recording of the call. This may be maintained on audiotape, CD, or the hard drive. It is difficult to answer the question as to how long to keep the documentation. Most lawyers would tell us to keep it until the statute of limitations runs out, which is until the patient reaches of 18 years of

age plus 2. Now that recordings can be compressed, keeping it this long may be achievable. From a more practical standpoint, if we haven't heard about a patient having an adverse outcome within 3 months after the call was made, it's highly unlikely that a lawsuit is forthcoming.

THE IMPERFECT CALL ACCUSATION

The chain of events in the accusation of an imperfect call goes as follows: The patient does not have a serious symptom or complication at the time of the first call. The patient then develops a serious disease or complication hours or days later. An example would be that the first pneumococcal bacteria crosses the blood-brain barrier after the end of the first call. Following the natural evolution of the patient's disease, a second call is made and the patient is referred for additional medical care or the family brings the child directly to an ED. The plaintiff's lawyer claims that we failed to diagnose the child's meningitis early enough. But we would ask, was the delay reasonable?

My view of imperfect call accusations is that they reflect unrealistic expectations of callers and lawyers. Perhaps the touting of medical technology in the media contributes to this expectation of perfection. In any event, hindsight is always 20/20. In my mind, the charge here is that the nurse had imperfect powers of prediction. He or she didn't have clairvoyance like the Monday morning quarterback always has. But the real question is, was his or her performance substandard?

How do we defend a good call? We need a "good-call checklist." We then can compare the call under question to the standards of care for a good call. Even an adequate, but not optimal, call can be defended in this way (Box 5). The recording, if there is one, and call documentation report are compared with the specific protocol that was used to triage the call. If the triage nurse is not using protocols, he or she is practicing medicine without a license. The benefit of protocols is that they've been preapproved by a medical advisory group, and they allow the reviewer to reconstruct the triage and advice that was provided. The triage nurse must meet the following criteria: use the appropriate protocol, adhere to the protocol, reach an appropriate disposition based on evidence, and gave callback instructions [7]. It can then be claimed that providing the callback instructions prompted the parents to call later, when the child's condition had changed, and for the triage nurse appropriately to make a timely referral following the second call.

The triage nurse needs to have followed any relevant policies or procedures that pertained to the call. For example, he or she may need to refer to the policy on child abuse and neglect legal requirements. The triage nurse needs to have completed a basic training program. It should be kept in mind that while registered nurses (RNs) have been accepted nationwide as qualified to do this type of work, it is difficult to defend a licensed practical nurse (LPN) who has provided telephone triage. The triage nurse's performance needs to be periodically reviewed. In addition, the completion of basic training and review needs to be documented. Since the PCP receives call reports on all of his or her patients, it

Box 5: Good-call checklist

- All calls are documented

  A written report for this specific call is available for review. Ideally, a recording of the call is available.
- All calls are managed by triage protocols

  Triage nurse used an appropriate protocol topic for this call

  Triage nurse adhered to the protocol

  Triage nurse reached an appropriate disposition based on history provided by the caller

  Triage nurse gave call-back instructions to the caller
- Triage nurse followed any relevant policy or procedure
- Triage nurse completed basic training program

  Triage nurse's performance is periodically reviewed
- Call system is monitored by a physician

can be pointed out that the PCP has been an ongoing reviewer of the triage nurse's work. Finally, the call system must be one that is monitored by a physician. In addition, call centers that are located within hospitals usually have met Joint Commission Accreditation of Hospitals standards.

Box 6: Protocols to reduce liability

- Don't delegate triaging task without protocols
- Use nationally recognized protocols
- Use protocols written and reviewed by physicians
- Use protocols that contain all common pediatric symptoms
- Chronic diseases are included as risk factors
- Child abuse is included
- Newborn topics are complete
- The disposition categories are realistic
- The decision-making process is easy to follow
- Life-threatening 911 emergencies are included
- Psychosocial emergencies are included (eg, suicide caller)
- Call-back instructions are present and specific
- The content has undergone a review process
- The content is referenced to the current pediatric literature
- The content has been widely used or tested in pediatric settings
- The content is updated on a regular basis

OTHER STRATEGIES FOR REDUCING MEDICAL LIABILITY

Defensible telephone triage is closely linked to protocols, documentation, policies, and procedures and training. Telephone triage should never be delegated to nurses without decision support tools. The protocols should be comprehensive, reviewed, compatible with American Academy of Pediatric policies, tested, and updated on a regular basis (Box 6) [8]. Adverse outcomes have occurred when calls are managed without protocols [9,10].

The calls must be documented. The minimal documentation for risk management was discussed earlier and is found in Box 4.

Policies and procedures that describe the roles of the triage nurse and the on-call health care provider should be written and in use (Box 7). Special policies to help the nurse access emergency referrals (eg, police, child protective

Box 7: Policies and procedures to reduce liability

- Have a system for prioritizing incoming calls.
- For 911 dispositions, verify compliance by calling the parent back in 3 to 5 minutes. If the caller is reluctant to call 911, clarify the reason for your concern about the child (''duty to terrify''). If the parent refuses to bring the child in, ask the primary care physician or the emergency room physician to talk with the family. Physicians have the authority to request a court order to treat if needed.
- Allow the nurse to override the protocol to a higher acuity and refer the child in for evaluation.
- Allow the nurse to transfer the call to the on-call PCP.
- Don't allow the nurse to downgrade the disposition to a lower acuity.
- Adhere to protocols. If not, justify any deviation in documentation.
- After reviewing home care advice, ask the caller, ''Do you feel comfortable with the plan?'' If not, either call back in 1 hour or have the caller come in without this step (ie, allow the caller to override the protocol to a higher acuity).
- If the caller calls again about the same problem within 12 hours, usually see the patient. (Reason: caller not reassured, child sicker than described, or hidden social agenda.) (Exception: checking a drug dosage or care advice.)
- All physician clients are required to have an on-call physician available to the triage nurse for consultation.
- If the patient needs to be seen and the on-call physician can't be reached or can't see the patient, always have someone else see the patient (eg, an emergency department physician).
- Chronic disease calls AND patients seen recently with complex acute illnesses (eg, infectious mono) are referred to the PCP.
- If after the call it is discovered that the wrong disposition or advice was given, call the family back.
- Exclude nonclinical staff from giving medical advice.
- Policies are available for emergency referrals (eg, to police, CPS, 911, ambulance service, crisis centers).

services, ambulance service, crisis center) should also be operational [11]. Clear guidelines on how to deal with calls about patients with chronic or complex diseases should also be available.

The emergence of national telehealth standards (eg, American Academy of Ambulatory Care and Utilization Review Accreditation Commission) has helped to emphasize the importance of ensuring competency of all telephone triage providers. As a result, training and quality improvement programs have become more comprehensive. Training and education must emphasize how to recognize and manage life-threatening and emergent conditions (Box 8). Selecting the most appropriate protocol for the caller's complaint is probably the most difficult step in triage. It is extremely important for optimal patient outcome. Special emphasis should be given to this aspect of nurse training (Box 9).

Box 8: Triage nurse training to reduce liability

- Emphasize that the child's safety and well-being are always the highest priority.
- Study all the triage and advice protocols.
- Study the anatomic version of the table of contents to appreciate the topics available within each body part (eg, respiratory or gastrointestinal).
- To improve the ability to recognize life-threatening or serious diseases, read the 911 section of each guideline.
- Study the diseases that have the highest rates of delayed diagnosis and malpractice claims. These are meningitis, appendicitis, and pneumonia.
- If the child sounds very sick to the triager, refer the patient in immediately even if no indicator is met on the protocol. Use the ''child sounds very sick or weak to the triager'' indicator.
- To recognize lethargic or toxic children, always ask about the child's current activity level. A helpful question is, ''What is she doing right now?'' If not active now, ask, ''How does she look?''
- If the caller calls about a diagnosis (eg, chickenpox) rather than a symptom (eg, headache), don't accept their diagnosis unless it meets the diagnostic criteria listed in that protocol.
- Observe experienced nurses and physicians triage and document calls.
- Learn how to select the most appropriate protocol (see that checklist).
- Study all telephone care policies and procedures.
- Document completion of basic training.
- Provide ongoing reviews of nurse performance with sick child calls. Critique for selection of appropriate protocol, correct disposition, and accurate documentation. Document these reviews.
- Provide ongoing continuing nurse education (eg, monthly in-service topics). Document attendance.

Box 9: Selecting the best protocol

- Selecting the best protocol for the call is the most difficult step in using a set of protocols. It's very important for optimal patient outcome.
- For one predominant symptom, use the protocol for that symptom.
- For multiple symptoms, select the most serious symptom or the one that appears to be the most emergent. If none of the symptoms are serious, select the one with the highest likelihood of needing to be seen (eg, ear ache instead of cough, cold, or fever).
- For fever, use the protocol for the most serious associated symptom, unless fever is the only symptom.
- If uncertain where to start, ask the caller ''Which symptom are you most concerned about?'' (Exception: If the caller's answer is ''fever,'' go to their second concern.)
- For a chronic disease and unrelated symptom, use the symptom protocol.
- For a chronic disease and related symptom, use the disease protocol if one is available (eg, asthma or seizures). If no disease protocol exists, put the call back to the PCP.
- Many protocols start with a section called ''See More Appropriate Protocol.'' Use these prompts to re-think your needs. These are usually more specific topics and provide more specific triage than the topic you are currently in.
- For symptoms that are from unrelated systems, you will need to use 2 protocols (eg, HIVES and DIARRHEA). This rule applies to 5% of calls.
- For an acute symptom not covered by a protocol, ask a more experienced triage nurse for a consult, use an appropriate book or other resource, or refer the call to the PCP.

SUMMARY

By assigning accusations of malpractice to one of three categories, reasonable responses can be initiated. For true accusations regarding medical errors, the case should usually be settled out of court. For false accusations, the written and recorded documentation should be shared with the patient's primary care provider as soon as possible. The physician in turn should share his or her interpretation of the call with the family. This proactive approach usually results in the caller withdrawing the complaint. If a lawyer is already involved, often the claim will be dropped. For accusations of an imperfect call, these usually account for the 5% of cases that go to trial. Once a plaintiff's lawyer is involved, it is unusual for this type of case to be dropped. The defendant's lawyer will need an expert witness to compare the nurse's actual performance to the "good call checklist." In over 80% of these cases, the case will be settled in favor of the physician and nurse by proving their performance met a reasonable standard of care.

References

[1] American Academy of Pediatrics. Committee on medical liability. Medical liability for pediatricians. 6th edition, Elk Grove Village (IL), 2003.

AMA Guidelines for Physician-Patient Electronic Communications

Excerpts from http://www.ama-assn.org/resources/doc/code-medical-ethics/5026a.pdf

Communication Guidelines

1. Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
2. Inform patient about privacy issues.
3. Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
4. Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mails communications with patients.
5. Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
6. Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
7. Request that patients put their name and patient identification number in the body of the message.
8. Configure automatic reply to acknowledge receipt of messages.
9. Send a new message to inform patient of completion of request.
10. Request that patients use auto-reply feature to acknowledge reading clinicians message.
11. Develop archival and retrieval mechanisms.
12. Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
13. Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
14. Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
15. Explain to patients that their messages should be concise.
16. When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
17. Remind patients when they do not adhere to the guidelines.
18. For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medico-legal and Administrative Guidelines

1. Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:
2. Terms in communication guidelines (stated above).
3. Provide instructions for when and how to convert to phone calls and office visits.
4. Describe security mechanisms in place.
5. Hold harmless the health care institution for information loss due to technical failures.
6. Waive encryption requirement, if any, at patient's insistence.
7. Describe security mechanisms in place including:
8. Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
9. Never forwarding patient-identifiable information to a third party without the patient's express permission.
10. Never using patient's e-mail address in a marketing scheme.
11. Not sharing professional e-mail accounts with family members.
12. Not using unencrypted wireless communications with patient-identifiable information.
13. Double-checking all "To" fields prior to sending messages.
14. Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
15. Commit policy decisions to writing and electronic form.

Telephone Management Quiz:

1. What are the **3 categories** under which patients should be triaged? What are the recommendations for disposition within these categories?

2. How should you end a non-urgent call?

3. **Discuss the ACQIP Telephone Advice Exercise**. Did you agree with the most common responses for each item? If not, where did your responses differ? Do our clinic nurses use telephone protocols? Should the residents use protocols when answering the Mommy Pager at night?

4. For the following phone triage scenarios, identify the **Error** and the **Risk Management Rule:**

(A) You receive a t-con about a 4 week-old with a fever of 102 F, while caring for a respiratory patient in the treatment room who ultimately gets transferred to the PICU. It takes you 2hrs to return the phone call, and the infant is found to be in septic shock by the time he reaches the ER.

(B) You receive a call about a 10 year-old with a fever of 102 F. He has no other localizing symptoms and is still maintaining PO, so you give "home care" advice. The patient, who turns out to have sickle cell disease, is admitted to the heme-onc service with pneumococcal sepsis in the morning.

(C) You receive a call about a 5 day-old breastfeeding infant whose mother is concerned about her milk supply. Since you now have booking keys, you book her a slot tomorrow with Dr. Kimball-Eayrs, who finds the infant severely dehydrated and with elevated bilirubin.

(D) The parent of your 2 year-old continuity patient calls 48hrs after you started her on amoxicillin for bilateral otitis media. She reports continued fevers and ear-tugging. You decide to switch her to Augmentin over the phone, thinking she must have a beta-lactamase resistant organism. She is admitted 3 days later with mastoiditis.

(E) You receive a call about a 3 year-old with a fever, seen in clinic today and diagnosed with URI. The provider gave mother instructions for Motrin, but she would like to alternate it with Tylenol and does not know the dose. You obtain the patient's weight from AHLTA and calculate the mg/kg dosage. The patient presents to the ER 2 days later vomiting, with high transaminases.

5. What is your best defense against **false accusation calls**?

6. Which diseases have the highest rates of **delayed diagnosis** and malpractice claims?

7. For *your* patient follow-ups, which do you use more— phone or secured messaging? What are pros and cons?

8. **Extra-credit**: How do you code for telephone and secured messaging f/u?

Telephone Management Cases/Role-Play:

Scenarios based on real-life cases. Names have been changed to protect the innocent.

Instructions:

Break into teams of 2. Resident A will play the Senior Resident, who takes primary responsibility for answering the t-con. Resident B will play the Junior Resident, who will listen in on the "phone call" and serve as "back-up" by finding and following along with the appropriate Barton Schmitt Telephone Protocol (*manual will be provided).*

Faculty Preceptors will play the parent on the other end of the phone.

Case 1:

Chief Complaint from Call Center: "Mrs. Thomas is calling because her son hasn't pooped in 5 days." Prior to calling back, you find her son, Ayden Thomas, in AHLTA and see that he is 6 weeks old. He had a normal follow-up on DOL4, and a normal 2 week well-baby visit. There are no other encounters.

Case 2:

Chief Complaint from Call Center: "CPT Kim is out of town and wants a refill on his daughter's puffer, because it was accidentally flushed down the toilet". Prior to calling back, you find his daughter, 6-year-old Marisa, in AHLTA. The first 4 encounters are for "ASTHMA" and "WHEEZING".