PRESIDENT'S MESSAGE

Dear AHRMNY Members,

As we begin the summer break from board meetings and committee work, I would like to take this opportunity to thank you for attending AHRMNY’s annual full day Education Conference on June 3, 2016. We had 121 attendees.

Kris Smith, M.D., MPP, Senior Vice President & Medical Director, Northwell Health Solutions, our keynote speaker, set the tone for a great day of learning with his engaging presentation “Journey to Value Based Care Re-evaluating Risks and Opportunities”. The breakout sessions featured speakers with expertise on a wide range of topics: Patient Safety Organizations: HIPAA; Informed Consent: Reducing Avoidable Patient Suffering; Behavioral Health; and Credentialing Risks related to Age, Health and Impairment. Thank you to Education Committee members Theresa Boland, Bonnie Boone, Victor Klein, CaraMia Hart, Peggy Sullivan and Carolyn Reinach Wolf, for reaching out to speakers and your thoughtful consideration of topics. The feedback from the evaluations was very positive.

The success of this conference reflected the tireless efforts of AHRMNY’s Fundraising Committee, chaired by Lesli Giglio and Gehan Soliman. They have cultivated strong relationships with various professionals within the risk management community. As a result, a diverse group of sponsors provided financial support while another group of professionals exhibited their products and services. Many AHRMNY members enjoyed the generosity of our exhibitors through raffles prizes.

The Publications Committee continues to educate our membership through the excellent articles contained in the Risk Management Quarterly. The committee welcomes ideas for articles and supports articles written by our members.

As you enjoy vacation time over the summer, please spend a few moments reflecting how you can contribute to AHRMNY. Each one of you has unique talents and skills. Sharing them with AHRMNY will enable us to better serve the risk management community.

Warmest regards,

Mary
**The Risk Management Quarterly (RMQ)** is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published four times a year.

**RMQ’s Mission Statement:** To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as other relevant information of interest to risk managers. The articles are usually written by AHRMNY members, so the journal serves as an opportunity for members to showcase their writing talents.

[Click here for the official RMQ Author Guidelines](#)

**Reminder:**
Maximum article length 3,500 words
Photo requirements: (high resolution JPEGs – at least 300 dpi)
AHRMNY will not publish those articles promoting products or services

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The information presented in **THE RISK MANAGEMENT QUARTERLY** is for educational purposes only

**CALL FOR ARTICLE SUBMISSION**
We are asking our readers to submit articles for future editions of the **RMQ** journal that focus on patient safety, environmental or staff safety, risk management, claims management, insurance issues and other relevant topics.

**RMQ** is published four times a year with a distribution of 300 copies per issue. Please forward any ideas or submissions for publication in the **RMQ** to “Editors”, via email with attachments to: ahrmny@gmail.com.

The deadline for submission and consideration for the next journal is August 31, 2016.

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**EDITOR’S CORNER**

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**MEMBERS AREA UNLEASHED**

Access to the “**Members Area**” on the AHRMNY website is a benefit provided with all membership subscriptions. This area holds many items that members frequently request. With your username and login passcode, the following items are at your fingertip whenever you need them:

**Member Directory**
Contains current list of AHRMNY members

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This section allows members to update their information that appears in the Member Directory

**Member Dues**
Link to renew member dues

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The database by default is designed to renew one membership per transaction. If purchasing a group membership, pay group member dues first and then complete group member application and submit for processing

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**The Risk Management Quarterly (RMQ) Journal**
Access current and back issues of RMQ

**Guidelines for Member Spotlight**
Instructions on completing the Member Spotlight Information Sheet

**Member Spotlight Information Sheet**
Form to complete and submit for inclusion in RMQ’s Member Spotlight column

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View a list of AHRMNY committees and what each committee handles for the organization

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Telemedicine: Understanding The Risks

By Jacqueline Bezaire and Robert L. Snyder

Telemedicine is increasingly a hot topic among health care providers, organizations and patients. Whether for better access to physicians, referrals, second opinions or remote consultations, both physicians and patients alike favor increased communication via electronic methods. Reimbursement for telecommunication encounters is on the rise and more health plans are encouraging it. Whether the modality is via your smartphone, tablet, laptop, computer or telephone, the growing popularity of telemedicine warrants a look at risk management, insurance and regulation issues.

The very definition of telemedicine is evolving along with its technology, regulations and practice guidelines. Undoubtedly we will see more of it in the future as reimbursement for telemedicine encounters, physician accessibility and consumer preference for it increase. So what is it and what are the liability, insurance and risk management issues involved with this evolving practice?

DEFINITIONS AND BACKGROUND

There is no one standard definition for telemedicine, but generally, the term refers to any medical activity that occurs at a distance using some form of telecommunication. In some states, telemedicine encompasses exchanges by telephone, fax and email.

The Centers for Medicare and Medicaid Services (CMS) defines telemedicine as ‘a two-way, real-time interactive communication between a patient and a physician or practitioner at a distant site through telecommunications equipment that includes, at a minimum, audio and visual equipment.”¹

The American Telemedicine Association (ATA) defines telemedicine as ‘the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.”²

Whatever the definition, telemedicine certainly involves patient-physician encounters via computer, camera, smart phone, tablet, telephone, email, fax – or whatever may develop in the future that allows interaction that is not face to face. The absence of a face-to-face encounter has many concerned that professional liability will increase because diagnostic capabilities are limited.

The ATA notes that telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of care. Even with respect to reimbursement, there is generally no distinction made between services delivered on site and those delivered via telemedicine; there is often no separate coding for billing of remote services.³

The principal services available through telemedicine fall into four categories:

- **Primary care and specialist referral services** may involve a primary care physician, allied health professional or specialist consultation with a patient in rendering a diagnosis, either through live interactive video or use of digitally stored and forwarded diagnostic images, vital signs, video clips and/or patient data.
- **Remote patient monitoring** includes home telehealth, using devices to remotely collect and monitor data for a specific vital sign; for instance, blood glucose, ECG or other indicators for a homebound patient, sent to a remote diagnostic testing facility, or a more sophisticated application, such as intraoperative neuromonitoring during orthopedic, neurological and neurovascular surgery.
- **Consumer medical and health information** means that consumers access specialized health information and on-line discussion groups on the internet via wireless devices.
- **Medical education** provides continuing medical education credits for health care professionals and specialized medical seminars for providers in remote locations.
The ATA references four fundamental benefits of telemedicine:

- **Improved Access** – Bringing health care services to patients in distant locations and allowing physicians and health facilities to expand their geographic reach.
- **Cost Efficiencies** – Reducing the cost to patients and payers of accessing both primary and specialist care, and increased efficiencies in the management of chronic diseases.
- **Improved Quality** – Studies have shown the quality of health care services delivered via telemedicine is equivalent to that of in-person consultations; in some specialties telemedicine has been demonstrated to deliver a superior product, with better outcomes and greater patient satisfaction.
- **Patient Demand** – Meeting increasing consumer demand for access and efficiency, reducing travel time and stress for patients and their families.4

**CHANGING LANDSCAPE**

**Practice Guidelines**

Telemedicine practice guidelines published by the ATA and the AMA outline specific protocols and practice parameters for physicians. In general, they suggest the importance of establishing a physician/patient relationship and using the standard of care common to face-to-face patient encounters. Issues addressed in the guidelines include:

- Referrals and emergencies
- Physical exam
- Informed consent and teaching
- Documentation
- Regulatory compliance
- Telemedicine patient management
- Quality reviews
- Provider training
- Follow-up
- Home monitoring

**REGULATIONS, LICENSING, REIMBURSEMENT AND JURISDICTIONAL CONFLICTS**

Regulations concerning licensing of telemedicine and reimbursement for services under both private insurance and government-funded programs, Medicaid in particular, are currently a mosaic across the 50 states and the District of Columbia. The permutations and intricacies, especially for multi-state telemedicine providers, require careful, individual analysis in consultation with legal counsel and are beyond the scope of this article.

For example, the American Medical Association has highlighted the practice of prescribing medication as one important topic that is a source of confusion. While state regulations vary, the general consensus, supported by the AMA, is that care provided by telemedicine needs to meet the same standard of care as care provided in person.

At a minimum, this requires an established patient-physician relationship before any prescriptions are issued. AMA supports the use of telemedicine for prescribing, but AMA policy makes it clear that the physician (or other authorized provider) must first establish the patient-physician relationship.7

The ‘patient-physician relationship’ is described in the AMA Code of Ethics simply and somewhat ambiguously as one ‘that exists when a physician serves a patient’s medical needs’.8 However, AMA policy further requires that establishing the patient-physician relationship includes obtaining a medical history, describing treatment risks, benefits and options, arranging for appropriate follow-up care, maintaining health records and recording any prescriptions issued in the patient’s file.9

Through its Council on Medical Service (called CMS, not to be confused with the Centers for Medicare/Medicaid Services, also ‘CMS’), the AMA has clarified its policy to state that ‘prior to delivering services via telemedicine, a valid patient-physician relationship must be established through, at minimum, a face-to-face examination.’ The face-to-face encounter could occur in person or virtually, through real-time audio and visual technology.10 Thus, issuing prescriptions based on a relationship established solely via an online questionnaire is ethically prohibited.

AMA policy likewise requires the face-to-face encounter (virtual or in person) as a component of establishing the patient relationship when consultation is with another physician who has a patient-physician relationship. Exceptions are recognized for situations, such as emergency medical treatment, on-call coverage and cross-coverage. The Federation of State Medical Boards (FSMB) has a model policy on telemedicine that is similar to the AMA’s policy.11

Even with the ethical relationship established, telemedicine providers still must abide by appropriate licensing and credentialing requirements. Physicians who use telemedicine to practice across state lines must have in most instances a full, unrestricted license in the state where the patient is located, as well as in the state where the provider is located. However, certain states have established limited licensing for telemedicine, e.g., AL, LA, MN, MT, NM, OH, OR, TN and TX. The limited licenses allow physicians to practice across state lines without obtaining a full license in each state where patients are located, based on the patient being located in the state that issues the limited license, and the practitioner being fully licensed in the practitioner’s home state.

Additionally, the FSMB has proposed a multi-state compact to allow multi-state licensing for physicians board-certified in one state to have their licenses reciprocally recognized in other states without having to apply for full licensure in other states. This compact would apply to telemedicine, in addition to in-person practice.12

The following examples illustrate the range of state laws and regulations governing telemedicine:

- **California:** Physicians who use telemedicine are held to the same standard of care as if they treated the patient in person. Before beginning any telemedicine procedures, the patient must verbally consent, and this consent must be noted in the patient’s file.13
- **Florida:** Florida also requires the same standard of care that applies to in-person encounters. Any technology used must convey the same information needed to meet the standard of care; physicians are responsible for the quality of this technology. Patient-physician relationships can be established via telemedicine alone (no in-person encounter required), but controlled substances may not be prescribed via telemedicine.14
- **New Hampshire:** Telemedicine is controlled by the same regulations as the general practice of medicine, making New Hampshire’s law among the strictest in the country regulating the use of telemedicine. Therefore, a patient-physician relationship can only be established with an in-person exam, history, diagnosis, treatment plan and prescriptions. An exception to the in-person requirements is made for the practice of teleradiology; however, any out-of-state physician practicing teleradiology on patients located in New Hampshire must be licensed to practice medicine in New Hampshire.15
- **Hawaii:** The only requirement for telemedicine is that it meets the necessary standard of care – the other end of the spectrum! Prescriptions via telemedicine are treated as if they were issued in connection with an in-person encounter.16
- **Texas:** Texas law is specific with respect to a variety of telemedicine scenarios. A distinction is made between telemedicine services provided to a patient who is at an established medical site, and telemedicine services provided to a patient who is not at an established medical site.17

An ‘established site’ means a location where there is ‘a patient site presenter and sufficient technology and medical equipment to allow for an adequate physical evaluation, as appropriate for the patient’s presenting complaint’ and does not include a private residence.18 If the patient is at an established medical site and distant-site physician may use telemedicine to establish a patient relationship, diagnose and treat.19 If the patient is not at an established medical site, Texas law requires that the physician and patient have had at least one face-to-face encounter before treatment can be provided, including issuing prescriptions, with the initial encounter being either in-person or remotely at an established medical site.20
However, controversy has arisen in Texas over the use of telemedicine and the face-to-face encounter. On April 10, 2015, the Texas Medical Board adopted a strict rule, effective June 1, 2015, requiring an in-person visit by a patient with a physician before providing diagnosis or prescribing drugs by phone or video. (Prior to June 1, the rules allowed telemedicine without a prior visit if a patient was at a health facility, such as a hospital, clinic or pharmacy, and had another health care professional with them, as well providing an exception for mental health visits.)

A well-established online and telephonic physician service, Teladoc, based in Dallas, filed a federal anti-trust suit against the Board on April 29, 2015. (Teladoc has completed more than 600,000 consultations, including 140,000 in Texas over the past 10 years, many of them on nights, weekends and holidays.) On May 29, 2015, U.S. District Judge Robert Pittman issued a temporary injunction blocking the implementation of the new rules, pending a trial on the issues. The Texas Medical Board contends the rules are necessary to ensure patient safety, while Teladoc, which has been at odds with the Board since 2011, contends the rules are an illegal restraint of trade designed mainly to protect the financial interests of physicians. This will be a case worth watching for its potentially broader implications nationally.

With respect to reimbursement under both Medicaid and private insurance for telemedicine services, the law is clearly moving in the direction of promoting the use of telemedicine. This trend has accelerated since the passage of the ACA. Currently, nine states and the District of Columbia have laws mandating coverage and reimbursement for telemedicine services under their Medicaid programs: CA, CO, KY, MD, MN, MS, NE, TX, VT, DC.

With respect to private insurance, as of 2015, 27 states and DC, covering nearly half the U.S. population, have ‘parity laws’ for private insurance coverage of telemedicine: AZ, AR, CA, CO, DC, GA, HI, IN, KY, LA, ME, MD, MI, MN, MS, MO, MT, NV, NH, NM, NY, OK, OR, TN, TX, VT, VA, WA. Ten other states have parity bills pending: CT, DE, IL, IA, MA, NJ, NC, OH, PA, RI. Thirteen states have no parity legislative activity: AK, AL, FL, ID, KS, ND, NE, SC, SD, WI, WV, WY, UT. Given the trend, it is reasonable to assume most of the ‘outlier’ states will adopt some form of parity legislation going forward.21

In an attempt to create a national level of consistency as to what constitutes telemedicine or telehealth (the terms are used interchangeably), a bi-partisan bill has been introduced in Congress. H.R. 691, Telehealth Modernization Act of 2015, is co-sponsored by Reps. Doris Matsui (D-CA) and Bill Johnson (R-OH). The bill seeks to break down barriers to the use of telehealth by establishing a federal standard for telehealth and serving as guidance to the states, subject to a number of specified conditions. The bill defines ‘telehealth’ to mean, ‘with respect to health care that a health care professional is authorized to deliver under State law, such health care delivered by such health care professional to such individual not in person, from any location to any other location, and by means of real-time video, secure chat or secure email, or integrated telephony.’ While having this uniform definition across the country is potentially helpful, perhaps especially as to the reimbursement by payers for telemedicine services on a consistent basis, the bill does not attempt to create any federal standard for licensing providers, meaning the current ‘mosaic’ of state regulation will remain in place, unless states agree to adopt some form of model legislation to facilitate the interstate providing of telemedicine services.

A highly recommended resource is the ‘State Telemedicine Gap Analysis’ for all 50 states and DC, freely available online through the American Telemedicine Association.22 The analysis reviews in detail key indicators, such as physician practice standards, telepresenter requirements, informed consent, licensure, and prescribing, with individual state report cards and an array of useful matrices and maps.

INSURANCE MARKET TREATMENT OF TELE MEDICINE – PROFESSIONAL LIABILITY

The current consensus across an array of leading Medical Professional Liability (MPL) insurers is that they are flexible in their underwriting approach and not overly concerned regarding telemedicine as an area of risk, recognizing it as an inevitable part of the evolution of health care. A consistent message from MPL insurers is that telemedicine per se is not a ‘professional health care service,’ but rather, a means of delivering professional services with which the insurers overall are generally comfortable and already insuring. From a professional liability standpoint, the MPL insurers are evaluating, on the front end, the risk posed by the health care professionals (primarily physicians, but also ‘physician extenders’) providing health care services as part of the telemedicine enterprise. Essentially the same criteria are used to underwrite the ‘professional’ risk associated with services provided from a ‘distant site’ as are used for services being provided at an established medical site.

That said, some underwriters do express individual concerns regarding the scope of telemedicine for certain medical services and other issues, such as:

- Intraoperative surgical monitoring, regarded as high severity risk by some insurers
- Remote diagnosing, as the principal activity
- Remote prescribing, as the principal activity, especially for controlled narcotics
- Teleradiology – The ‘original’ application of telemedicine, where there is some concern that market pricing has become so competitive, the premiums may be insufficient to support claim frequency
- Applications of telemedicine that might not yet be recognized and accepted by the American Telemedicine Association
- Credentialing of remote providers – A significant concern for some insurers

Also, a consistent theme is concern about the network security and privacy (a/k/a ‘cyber liability’) exposure. Part of the risk evaluation process for most MPL insurers is having an understanding of the technology standards and safeguards being utilized primarily by the remote telemedicine provider, but also by the established medical site, if applicable. Telemedicine providers are well advised to make sure they have robust cyber coverage in place, whether through the same insurer as their MPL coverage or otherwise, owing to the implications for both patient privacy under HIPAA and potential professional liability claims that might be subject to exclusions or sublimits that can prove to be inadequate. Additionally, the prudent telemedicine provider will seek to protect itself contractually or by way of insurance that a third-party technology provider will provide for its errors or omissions.

Further, the onus is clearly on the telemedicine provider to ascertain what licensing might be required for remote location health care providers rendering any form of care to patients in distant states. Most, if not all, MPL insurance policies contain exclusions for ‘illegal’ acts or acts beyond the scope of the license of the health care provider. Thus, the telemedicine entity, with the assistance of legal counsel, must determine for purposes of obtaining insurance that all appropriate licenses are in place. The ‘oops’ factor after a claim occurs will most likely lead to unpleasant consequences. To this point, major MPL insurers are likewise consistent in having not developed specific coverage forms relating to telemedicine.

For the most part, existing MPL (and, where appropriate, GL) coverage forms are used, endorsed as needed to reflect any particular concerns about the exposure.
TELEMEDICINE LIABILITY

Current Claim Experience

To date, the incidence of medical malpractice claims involving telemedicine has been low, perhaps due to the facts that there are still many more personal patient-physician encounters than via telemedicine, and liability is still developing. Also, most suits are settled and it is difficult to get a good number due to the lack of reporting in this area. Those claims that we have seen still tend to be in radiology. However, all seem to agree that claims will be on the rise.23

CLAIM AND RISK MANAGEMENT CONSIDERATIONS

Professional liability issues follow closely with the adherence to practice guidelines, state regulations and established law in the various states to shape the standard of practice in this area. In reality, however, much of this is the same standard of care that we have always had; only the mode of transmission is different.

SO WHAT CAN WE DO ABOUT THIS?

Finding solutions for anticipated risk before it happens is part of what risk management is all about. Although we do not know exactly what will develop in telemedicine liability, it might look something like this:

<table>
<thead>
<tr>
<th>RISK</th>
<th>POTENTIAL CLAIM</th>
<th>SOLUTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inaccurate diagnosis based on telemedicine</td>
<td>Physician did not receive prior documentation of patient’s medical history and diagnosed patient incorrectly</td>
<td>Design protocols and guidelines (ATA, AMA) for history and diagnostic information that must be present prior to consultation via telemedicine</td>
</tr>
<tr>
<td>Remote assessment may rely on another practitioner’s ‘eyes on’ assessment</td>
<td>Physician relied on bedside assessment of nurse to diagnose abdominal tympany and liver palpation for ascites leading to misdiagnosis</td>
<td>Ensure there is adequate skill level of practitioner at patient bedside via credentialing and standards of practice</td>
</tr>
<tr>
<td>Documentation problems/continuity of care</td>
<td>Patient contacts several doctors via different telemedicine systems which do not communicate. Doctor prescribes wrong drug</td>
<td>Consistent electronic medical records accessible to treating practitioners should be part of the telemedicine program; document mode of service, practitioners involved, difficulties</td>
</tr>
<tr>
<td>Credentialing/scope of practice</td>
<td>Doctor A is covering for Doctor B and has not been oriented correctly to telemedicine protocols and does not follow up with the patient, causing injury</td>
<td>Telemedicine credentialing should include technology orientation, regulation compliance and remote assessment training</td>
</tr>
<tr>
<td>Informed consent/transparency</td>
<td>Online enrollment for telemedicine services does not require patient’s consent for remote consultations causing allegation of lack of informed consent</td>
<td>Patient must consent to telemedicine consultation as well as to any procedures planned</td>
</tr>
<tr>
<td>Technology failure</td>
<td>Physician cannot adequately visualize patient’s wound leading to inadequate treatment and infection</td>
<td>Technology adequate for high level visualization, backup and support should be employed</td>
</tr>
<tr>
<td>Cyber breaches/privacy breaches</td>
<td>Telemedicine system was not secure, leading to hacking personal information of patients</td>
<td>Risk management should work closely with administration and IT to ensure security of system; cyber breach insurance may be recommended</td>
</tr>
</tbody>
</table>

CONCLUSION

Telemedicine is evolving and expanding rapidly on a global basis. Like many technological advances in health care, it offers great promise with respect to cost efficiency, access and quality outcomes. At the same time, telemedicine presents risk challenges to telemedicine operators, remote health care providers and on-site providers, relating to the reliability of the applicable technology, inconsistencies with respect to regulation, patient expectations and insurable risk. Providers contemplating involvement with telemedicine at any level should work with their appropriate professional advisers to carefully evaluate both potential risks and benefits of participating in telemedicine initiatives.

About the Authors

Bob Snyder is based in Houston, TX as a member of the Willis Towers Watson National Health Care Practice. A 40 year veteran of the insurance brokerage industry, he has served with Johnson & Higgins, Marsh, Myron F. Steves & Co., HRH, Willis and Willis Towers Watson over that time. Much of his work has been focused on implementing alternative risk financing strategies for an array of health care providers, including the formation of trusts, captives and Risk Retention Groups. Bob is a member of the State Bar of Texas. He began working with health care providers on designing self-funded liability program at Johnson & Higgins during the first medical malpractice insurance crisis in 1976. Bob has presented to numerous professional organizations over the years. He is a 30+ year member of ASHRM and a founding member and past president of the Greater Houston chapter. He has served on the ASHRM national nominating committee and as an adjunct lecturer on insurance and risk management at the University of Houston – Downtown College of Business.

Jacqueline Bezaire has over 35 years of experience in the field of Healthcare Managed Care and Medical Malpractice Claims Management and Clinical Loss Control. She also has experience with international claims and loss control issues and is a Global Technical Director or the Willis Claims Practice. She has worked for several international insurance carriers and has supervised all aspects of claims management for physicians, hospitals, and Other health care entities. Jackie is currently a member of the Willis National Healthcare consulting team and the Willis Claims Advocacy Practice. She specializes in managed care and professional liability claims process evaluation and case advocacy. She is a member of the clinical loss control consulting team for the practice which includes assessments, audits, specialized educational programs and clinical standards evaluations. Jackie is the recipient of the Premier Risk Award for Outstanding Achievement in Risk Management.

References listed on page 17
AHRMNY wishes to thank all of our sponsors who generously donated towards expenses associated with all of our educational programs from September 2015 to June 2016.
“First Do No Harm”: Liability for Improper Discharge and the Case of Barbara Dawson

By Samantha E. Quinn, Richard W. Nicholson and Lisa M. Fletcher

INTRODUCTION

In December of 2015, 57 year-old Barbara Dawson was discharged from Calhoun-Liberty Hospital in Blountstown Florida against her will. Hospital staff allege that she became combative and loud, was disturbing other patients and refused to leave the hospital premises claiming she was still ill. As a result, the local police were called. The responding officer spoke with Ms. Dawson and informed her that she had been discharged from the hospital and if she required further medical treatment she would need to seek it at another facility. Ms. Dawson protested and at approximately 4:46 am, she was arrested for disorderly conduct and trespassing. She was described as non-violent but non-compliant.

Throughout these events Ms. Dawson continued to express that she was feeling unwell and “could not breathe” and refused the officer’s attempt to remove her oxygen hose. Upon the instructions of the hospital staff, the officer unplugged the patient’s oxygen tank and attempted to handcuff the patient and put her in the police car. While still in the hospital parking lot, Ms. Dawson collapsed and approximately 18 minutes later a doctor took the patient’s vitals and declared that she needed to be readmitted.1 Doctors attempted CPR unsuccessfully and Ms. Dawson was pronounced dead at 6:24 am. Upon autopsy it was discovered that she had been suffering from a pulmonary embolism.8

Ms. Dawson’s incident is particularly egregious, shocking even. Incidents like this do arise, however, when a patient or a patient’s family patient disagree with the determination of the hospital staff regarding admission and discharge. Patients have certain rights to ensure they can access medical treatment when needed and medical professionals must always be mindful of these rights and the potential consequences for violating them. Both Federal and New York State laws exist to ensure that patients are not “dumped” or turned away when they are in need of treatment. Separate and apart from these laws, hospitals may be found negligent by improperly discharging patients who then engage in acts which cause harm to themselves or others. In this article we will review the basic principles to which hospitals must adhere to prevent liability for the improper discharge of a patient.

Prohibition Against “Patient Dumping”

The incident at Calhoun-Liberty Hospital has been described by the victim’s family as a classic example of “patient dumping”, a phenomenon which the United States Government enacted the Emergency Medical Treatment and Active Labor Act to combat. The 1986 statute is intended to prevent Hospitals from discharging an ill patient for improper reasons such as an inability to pay. Pursuant to EMTALA, a hospital must provide an appropriate medical screening examination of an individual presenting to the hospital’s emergency department to determine whether an emergency medical condition exists.9 Upon determining that an emergency medical condition exists, the hospital must provide for a further medical examination and such treatment as is required to stabilize the condition.10 EMTALA does not protect a patient from improper diagnosis or treatment; rather, it “create[s] a new cause of action, generally unavailable under state tort law, for what amounts to failure to treat”.11 If a patient with an emergency medical condition or in active labor is turned away from a hospital and harm ensues, that patient has a federal statutory right to recover from the hospital.

New York State has itself enacted similar laws to prevent improper discharge of patients. For example, New York Public Health Law requires that Hospitals publicize the following:

You have the following rights under the New York State law: Before you are discharged, you must receive a written Discharge Plan. You or your representative have the right to be involved in your discharge planning. Your written Discharge Plan must describe the arrangements for any future health care that you may need after discharge. You may not be discharged until the services required in your written Discharge Plan are secured or determined to be reasonably available. If you do not agree with the Discharge Plan or believe the services are not reasonably available, you may call the New York State Health Department to investigate your complaint and the safety of your discharge. The hospital must provide you with the Health Department’s telephone number if you ask for it.12

Further, hospitals must inform patients that they have the right to receive all of the hospital care that they need for the treatment of their illness or injury. The rule outlines in its section on patients’ rights that:

Your (the patient) discharge date is determined only by YOUR health care needs, not by your DRG category or your insurance. You have the right to be fully informed about decisions affecting your care and your insurance coverage. You have the right to designate a representative to act on your behalf. You have the right to know about your medical condition. Talk to your doctor about your condition and your health care needs. If you have questions or concerns about hospital services, your discharge date or your discharge plan, consult your doctor or a hospital representative (such as the nurse, social worker, or discharge planner).13

Additionally, New York Public Health Law requires that before a patient is discharged, he must receive a written discharge notice and a written discharge plan and patients have the right to be involved in their discharge planning. Further, a patient has the right to appeal the written discharge plan or notice received from the hospital if she feels she is being discharged too soon.14 A patient may not be discharged until the services required in the written discharge plan are secured or determined by the hospital to be reasonably available.

The foregoing is simply an overview of some of the Federal and State laws applicable to patient discharge and is by no means exhaustive. It is essential that medical professionals and hospital personnel are aware of these laws and understand both EMTALA and relevant state laws regarding the discharge of a patient or failure to admit a patient who is seeking treatment. Patient safety should always be the paramount concern and it is the responsibility of the discharging facility to outline appropriate follow-up treatment.15

Medical Professionals’ Continuing Responsibility for Improperly Discharged Patients: A Case Review

Another circumstance under which a hospital or doctor may run the risk of being found liable for the premature discharge of a patient is in the care and treatment of psychiatric patients. In these cases, allegations by the patient are more likely to sound in negligence as opposed to the statutorily based claims discussed above.

8 The Risk Management Quarterly
A seminal case in this area of law is Davitt v. State. In Davitt the claimant, Ms. Davitt, filed suit against the State based on self-inflicted injuries experienced after release from a state-operated psychiatric facility. The Supreme Court, Appellate Division, held that the supervising psychiatrist who approved the release of the patient could not be held liable for the patient’s injuries where he had exercised appropriate medical judgment.

Ms. Davitt had initially been involuntarily admitted due to self-harm. After two months of treatment and steady improvement, she received day passes to visit family and friends. On August 6, 1981, the center’s release committee met with the plaintiff and concluded that she should be given extended home leave in preparation for discharge. Thereafter, the plaintiff refused to return to the facility and was treated at home on one occasion by one of the center’s social workers. During this visit he noticed that the plaintiff’s eye was swollen and was told she had tried to hurt herself once but had not tried to harm herself again since. After this visit, it was determined that the plaintiff should be formally discharged and treated on an outpatient basis. Shortly thereafter, the plaintiff gouged out her right eye and attempted to do the same to her left eye leaving herself totally blind.

The court stated that the established rule in cases of allegedly premature discharge is that “doctors or a governmental subdivision of the State that employs them cannot be held responsible for damages resulting from the actions of a psychiatric patient who has been released when the patient’s release is a matter of professional judgment.” In order for liability to ensue, it must be shown that the decision to release the patient was “something less than a professional medical determination.” The court found that the plaintiff had failed to meet that burden because the treating doctors demonstrated sufficient knowledge and consideration of the plaintiff’s case to make an informed determination as to her discharge. The fact that they made an error in judgment was not dispositive.

Davitt sets a standard for what constitutes appropriate methodology for the discharge of a patient. When the claimed malpractice concerns the wrongful release of a patient, courts have refused to impose liability unless there was “something more” than an error of judgment. For example in Bell v. New York City Health & Hosp. Corp., the hospital was found to have acted negligently where they released a patient who later set fire to himself in an act of attempted suicide. The plaintiff, Mr. Bell, had a long history of psychiatric problems and had attempted suicide in the past. He was admitted to the Kings County Hospital pursuant to a Court Order requested by his wife. The plaintiff continued to hear voices throughout his stay and on September 9, he had to be restrained in a straightjacket. Nonetheless on that same day a doctor determined he could be released. He stated that he would prefer if the plaintiff remained hospitalized but could not keep him admitted unless he was a danger to himself or others. He recommended outpatient treatment and medication. However, during his admission the plaintiff had expressed an unwillingness to take medication.

In the Bell case, the defendant physician admitted that he failed to inquire as to the nature of the plaintiff’s voices and delusions and admitted that in the absence of such inquiry, it was a departure from accepted medical practice for him to write that the patient was “not a danger to self or others” in his note recommending release. The very predicate for the decision to release Bell was admittedly founded upon insufficient inquiry. Further, on the same day the plaintiff had to be restrained, the doctor noted, contrary to the notes of all other medical professionals in the hospital that the patient was improving.

In Selbert v. Fink, the Appellate Division held that material issues of fact as to whether a treating psychiatrist conducted adequate review before issuing a day pass to a psychiatric patient, precluded summary judgment. Following an apparent suicide attempt involving a leap from a moving car, the plaintiff’s decedent was hospitalized for acute postpartum depression. In the emergency room, the plaintiff acknowledged that she had attempted suicide, and she was regarded as a suicide risk. She was admitted to the hospital and came under the care of the appellant, who was her attending psychiatrist. During her hospitalization, she generally denied that her fall from the moving car was a suicide attempt, but she made conflicting statements, and a nurse suspected that the denials were part of a “game” to facilitate her discharge. Approximately one week after admission, while home on a 12 hour pass approved by the appellant, the plaintiff’s decedent took her own life. Appellant admitted that he did not read the decedent’s complete chart before approving the pass and prescribed no medication for the decedent before releasing her, and was unaware of the nature and dosage of the medication she had been taking.

In Laura I.M. v. Hillside Children’s Ctr., the plaintiff filed suit against Hillside Children’s Center, a treatment facility for emotionally disturbed children aged 10 to 18, to recover damages for instances of abuse against her children meted out by an outpatient of the facility. The outpatient in question, S. R., presented at Hillside with a well-documented history of pedophilic behavior. He was classified as a “status 3” client which, according to Hillside’s policy manual, meant he required monitoring at all times except when bathing or showering. The manual further elaborated that without this close supervision a “status 3” client may enter into or engage in situations which could lead to danger to self or others.

During his residency at Hillside, S. R. was permitted to make unaccompanied weekend visits to his home in New York City; during these visits, S. R. was allegedly supervised by his mother and an older sister. The home visits were approved by S. R.’s therapist at Hillside, a social worker. It is not clear from the record whether Hillside’s staff psychiatrist or any other Hillside professionals participated in the decision to permit such visits. The social worker and one of her supervisors did testify, however, that factors generally considered in determining whether to permit such home visits were the client’s progress in treatment, the likelihood of harm to the client or others during such a visit, and the ability of the client’s family to provide supervision.

During these home visits, S. R. took a job as a babysitter for the plaintiff’s children. The plaintiff contended that in permitting S. R. to make unaccompanied visits home in spite of his known proclivities, Hillside did not make an honest error of professional judgment but failed to exercise any professional judgment at all. After discovery, both parties cross moved for summary judgment. The plaintiff was found to have met their burden to establish a prima facie case for the defendant’s liability by submitting the testimony of the S. R.’s mother that she was unable to control her son and no one from Hillside ever asked if she would be able to supervise or control her son during his home visits despite that being Hillside’s criteria for his discharge. The court found that no medical judgment was made as the decision to release S. R. was not founded upon a careful examination of all relevant facts. Therefore the court found the center to be negligent in discharging the patient.

The above cases make it clear that the court is unlikely to punish a hospital or physician where a careful consideration of relevant facts and exercise of medical judgment is demonstrated. The court will, however, impose liability where professionals fail to adhere to statutory guidelines, violate their own discharge policy or clearly do not exercise any medical judgment at all in the discharge of a patient. From failing to review the patient’s medical chart which indicates that she is suicidal, to failing to communicate with family members where the discharge plan requires that family members supervise the patient, to prescribing a psychotic patient medication when he has refused to take medication in the past, the professionals in the above cases did not simply make erroneous medical judgments, they lacked the basis to make any medical judgment whatsoever.
Conclusion

In the aftermath of the tragedy experienced by Ms. Dawson, her family has retained counsel who intend to file suit against the hospital and local police. Additionally, in February of this year, Calhoun-Liberty hospital was cited by the Agency for Health Care Administration (AHCA) of Florida in connection with the incident. Acknowledging that Dawson is an extreme case which is unlikely to recur, medical professionals can and should use this horrific incident as a reminder of the appropriate measures to engage in when discharging even an unruly or combative patient. In discharging any patient, physicians and other medical professionals must ensure that they have complied with all statutes as well as their own policies and have thoroughly documented the well thought out medical reasoning behind the release of the patient. Further, case law demonstrates that where a medical professional can show that he made a sound medical judgment in the discharge of a patient, even if such a judgment was erroneous, liability can often be avoided. Courts are well aware that medical professionals are more suited to determine when a patient should be discharged than a post hoc court would be. Therefore, even when the end result is tragic, a court will generally impose liability only where a failure to exercise medical judgment can be demonstrated. Careful documentation is the practitioner’s best weapon to avoid this.

References listed on page 18

About the Authors

Samantha E. Quinn and Richard W. Nicholson are partners and Lisa M. Fletcher is an associate with the firm of Schiavetti, Corgan, DiEdwards, Weinberg & Nicholson, LLP which specializes in the defense of hospitals, doctors and other health care providers.

AHRMNY EVENING EDUCATIONAL NETWORKING EVENT
Thursday, March 10th, 2016
Holiday Inn – Midtown NYC – Embassy Ballroom

Mary Steffany and the Education Committee did another outstanding job with the AHRMNY Annual Evening Networking Event. We had fifty three members attend this event that was held on March 10th, at our new venue, the Holiday Inn on W. 57th Street. Graham Billingham, MD, FACEP, FAAEM, Chief Medical Officer at Medical Protective Company was our guest speaker for the evening. Dr. Billingham presented Healthcare Reform and Emerging Risk that highlighted the impact future changes to healthcare will have on providers, patients, and carriers. Changes that Dr. Billingham focused on included utilization, technology, and medical malpractice claims severity.

Utilization
As the Affordable Care Act (ACA) evolves, it is predicted that frequency in patient visits will increase by moving older, more complex patients faster through the system by ordering fewer tests and consults, and lowering readmission rates. As a result, the supply of physicians won’t meet up with demand, especially with the baby boomers expected to reach 75 million in the next decade. The reason for this is the fact that the physician pool is shrinking with more than 50% actively seeking to retire, sell, or close his/her practice. We can expect that the FTE physician demand will experience a shortfall of 130,000 by 2025. To fill this gap in primary care providers, it is expected that more than forty percent of primary care will be provided by PAs and Nurse Practitioners by 2025.

Technology
Dr. Graham identified several technologic issues on the ECRI 2016 top 10 hospital C-suite watch list including mobile stroke units, new high-cost cardiovascular drugs, and miniature leadless pacemakers. Metadata is being questioned as the new asbestosis because of the various issues related to EHR usage. The PIAA EHR litigation data shows that 53% of participants had already seen an EHR-related claim. The top trends include cut- and-paste practices, failure to review additional electronic records, failure to interface with other systems, and allegations of HIPAA violations. Handheld and mobile devices continue to pose significant risk. For example, one laptop is stolen every 53 seconds, 4.3% of smartphones issued to employees are lost, and 52% of devices are stolen from the workplace. Threats to be concerned with include data breach, loss of intellectual property and trade secrets, loss of personal information, mobile malware, and web-based threats.

Medical Malpractice Severity
The 2015 SNL P&C Industry results for Healthcare liability shows frequency decreasing, while severity is increasing, paying on average $354,000 per defendant that is up from $313,000 in 2010. The most recent CRICO study showed that high severity claims drive both the in-patient (73%) and out-patient (60%) setting. It appears that "super losses" are on the rise with the percentage of total dollars spent on claims for losses of $5m creeping up from the 7.5% to 10% range in the early 2000’s to the 15% - 25% range that is expected to increase. Long term care liability frequency and severity was noted to be on the rise, according to the Aon General Liability and Professional Liability Actuarial Analysis, published November 2104. Loss rates are increasing by 5.0%, frequency is up 3%, and severity is increasing by 2% annually. A quote from Justin Keith, Hiscox Bermuda was stated, "There’s a sentiment in the US of general distrust with big business, so when your community hospital that you’ve known for 30 years becomes part of a much bigger national hospital corporation, you’re no longer suing your friend. You’re suing some faceless name."

Dr. Billingham concluded his presentation with a few observations, one of which is that this complex method of delivering healthcare will take a decade to sort out.
Wake Me Up!! I’ve Had Enough!!
Litigation Nightmares with the Electronic Medical Record

By Matthew P. Keris

There are few developments that have affected the practice of medicine like the adoption of the electronic medical record (EMR) approximately a dozen years ago, when President George W. Bush advocated for its complete adoption by 2014. As a commentator on this topic since then, I can state that if anyone declared at that time how the adoption of EMRs would affect medical liability claims with absolute certainty, they were less than truthful. Now, after 10 years worth of care involving the EMR, we are beginning to emerge from the fog of uncertainty in dealing with the novel clinical, preservation and production issues associated with the EMR. The following is an overview of what EMR issues we anticipated correctly a decade ago and where we were wrong.

WHAT WE PREDICTED CORRECTLY

Review of EMR Metadata Would Increase and Be Considered the New Normal

Ten years ago, few knew what “metadata” was. About that same time, the Federal Rules of Civil Procedure were amended following the seminal case of Zubulake v. UBS Warburg, where Judge Shira Scheindlin issued a series of legal decisions that provided the first guidance for preserving and producing the embedded data that tracks changes to computerized records.

Where metadata has impacted medical professional liability claims is in the “audit trail.” In my practice, producing an audit trail along with a hard copy printout of the EMR has become the new normal. For those not familiar with the term, “audit trail” is essentially a chronological breakdown of when information was recorded in the EMR that is visually hidden on screen but is fairly easy to recreate and produce in a printout. Due to its ease in production, the typical discovery objections that the information sought in an audit trail is “unduly burdensome” or “unlikely to lead to relevant information” is not the case. It is easy to produce, and it is likely to lead to relevant information.

One may ask why the audit trail is being sought. In medical malpractice cases, it can show large time gaps between when the treatment was rendered and when the documentation of that treatment was entered into the computer. It can also point out alterations or supplementation to the record. When documentation time gaps and supplemental entries are discovered, it leads to additional inquiries, such as, “Why the time delay—What were you doing between the care and the chart entry?”; “Was what you documented after treating the patient different from what you would have documented had it been done simultaneously to the treatment?”; and, “Why did you supplement and/or change the record?” The EMR’s audit trail, which was not available with the hard copy record, has provided an opportunity for further inquiry into areas that were of little interest in the past. Now, healthcare providers should anticipate scrutiny regarding late or supplemental inquiries. They should be prepared to explain why it occurred because the audit trail will easily show the discrepancies. For health risk professionals, you may not like the answer.

Access to Entire Patient History Has Advantages and Disadvantages

One of the touted potential benefits of the EMR was that it would create a literal world wide web of health information on a patient, hypothetically providing a patient’s complete record, from cradle to grave. In theory, this capability would improve care because physicians would have a patient’s complete medical history at their fingertips. With more patient information, at least theoretically, most thought that healthcare would improve, which would reduce hospital stays and lower healthcare costs.

However, in medical negligence claims, complete access to a patient’s health record through the use of a comprehensive EMR system can be used against healthcare providers if they do not utilize it in the care of their patients. Healthcare providers need to be cautioned that, now that they have access to a patient’s complete health record through the EMR, they are expected to utilize that information. For example, if a patient’s chart from a separate institution years prior indicates they have a medication allergy, it can be anticipated that a criticism will be made against the healthcare provider for not reviewing that record if the patient was given that medication in error and suffered an injury.

Just as the complete healthcare record can be used by healthcare providers to assist in preparing a medical defense, the converse is true. Healthcare providers should be encouraged to access the complete medical history in the care of their patients, otherwise, the failure to use this new feature can be used against them.

There Would be Increased Scrutiny on Health Information System Professionals

The last area that was correctly predicted was that, in addition to the medicine, there would be an increased interest by patients’ lawyers in how EMR systems are used and what features are available to healthcare providers when they are using these systems. It didn’t take long for them to learn that the hard copy printout of the EMR does not demonstrate the breadth of the EMR system and what it can do. They’ve discovered that the hard copy of the EMR is a one-dimensional view of a three-dimensional system. Through research, education and learning from their experts, patients’ lawyers realized that EMR systems offered different features that don’t translate into paper production of their clients’ health record. Screenshots of the EMR are not produced, nor is EMR data provided in native form to be viewed at a computer. In addition, they discovered that the options available to a healthcare provider in a drop-down box were not being provided, only what was selected. They learned that some EMR systems make clinical treatment recommendations based on the leveraging of treatment data for similarly situated patients.

Slowly, we are seeing an increase in requests by plaintiffs’ lawyers, when conducting discovery, to view the EMR system “live” on a monitor to see how it works and what functions are offered. Why wouldn’t they want to see how the EMR works? Given that the relevancy standard for discovery tends to be low (as opposed to the admissibility standard at trial) and that the use and complexity of the EMRs will increase, healthcare providers should anticipate that these types of requests will be permitted in the future and may become standard medical malpractice discovery practice.

WHAT WE GOT WRONG

In 2005, electronic medical record keeping was touted as a way to improve medical care by reducing errors due to documentation mistakes. It was projected that handwriting legibility issues would be eliminated and that the record would be very clear. While the handwriting issues associated with the chart have disappeared, we now know that new record keeping issues have developed that were not anticipated.

The EMR Would Offer More Patient Detail

One of the biggest differences in medical records documentation is that “charting by exception” is now the typical documentation practice due to the way the EMR works. By its own definition,
“charting by exception” requires the documentation of pertinent negatives. Even with the paper chart, “charting by exception” did not reveal much about a patient. Now, with the addition of drop-down options using pre-determined descriptions, there is a tendency for healthcare providers to only “click-click-click” the drop-down options rather than use the narrative. Charts now look generic, lacking specific details about the patient and their treatment.

Along those same lines, drop-down boxes can be a challenge because, although EMR designers try to be exhaustive in their options, practical experience shows that not all options can be listed. As a result, in situations where the descriptive term is not available for the healthcare provider’s selection, the next closest option is selected. While this practice may be appropriate in a multiple choice school examination, in healthcare this can result in inaccurate information being placed in the chart. Drop-down selections, although convenient, have not solved documentation errors and, in some instances, may encourage them if healthcare providers forgo the use of the narrative and choose drop-down options that are not completely accurate.

Medical Abbreviation Errors Would Be Eliminated

When free text narrative sections are being used, new and unanticipated abbreviation issues have developed. In the hard copy record, there may have been medical abbreviations being used that were misinterpreted because of sloppy penmanship or because the abbreviations could have had multiple meanings. Now we are seeing abbreviation errors based on society’s reliance on personal text messaging from their smart devices. In essence, we have swapped the medical abbreviation problem with a texting abbreviation problem. To that, I say, “OMG!”

Log-Ins, the New Electronic Signature, Would Resolve Identity Issues

The signature associated with chart entries has also changed to “log-on/log-off.” Theoretically, with the “log-on/log-off” practice, the identity of those who have documented in the chart should be 100 percent clear. However, in reality, when users log-in under someone else’s identity, or under a group identity, it can be nearly impossible to retrospectively decipher who made a specific chart entry. So while the log-in process should clear up any ambiguity of who documented a specific entry, it is only as good as those who properly identify themselves using correct log-in protocol.

Embedded EMR Warnings Would Eliminate Medical Errors

One of the specific features the EMR would possess, that the hard copy did not, was the ability for the systems to warn healthcare providers ahead of time if they were going to recommend treatment that may be contraindicated or risky. However, we now know that EMR systems with too many warnings can cause “warning fatigue.” Despite the ability to embed fail-safe patient safety warnings in the EMR, users may deliberately consider them “Henny Penny” and ignore them for no good reason, especially if they are considered cumbersome and another hurdle interfering with patient treatment.

Corrections or Amendments to the Chart Would Be Easy

The last documentation issue to be addressed centers on corrections and amendments. With a hard copy record, it is very easy to make changes to the record and can be done in a near universal format—line out/make the amendment in an area near the entry or in an area where one would anticipate a change, sign the change and date when the change was made. This was very simple because paper allowed for changes nearly anywhere—in the margins, additional spaces or altogether new pages. With the EMR, changes to the record are dependent on where the system allows you to make an amendment. In other words, if there is not a space or templated area where a change can be made, how will one know how and where to make a change? Furthermore, a change to the record directly (i.e., delete and change) is something that is tracked by metadata and revealed in the audit trail. If the change is made for self-serving reasons, the metadata/audit trail will make that clear. The EMR, while proficient in many ways, does not lend itself to the reality that after-the-fact corrections and amendments may need to be easily made in a universal manner.

The Production of Hard Copy of the EMR Would Not Be an Issue

As most know, when patients or lawyers request copies of the medical records, they are not getting screen shots, nor can they receive a copy of the EMR data in native form. Despite all the time, money and planning invested into the adoption of the EMR, little thought was put into the production of the hard copy EMR printout for litigation purposes. To this day, EMR developers have never made the paper copy of the EMR easier to understand. This issue remains one of the biggest difficulties in medical malpractice cases for all involved.

Compounding this problem—that the hard copy of the EMR does not reflect how it looks on a computer monitor—is EMR system upgrades and changes. EMR systems are always being upgraded with new options and features, just like other computer programs. Remember how Windows used to look? Over the years, Windows has changed in appearance, made upgrades and eliminated some features. The same is true with EMR systems. The first version of an EMR may look nothing like the eighth version. For example, the drop-down options for various chart entries may have changed, including the number of options and descriptive terms. We know that when the EMR is printed, what is shown on the record with respect to the drop-down box is the option that was chosen, not all of other options offered. In this regard, unless the drop-down options are archived in some manner, it may be impossible in 2016 to recreate what was available as an option in a drop-down box in 2011, after several upgrades.

Another example deals with EMR system templates. A certain entry may exist in a 2016 EMR template that was not available in 2011. When the information from the 2011 EMR is printed in 2016, it shows the 2011 information in the 2016 template, not the one from 2011. Most persons, including healthcare providers, may not know or remember how the 2011 EMR template appeared. When the 2011 information is provided in a 2016 EMR template, there may be a 2016 template item that is blank, appearing to have been unanswered. The explanation for the blank template entry may be because that entry was not available in 2011. Verifying why an entry is left blank may mean questioning a health information professional if a templated entry existed in the past. Unless an older template is available in some manner, there may not be a way to answer that question. Further, if there is no older EMR template or version available, it may be impossible to recreate the record as it existed at the time at issue. This is a dramatic change in medical malpractice litigation because the hard copy record is a static document that cannot be easily changed. The hard copy record you had in 2011, when the case was rendered, is what is produced in 2016 for litigation purposes. Now, it may be impossible to recreate what medical information was available to a healthcare provider at a given time in the past.

The Future?

We dream of the return of the use of the hard copy medical chart, but make no mistake, it is never coming back. Change is the only constant, and EMR systems will continue to evolve and incorporate the latest technological advances, including the greater utilization of handheld smart devices in patient care. Issues will emerge five years from now that we simply cannot predict. For the health risk professional, it is imperative that you not only stay current on medical trends, but also on the technology being used at your facility, and that you anticipate where things may go wrong. There is no perfect EMR system, and its users are never infallible.
Dear RMQ Readers:

The Risky Business column will not appear in this edition. Our authors are taking off during the summer for some R&R and creative brainstorming. Risky Business will return in the Fall edition.

Please continue to forward your ideas and experiences for future issues. Suggestions may be submitted to ahrmny@gmail.com or you may complete the Confidential Risky Business Form and mail to the authors.

Have a lovely summer and we look forward to sharing new Risky Business issues soon.

AHRMNY Publications Committee
Christine McMullan, MPA CPHQ CPHRM
Vice President, Patient Safety and Loss Prevention
MCIC Vermont, LLC

Christine McMullan joined MCIC as its VP for Patient Safety and Loss Prevention in 2013. Prior to joining MCIC she was Director of the Continuous Quality Improvement at Stony Brook University Hospital. During her time at Stony Brook Hospital she was also an adjunct faculty member for both the Harriman School of Management and Policy, and the School of Professional Development at Stony Brook University. During this time she was also a faculty member for the Institute for Healthcare Improvement. She possesses 25+ years of experience in quality improvement, human resource management and administration. Christine is a current member of AHRMNY and obtained CPHRM designation on May 20, 2016.

Wilhemina Nyarko, RN JD CPHRM
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Wilhemina Nyarko was awarded the Certified Professional in Health Care Risk Management certificate in March 2016. She currently works as Director of Risk Management at Mount Sinai Queens. She is also a current member of AHRMNY and ASHRM.

Ely Jacobs, MHA CPHQ CPHRM
Manager, Quality Initiatives
Physicians’ Reciprocal Insurers

Ely Jacobs has a Masters in Health Administration from Hofstra University and has a background in data management & analysis, quality metrics, public reporting, patient safety and risk management. He is CPHQ certified and was recently awarded CPHRM certification in February of 2016. Ely is Manager of Quality Initiatives for PRI. In this role he provides risk management support to clients inclusive of educational programming, special projects and data analysis for purposes of tracking and trending facility performance. Ely is a member of ASHRM, NAHQ, NYAHQ and AHRMNY where he serves as a member of its Public Relations Committee.

Pamela Monastero, MBA
Assistant Director, Patient Safety & Risk Management
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Pamela Monastero, MBA and member of the AHRMNY Board for two decades will be embarking on a new journey. In June 2016, she will be joining NYU Lutheran Medical Center as the Assistant Director for Patient Safety and Risk Management. She has devoted the past ten years to Coney Island Hospital, a New York City Health & Hospitals facility, where she was Senior Associate Director for Risk Management. She has a strong background in clinical risk management, quality management and patient safety and is very enthusiastic to join the NYU Lutheran team.

Paulette Taylor, CPHRM
Risk Management Specialist
Emblem Health, Inc.

Paulette Taylor has over 28 years of experience in Risk Management. The last 18 of which have been focused exclusively on addressing the full array of corporate risks for Managed Care and Healthcare Provider Organizations. Paulette received her CPHRM designation in November 2015 and joined AHRMNY in April of 2016. Prior to beginning her career in Risk Management, Paulette obtained her B.A. in English from Wesleyan University in Middletown, CT where she was a CIGNA Scholar. Paulette specializes in healthcare facility safety, contractual liability, cyber/privacy breach risk assessment and risk mitigation.

Theresa Harris, BSN JD CPHRM
Director, Patient Safety and Loss Prevention
MCIC Vermont, LLC

Theresa Harris spent 15 years in nursing and 20 years as an attorney litigating complex medical malpractice cases, but is now privileged to be working in patient safety at MCIC Vermont as the Director of Patient Safety and Loss Prevention. She states: “The stakes are high, the challenges are tremendous and yet the individuals dedicated to patient care have made this position so rewarding”. Theresa is looking forward to moving safety initiatives forward with data driven, evidence based practices and innovative solutions to the problems presented by the evolving healthcare system. Theresa recently obtained her CPHRM certification on April 19, 2016 and is a current member of AHRMNY.

Jennifer K. Vitale, RN ESQ CPHQ CPHRM
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Jennifer Vitale is a registered nurse and has worked the bulk of her career in several areas of critical care. While working at New York Presbyterian Weill Cornell Medical Center she obtained her CCRN certification, as well as attended law school part-time at the Pace University School of Law. Upon graduation in 2011, she began her legal career in medical malpractice defense litigation at Aaronson, Rappaport, Feinstein & Deutsch, LLP. Currently, she works at MCIC Vermont, LLC, where she reviews and analyzes past medical malpractice claims to identify potential patient safety concerns in order to contribute and support the company’s patient safety initiatives. Jennifer is a current member of AHRMNY and obtained CPHRM designation in February of 2016. She also obtained her CPHQ designation back in 2014.

Want to share your achievements with your colleagues? Submit your member spotlight application to the AHRMNY Publications Committee for review and inclusion in our next issue at ahrmy@gmail.com
Green Light to Arbitrate Nursing Home Claims in New York

By Lori Semlies

In February 2012, the U.S. Supreme Court in Marmet Health Care Center v. Brown et al., 132 S.Ct. 1201, declared that the Federal Arbitration Act pre-empts state law, even public policy, which prohibits arbitration of personal injury cases. Since then, nursing homes across the country have amended their admission agreements to include a provision that requires residents to waive their right to a jury trial and agree to have all disputes resolved by binding arbitration. From an economic standpoint, arbitration serves as an effective means to resolve disputes. Lawsuits can take years to resolve, driving up costs. Formal or informal arbitration is a means to cut costs by reducing the amount of time spent on discovery or trial. Jury selection alone in some counties in New York can take days; avoiding trial-related expenses is a significant savings for clients. Indeed, in an AON study conducted in 2012, a 21% reduction in defense costs was found when arbitration was utilized, even where arbitration was challenged. This cost savings is often times passed onto the facilities directly as they may have a self insured retention or deductible.

Other and perhaps more compelling arguments in favor of arbitration from the defense perspective include:

- A verdict or decision is less likely to be influenced by sympathy; particularly in plaintiff friendly venues like Bronx County.
- An arbitrator is generally more adept at understanding complex medical defenses.
- Arbitration awards eliminate the possibility of runaway jury verdicts.
- An arbitrator is more receptive to the idea that falls and pressure ulcers can be unavoidable.

Perhaps one of the most compelling reasons facilities prefer arbitration is that punitive damages, which are uninsured in New York, are far less likely to be awarded. New York’s Public Health Law §2801-d specifically allows for the imposition of punitive damages for violations of a resident’s rights in a residential health care setting, with generally a lower standard. Verdicts have been awarded here in New York in upwards of eight figures. An award of punitive damages is technically possible in arbitration, but they are much less likely to be awarded since there is no jury to enrage.

**The Federal Arbitration Act**

Swifter and more economical resolutions of lawsuits were the impetus behind enactment of the Federal Arbitration Act (FAA). The *Marmet* decision determined that the FAA preempts any state law (even public policy) that declares the use of arbitration to resolve personal injury lawsuits void. The Court determined that the FAA does not limit its application to non-personal injury suits. For its application to nursing home suits, all that needs to be established is that the facilities are engaged in interstate commerce. This is easily demonstrated by production of contracts with vendors located out of state and, of course, by virtue of the facility’s participation in Medicare or Medicaid.

Once interstate commerce is shown, per *Marmet*, to enforce arbitration, the attorneys need only establish that the contract is procedurally and substantively conscionable. Such a determination requires an analysis of the state’s basic contract principles, such as whether (1) the arbitration agreement is one of adhesion, (2) there was equal bargaining power on both sides, and (3) the parties entering into the contract had the capacity to do so. No one factor is dispositive, although the third principle can be.

**Practical Application: Case One**

Wilson Elser had the opportunity to test the first arbitration provision in a nursing home admission agreement in New York. In *Friedman v. Hebrew Home for the Aged at Riverdale*, 2015 Slip Op. 06478 (August 11, 2015), Mr. Friedman brought suit as his mother’s power of attorney alleging negligence and violations of the Public Health Law in allowing his mother to sustain a hip fracture as a result of a fall. On admission to the facility in September 2012, Mr. Friedman signed the admission agreement containing a mandatory arbitration clause was in his capacity of power of attorney. The arbitration clause read as follows:

10.14 GOVERNING LAW AND DISPUTE RESOLUTION. This agreement shall be governed by and construed in accordance with the laws of the State of New York.

Although we hope that disputes between the parties will not occur, we believe that when disputes do arise, it is in our mutual interest to handle them promptly and with a minimum disturbance. Accordingly, to provide for a faster, less costly and more confidential solution to disputes that may arise, the parties agree that any dispute or controversy exceeding the jurisdictional threshold for small claims court shall be resolved by final and binding arbitration, as more fully detailed in Exhibit 4.

By executing this agreement, the undersigned acknowledge that he/she/they are waiving the right to a trial by jury or a judge in a court of law, except for small claims matters, and have instead agreed to binding arbitration.

This is the last section of the main agreement and appears just above the signature line; the document then references two pages of detail about how the arbitration is to take place. These pages close with a paragraph that starts as follows:

Because [Hebrew Home] is engaged in interstate commerce, these arbitration provisions are governed by the Federal Arbitration Act, 9 U.S.C. § 1, et seq. [T]he arbitrator, and not any federal, state or local court or agency shall have exclusive authority to resolve any dispute relating to the interpretation, applicability, enforceability or formation of this agreement, including but not limited to, any claim that all or any part of this agreement is void or voidable.

Mr. Friedman, an attorney, signed the admission agreement in every place where a signature was required, and in each instance identified himself as possessor of the power of attorney.

In opposition to Wilson Elser’s motion to compel arbitration, the plaintiff argued, among other things, that despite the U.S. Supreme Court decision in *Marmet*, because Public Health Law (PHL) §2801-d is engaged in the business of regulating insurance, at that time pursuant to the McCarran-Ferguson Act, 15 U.S.C.A. §1012, reverse preemption applies and therefore the FAA does not nullify the PHL provision prohibiting arbitration of such claims.

In oral argument of the motion in Bronx County, it was suggested that the provision was buried among other documents that most people do not read at a time when stressors are high, similar to the argument medical malpractice plaintiffs make in support of an informed consent claim. It was presumed that the resident had no choice but to sign the agreement, despite the fact that the facility was selected by the son.
The Judge declined to compel arbitration finding that the facility’s choice of law provision establishing New York as the governing law contradicted the presence of an arbitration provision, because New York also has a specific statutory prohibition on arbitration. He thus ruled that Marmet did not apply.

The First Department was not influenced by the arguments raised by the plaintiff’s attorney and the New York State Trial Attorneys Association in its amicus brief. In a one-page decision and without dissent, the court unequivocally concluded that the PHL was not enacted for the purpose of regulating insurance and therefore no reverse preemption applied. The court also found that the agreement was neither procedurally nor substantively unconscionable.

**Practical Application: Case Two**

The Friedman decision created an opportunity to renew and reargue another motion Wilson Elser made to enforce arbitration in New York County. In an unpublished, still pending case, the resident was admitted to a facility for short-term rehabilitation following an admission to a hospital for cardiac care. She signed the admission agreement, which contained a voluntary arbitration agreement. The arbitration provision had a separate signature line independent of the rest of the agreement. The resident died months later at a different facility.

In opposition to Wilson Elser’s motion, plaintiff’s counsel argued that since the resident later had mental status changes and was transferred to the hospital where she was given a diagnosis of dementia, she could not have understood what she was signing two weeks earlier. Before denying our motion, the court presumed that the resident did not have capacity at the time she signed the agreement. This is in contrast to New York State’s PHL §2980, which affords every individual the presumption of capacity, shifting the burden to the opponent to prove otherwise. In this instance, the court gave both sides an opportunity to submit medical affidavits as to the resident’s capacity at the time that she signed the agreement. Not surprisingly, plaintiff’s counsel was able to present an affidavit from a physician who concluded that she did not have capacity when she waived her right to trial, and the motion was denied.

A motion to reargue and renew is ripe based not only on the Friedman decision but also on the testimony of the resident’s husband that his wife did indeed have the ability to make all of her own medical decisions around this same time and in fact did sign all of her own medical paperwork.

The concern about a resident’s capacity upon admission to a facility for short-term or long-term care has been identified by the Centers for Medicare & Medicaid Services (CMS). In its proposed new regulations, CMS recommends that the arbitration be done by a neutral arbitrator (which most agreements already state); that the resident must fully understand the agreements and agree voluntarily; and that the admission cannot be contingent on signing the arbitration provision (which they generally are not).

Establishing that admission was not contingent on signature of an arbitration provision arguably defeated the presence of a mandatory arbitration provision. If this indeed was the law in effect before Friedman, then the outcome would have been entirely different.

As dementia is so often a diagnosis on admission to a nursing home for long- or short-term care, lack of capacity to sign is evident. Many residents already have designated a family member, usually a child, to exercise power of attorney. As in Friedman, this is the ideal circumstance on which to enforce an agreement to arbitrate. However, if a family member without legal authority signs the agreement, the question becomes whether that person can waive the resident’s right to a trial for a personal injury claim.

Not yet addressed in New York is whether an arbitration provision is binding on the heirs or distributees in a wrongful death claim. In states where this issue has already been litigated, the results are largely inconsistent. Currently, Florida, New Mexico, California, Texas, Mississippi, Alabama and Michigan have ruled that arbitration is binding on the survivors’ heirs. Arizona, Pennsylvania, Kentucky, Illinois, Washington, Missouri, Utah and Ohio hold otherwise. In the fall of 2014, the U.S. Supreme Court declined to review a decision out of Oklahoma addressing whether an arbitration agreement signed by the now-deceased resident of a nursing home could bind the heirs. There, the trial court in Oklahoma determined that consent to arbitration is an essential element to its enforceability.

The difference between the rulings of the state courts is dependent on their interpretation of their own individual state’s wrongful death law. The issue is usually contingent on whether the wrongful death claim is considered derivative of the personal injury claim the resident had before death. In those cases, arbitration is generally enforceable. In New York it would stand to reason that the arbitration provision would bind the heirs. Principles such as third-party beneficiary may assist in enforceability or even estoppel to the extent all other terms of the agreement are acceptable.

**Conclusion**

The tenet on which Marmet stands can lead residents, patient advocacy groups or perhaps CMS to insist on an amendment to the FAA restricting its application to non-personal injury types of suits. Advocates for the facilities naturally embrace the decision as it, at least for now, compensates for the unfortunate reality that verdicts are disproportionate to the value of other personal injury cases, particularly with the imposition of punitive damages by juries. Nursing homes should take advantage of this quasi tort reform while they still can and include an arbitration clause in their admission agreements.

**About the Author**

Lori Semlies is a partner in Wilson Elser’s New York Metro offices. She focuses her practice on the defense of medical and nursing home malpractice claims in both state and federal courts, including all phases of litigation through trial.
ARTICLE REFERENCES

Telemedicine: Understanding The Risks ................................................................................................................. from page 3

ATAGUIDELINES FOR PRACTICE 2014

CMS TELE HEALTH SERVICES LIST

1 Teledmedicine Medicaid.gov https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-systems/Telemedicine.html
3 What is Telemedicine?: http://www.americantelemed.org/
4 http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#_V2GhC7srLIU
7 AMA Policy H–120.949, Guidance for Physicians on Internet Prescribing
8 AMA Code of Medical Ethics, adopted June 2001
9 AMA Policy H–120.949, Guidance for Physicians on Internet Prescribing
10 AMA Policy H-480.956, Coverage of and Payment for Telemedicine
11 http://www.ama-assn.org/ama/pub/physician-resources/legal-topics.page?
12 http://www.ama-assn.org/ama/pub/physician-resources/legal-topics.page?
13 Cal. Bus and Prof Code Sec. 2290.5(b)
14 Fla. Admin. Code R.64B8-9.014
16 H.R.S. Secs. 453-1.3(d) and 453-1.3
17 22 TX A.D.C. Sec. 174.2
18 22 TX A.D.C. Sec. 174.2
19 22 TX A.D.C. Sec. 174.6
20 22 TX A.D.C. Sec. 174.7

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ARTICLE REFERENCES

<table>
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<tr>
<th>Reference</th>
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<tbody>
<tr>
<td>ii The Blountstown Police Department Arrest Report for Barbara Dawson</td>
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<tr>
<td>iii (42 U.S.C. § 1395dd [a])</td>
</tr>
<tr>
<td>vi N.Y. Comp. Codes R. &amp; Regs. tit. 10, § 405.9</td>
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<td>vii N.Y. Comp. Codes R. &amp; Regs. tit. 10, § 405.9</td>
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<td>viii N.Y. Comp. Codes R. &amp; Regs. tit. 10, § 405.9</td>
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<td>ix N.Y. Comp. Codes R. &amp; Regs. tit. 10, § 405.9</td>
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