AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

The Risk Management Quarterly

SUMMER 2011

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PRESIDENT'S MESSAGE

Dear Members:

Best wishes for a wonderful summer season from your AHRMNY President and Board of Directors. We hope everyone has had time to relax and enjoy the laid back pace of the season. While you are relaxing please take the time to register/renew your AHRMNY membership. There are membership "deals" to be had; membership dues are currently $100 a year. AHRMNY offers an organizational discount of $250 for three members all from the same company. We also have an ECONOMIC STIMULUS PROGRAM. A current member who successfully refers two new members will receive a complimentary extension of their individual membership for one additional year. So check out our membership tab. (http://ahrmny.com/register.php)

I want to thank you for the trust and confidence you have shown by electing me as president and I am committed to continuing in the footsteps of the esteemed Past Presidents in working with our talented Board of Directors for another year of top notch support and resource for our members. Our Board will be taking a little breather in July to have some well earned R&R but will be back in the planning stages in August to ensure a wonderful start to the new academic year. On September 23, 2011, we will be hosting our first ever Webinar. Michael Merlino from Sedgwick CMS will be speaking on important updates to the Section 111 reporting. The time of this Webinar will be finalized soon as well as the details on the call in for this event. Please check the AHRMNY website in August for more information on the Webinar. We are also planning a December 8, 2011 half day conference to be held at Lenox Hill Hospital. Topics and speakers are in the works.

The Annual ASHRM conference will be on October 16th-19th at the Phoenix Convention Center, in Arizona and we invite all our members who attend to join us for cocktails while we are there. The date and time for this event will be announced. We had a great turnout in Tampa last year.

As an organization we rely on you, our members not only for financial support but also to share your talents as active members on one or more of our working committees. Be it Bylaws, Education, Finance, Membership, Nominating, Publications, or Public Relations, find your area of interest and contact us. Our committees would welcome new participants. Through active participation of all our members our organization will continue its successful and vital mission of enhancing healthcare risk management and patient safety initiatives for the benefit of the entire New York healthcare community.

Best regards,

Jonathan D. Rubin
President
July 1, 2011-June 30, 2012

EDITOR'S CORNER

The Risk Management Quarterly (RMQ), the official journal of the Association for Healthcare Risk Management of New York, Inc. 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.

For the official ***RMQ*** Author Guidelines visit our website http://www.ahrmny.com

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 and not intended to be relied upon in any particular situation.

WE WANT TO HEAR FROM YOU FOR THE FALL AND WINTER EDITIONS

We are asking our readers to submit articles to appear in the fall and winter editions of ***The Risk Management Quarterly***. Submission of articles that focus on safe patient care practices, safe working environments, legal and financial updates in the health care arena are some of the topics we seek.

RMQ is published four times a year with a distribution of 200-300 copies per quarter. Please forward any ideas or submissions for publication in the ***RMQ*** to **"Editors"**, via email with attachments to: ahrm@optimum.net

The deadline for submission and consideration for the next journal is **October 15, 2011**.

AHRMNY will host its first Webinar on Friday, September 23, 2011

Topic: SECTION 111 REPORTING
Time: 10am – 11am
Speaker: Michael R. Merlino, Esq.
Director of Medicare Compliance
Sedgwick CMS Inc.

WEBINAR FREE FOR ALL ATTENDEES

This webinar will review the latest developments on Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

Click here to register for the event and/or join as a member:
http://www.ahrmny.com/events.php

SAVE THE DATE

DECEMBER 8, 2011

AHRMNY will host a half-day educational conference at Lenox Hill Hospital on the:

New York State Medical Indemnity Fund for Neurologically Impaired Newborns and Early Resolution of Law Suits

Speakers will include:

New York Supreme Court Justice Douglas E. McKeon
&
Dan Vukelich, President of the National Association of Medical Device Reprocessors

Registration Details TBA at a later date

AHRMNY TAX STATUS ANNOUNCEMENT

The Association for Health Care Risk Management of New York, Inc. (AHRMNY) is pleased to announce that it has successfully applied for and was granted tax exempt status under section 501(c) (3) of the Internal Revenue Code. As such, contributions to AHRMNY are deductible under section 170 of the code. Organizations exempt under section 501(c) (3) of the Code are further classified as either public charities or private foundations.

A TRIAL LAWYER'S TAKE ON BILL S.3766/A.625

By: Samantha E. Quinn and Richard W. Nicholson

Introduction

New York State legislators are currently advancing bill S.3766/A.625[1] through the political process, and with it seek to undo much of the work done by Albany to reduce the cost of medical treatment and malpractice costs within the state. The bill plans to amend General Obligation Law § 15-108,[2] a statute important to litigation procedure, and one particularly relevant to the defense of medical malpractice cases. As often happens in a medical malpractice action, several defendants are joined together in a single action brought by one plaintiff. While the defendants are joined together in one action, the plaintiff may settle with any defendant either before or during the litigation, without discontinuing the action against the other defendants. When the plaintiff does elect to settle, with one or more but not all defendants, that settlement amount then reflects what that defendant is obligated to pay to the plaintiff, regardless of the results of the rest of the litigation. Yet, the value of that settlement still represents part of the plaintiff's recovery and must be included in the final apportioning of damages in any resulting verdict against any non-settling tortfeasor.

This apportioning becomes complicated by New York's comparative liability statute codified in CPLR 1411.[3] Juries return verdicts that will delineate the percentage of each defendant's fault, even for those who have settled, and often times that percentage does not align with the relative amount a settling defendant has already agreed to pay. While the verdict has no effect on the settling defendant or defendants who have already purchased their release from the suit, it can have significant impact on the non-settling defendants. Do these defendants have to pay the remaining amount of the verdict, regardless of share of fault, or are they able to pay their equitable share of the verdict as determined by the jury? This question is precisely what General Obligation law § 15-108 sought to answer and that answer has been clarified by the Court of Appeals in *Whalen v. Kawasaki Motors Corp.*[4] Yet, some legislators in Albany still wish to change settled law to cater to their own special interests.

The Current Law

At its heart, General Obligation Law § 15-108 is a procedural law, and before going further it is necessary to understand the core of that procedure. While application of General Obligation Law § 15-108 can be challenging in some multi-party litigation, the actual the operation of General Obligation Law § 15-108 is fairly straightforward. A settlement reduces the actual recovery of the plaintiff by the greatest amount of 1) the amount stipulated as consideration for the settling defendant's release or 2) the amount actually paid for the release or 3) the settling tortfeasor's share of the plaintiff's damages as determined by verdict.[5] While 1) and 2) are generally the same amount, except in the case of a bankrupt settling defendant, the amount a co-defendant settles for and the co-defendant's equitable share will often vary. Yet, the statute is clear, and the defendant need not "choose" which value to use as an offset for the settlement; the greater amount of the two will be chosen. Nor would any rational defendant choose the lesser amount if actually given a choice.

Some peripheral procedural points that will also clarify the substance of the statute. First, General Obligation Law § 15-108 does not create an absolute right for a defendant, but an affirmative defense that must be plead for it to be operative.[6] Second, a more obvious but nonetheless critical point, the defendant does not control the timing of when co-defendants settle, nor are most cases settled before a responsive pleading is filed. Thus, a defendant will likely not plead General Obligation Law § 15-108 as an affirmative defense in their original answer, but will have to be given leave by the court to amend their answer.[7] Under the CPLR's liberal pleading standard, a party may amend its pleadings to raise General Obligation Law § 15-108 as a defense at any time, even after trial, provided the late amendment does not prejudice the other party.[8] The Court of Appeals in *Whalen* held that, "[p]rejudice may be found where a party has incurred some change in position or hindrance in the preparation of its case which could have been avoided had the original pleading contained the proposed amendment."[9] Thus, a defendant is given the freedom to include the defense either before or after trial, and the court protects the plaintiff from a defendant who would use the defense way to surprise or damage the plaintiff's case. All and all, the rule represents a fair balance.

The Proposed Law

Bill S.3766/A.625 seeks to change that balance. First, Bill S.3766/A.625 would foist upon a defendant a difficult and thorny choice. Namely, the amendment of General Obligation law § 15-108 created by Bill S.3766/A.625 would create a new "choice" between the settlement value and the assessed share of the co-defendant's liability.[10] The "greater value" language would be stricken. Second,

the new rule would *require* a defendant to amend their complaint to include General Obligation Law § 15-108 as a defense if a settlement was reached before trial.[11] Furthermore, if a settlement is reached during trial, the "election shall be made as soon as reasonably practicable after the party making the election is apprised of the settlement or settlements in issue, and if feasible, prior to return of a verdict."[12] Thus, the bill is designed to force a defendant's choice *before the verdict.* A defendant must predict the apportionment of liability before a verdict is rendered, and in most cases before opening statements have even been made, and then, based on that prediction, make a judgment as to whether the co-defendant's settlement value or equitable share of liability is the preferable option. If the defendant does not make a choice, then the statute would default to the co-defendant's equitable share of liability.

These changes represent several troubling developments. First, what constitutes a "reasonable" time? What constitutes "feasible?" Such language inserts grave uncertainty into a previously straightforward piece of procedure. Beyond the language itself, the choice of a calculation formula for a jury verdict that does not exist forces the defendant to make an uninformed decision and creates further uncertainty. While many people in the legal world enjoy the thrills of the casino, a blind roll of the dice in the courtroom is the last thing any defense attorney or any defendant would like to see. Such uncertainty will lead to more litigation and potentially greater costs for litigants. Second, forcing the election to be made *before trial* flies in the face of the liberal pleading standard that serves as the bedrock of modern New York civil procedure. The court already protects the plaintiff from any type of prejudicial pleading strategy, thus one has to wonder what this proposed change is hoping to accomplish? Why does the election need to be made before the verdict? The answer to this question is rather simple. The proposed rule can create a windfall for plaintiffs. A hypothetical litigation will articulate this possibility and also show the threat this proposed bill creates for a non-settling medical malpractice defendant.

A Hypothetical Litigation

Let's create our hypothetical case, shall we? There will be one plaintiff, Ms. P., and two defendants, Dr. D. and H. Hospital. Ms. P. is suing Dr. D. and H. Hospital for medical malpractice and the case is still in the discovery phase of the litigation, before trial. Ms. P. believes she has a good case against both Dr. D. and H. Hospital and has very high settlement demands, seeking $10,000,000 dollars. While H. Hospital is prepared to head to trial, confident in it's own case, Dr. D. is more risk averse and pushes to settle. Dr. D.'s insurance coverage is $3,000,000 dollars and he settles with the plaintiff for that amount. Ms. P. approaches H. Hospital and renews her demand, seeking $7,000,000. H. Hospital is confident it is not liable for 70% of the damages in this case, and chooses to proceed to trial.

Let's envision two scenarios. In the first, the jury awards Ms. P. $10,000,000 in damages, but finds that H. Hospital is only liable for 50% of those damages, while Dr. D. is "liable" for the other 50%. In the second, the jury awards Ms. P. $5,000,000 in damages and finds a 50%-50% split of liability between Dr. D. and H. Hospital. Now the question becomes, how much does H. Hospital owe?

Current Application of the Law

In *Whalen v. Kawasaki Motors Corp,* the Court of Appeals carefully laid out how to calculate the non-settling defendants share of the verdict. The first step is to invoke General Obligation law § 15-108 and determine whether the actual settlement or the equitable share of liability is greater. In the first hypothetical, the settlement value is $3,000,000 and the equitable share of liability, 50% of $10,000,000, is $5,000,000. Thus, General Obligation law § 15-108 would require the use of the equitable share of liability as the set-off for the Dr. D.'s liability; the $5,000,000 equitable share is greater than the $3,000,000 settlement. Thus, in the first scenario, H. Hospital would be liable for $5,000,000. In the second, the settlement value of $3,000,000 would actually be greater than the equitable share of $2,500,000, 50% of $5,000,000. Thus, H. Hospital would only be liable to pay $2,000,000 because the $3,000,000 would be used as the set-off.

Proposed Application of the Law

Bill S.3766/A.625 would change this calculation significantly. First, the statute would require that H. Hospital choose between the settlement amount or the equitable share of liability before the verdict. This creates two possible results for the both the $10,000,000 and $5,000,000 verdict scenarios. If in the first scenario, H. Hospital chooses the equitable share value, the calculation is the same as above, and H. Hospital is liable for $5,000,000. However, if H. Hospital chose to use the amount the defendant actually settled for, $3,000,000, H. Hospital would be now liable for $7,000,000. This would represent $2,000,000 more than the equitable share decided by the jury. Conversely, if H. Hospital chooses the actual settlement value in the second scenario, where Dr. D. settles for $3,000,000 and H. Hospital would have been liable for $2,500,000 as its equitable share. This would actually give Ms. P. a windfall, and she would now recover $5,500,000, which is $500,000 *more* than the jury awarded. This is the scenario and the result that is driving the change to General Obligations Law § 15-108.

Consequences of the Change

The most obvious consequence of the change is illustrated by the hypothetical above. On one hand Bill S.3766/A.625 creates a scenario where a non-settling defendant is forced to pay out more than it's equitable share in damages and on the other, a plaintiff can make off with more damages than the jury actually awarded. Such a change to the law would seriously damage both existing legal precedent and public policy.

In *Williams v. Niske,* the Court of Appeals held that, "while the general purpose of General Obligations Law § 15-108(a) is to encourage settlement, the statute is concerned as well with assuring that a non-settling defendant does not pay more than its equitable share."[1] As is apparent from the hypothetical above, the proposed bill appears only concerned with one part of the law's function - encouraging settlements. While settlement is an obvious goal of dispute resolution, it is not a single-minded focus and cannot be separated from the goal of equitable allocation of fault. Settlement is a valued tool precisely because it allows private parties to price out fault and come to solutions they deem equitable. Sometimes, however, parties cannot find a middle ground and settlement without adjudication is unattainable. These cases, usually ones that do make it to trial, are hotly contested, and any resolution must and *should* be determined by an independent fact-finder. Conversely, Bill S.3766/A.625 would seek to replace a judge and jury with a procedural rule that fosters uncertainty and would bluntly compel defendants to settle, regardless of the strength of the plaintiff's case or any notion of equity. Faced with that uncertainty and the possibility of having to pay more than their equitable share of a verdict, what defendant would not feel the compulsion to settle, even at an unfavorable rate? Thus the rule would be doubly favorable for plaintiffs. First, defendants would have to consider settlements that, in the absence of the new rule, they would have never considered, and ultimately settle with plaintiffs at a higher rate. Second, even if a defendant does brave the new rule and go to trial, the plaintiff has the opportunity to receive a windfall if the defendant guesses wrong in its General Obligations Law § 15-108 election.

It is no surprise, then, that the Greater New York Hospital Association estimates that the bill, if adopted, could lead to an increase in hospital malpractice premiums by 5% of $80 million a year. It goes without saying that such a burden on hospitals will only lead to increased medical costs for patients in the New York State. As a general policy matter, one wonder if it has occurred to the sponsors of Bill S.3766/A.625 that keeping resources within the strained budgets of New York hospitals would likely lead to better care for New Yorkers and to better outcomes for all patients, not just those who bring lawsuits.

Ultimately, Bill S.3766/A.625 wishes to add a lottery effect to the New York code that would allow plaintiffs and plaintiff's attorneys to recover more money than a jury would award while inflicting on defendants more than their equitable share of liability. The Court of Appeals held in *Williams* that the "Legislature was well aware of such concerns [with General Obligations Law § 15-108] but saw the risk of chilling plaintiff's desire to settle as largely outweighed by the benefits of early settlement and the potential windfall to defendants as necessary to ensure that plaintiffs do not in effect have a double recovery against non-settling defendants."[14] Obviously, the proponents of Bill S.3766/A.625 seek otherwise. While, it is undeniable that people are often injured by negligence, and should be compensated for that harm, sentimentality and special interests should not obscure justice. New York has a strong legal tradition committed to a system where the merits of a case and a trial by jury determine the outcome of a controversy. Creating procedural pitfalls, such as the proposed version of General Obligations Law § 15-108 espoused in Bill S.3766/A.625, will only take more cases from the hands of the jury, who are charged by the Constitution to decide such matters, and place them in the hands of plaintiff's attorneys emboldened with the leverage of rigged procedural system. Furthermore, even when a jury ends up rendering a decision, that decision will often be made moot by the chicanery of a procedural "choice" that would greatly hamstring a non-settling defendant in the execution of their case while potentially awarding a plaintiff more than a jury would deem appropriate.

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[1] S. 3766, 2011 Leg. 234th Sess. (N.Y. 2011).
[2] N.Y. GEN OBLIG. Law § 15-108 (McKinney 2011).
[3] N.Y. C.P.L.R. 1411 (McKinney 2011).
[4] *Whalen v. Kawasaki Motors Corp.*, 92 N.Y.2d 288, 680 N.Y.S.2d 435 (1998).
[5] *See id.* at 292.
[6] *Id.* at 293.
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] S. 3766, 2011 Leg. 234th Sess. (N.Y. 2011).
[11] *Id.*
[12] *Id.*
[13] *Williams v. Niske*, N.Y.2d 437, 599 N.Y.S2d 519 (1993).
[14] *Id.* at 443.

Samantha E. Quinn and Richard W. Nicholson are partners in the firm of Schiavetti, Corgan, DiEdwards & Nicholson, LLP which specializes in the representation of hospitals, doctors and other health care providers. **Special thanks to Richard W. Nicholson Jr. for his assistance with this article.**

FHCDA MEDICAL DECISION SUMMARY SHEET

Type of Decision	Family Health Care Decisions Act Applies?	Documentation Required
Patient with capacity consent for treatment	No	1) Patient signs own consent
Patient lacks capacity has Health Care Proxy consent for treatment	No	1) Health Care Proxy in chart 2) Agent signs consent
Patient with developmental disabilities (NYS Regs are being amended, further instructions to follow)	No	Required documentation to be issued as a separate "cheat sheet" when NYS Regs are completed
Adult patient w/o Proxy lacks capacity and needs consent for treatment. Surrogate is available	Yes	1) Determination of Capacity, one physician 2) Selection of Surrogate 3) Determine if patient's wishes are known 4) **Medical Decisions Form #1 completed**
Adult patient w/o Proxy lacks capacity and needs consent for treatment. No Surrogate is available	Yes	1) Determination of Capacity, one physician 2) Document diligent search for Surrogate 3) Determine if patient's wishes are known 4) 2 physicians determine medical necessity 5) **Medical Decisions Form #3 completed**
Adult patient w/o Proxy lacks capacity. Surrogate available wishes to withhold or withdraw treatment includes DNR	Yes	1) Determination of Capacity, two physicians 2) Determination of suitability for withdrawal with two physicians 3) Selection of Surrogate 4) Determine if patient's wishes are known (medical) 5) **Medical Decisions Form #4 completed**
Adult patient w/o Proxy lacks capacity. Surrogate not available. Authorization needed to withhold or withdraw treatment includes DNR	Yes	1) Determination of Capacity with two physicians 2) Determine if patient's wishes are known 3) Determination of no medical benefit to treatment two physicians 4) **Medical Decisions Form #5 completed**
Minor patient. Parent or Guardian available wishes to withhold or withdraw treatment includes DNR	Yes	1) Determine if Emancipated 2) Determination of Capacity of Minor with consultation of parent/guardian 3) If Guardian obtain guardian papers for legal evaluation 4) Determination of suitability for withdrawal with concurring opinion 5) Notify other parent/guardian of decision if they show interest in Minor 6) **Medical Decisions Form #6 completed**
Non Hospital DNR	No	1) Accept DOH Form 3474, no need to obtain new DNR 2) 1st physician who examines patient issues order to continue or revoke DNR 3) **If patient wants Non-Hospital DNR use Decisions Form #7**
MOLST Form	No	1) Accept MOLST Form, no need to obtain new forms 2) 1st physician who examines patient issues order to continue or revoke
Patient with Capacity or Health Care Agent wishes to withhold or withdraw or refuse treatment includes DNR	No	1) **Complete Decisions Form #8**
Patient transferred from another health care facility withdrawal of care	Yes	1) Accept the prior institutions papers, no need to obtain new forms 2) 1st physician who examines patient issues order to continue or revoke
Patient transferred from another health care facility consent to care	No	1) Accept paperwork from prior institution 2) Assume the institution made good faith effort to obtain consent 3) If no paperwork received contact institution and document paperwork 4) If no consent obtained from prior institution contact OLA

The Medical Decision Summary Sheet was developed by Alvin Safran for use in New York Hospital Medical Center of Queens. The section on the developmentally disabled is not yet complete.

Alvin Safran, President Elect of AHRMNY, is Director of Risk and Claims Management at the New York Hospital Medical Center of Queens, (NYHQ). He is the administrator of its self-insured, self-administered insurance program. He has also been administrator of the NYHQ IRB. Mr. Safran has enjoyed more than twenty-one years of Risk Management and Claims Management experience at NYHQ.

THE PITFALLS OF RECORD ALTERATION

By: Tracey A. Reiser, Esq.

If there is one piece of advice medical professionals can take away from their counsel, it would be with respect to record alteration. Simply stated, don't do it.

Medical records made at the time treatment is rendered provide the most accurate recitation of patient's complaints, symptoms, and treatment plan. Good record keeping habits are essential. Legible, detailed documentation, created shortly following patient contact, is paramount. Writing notes days or weeks following patient contact is an invitation for trouble. Waiting to chart provides an opportunity for information to be forgot and can increase the chances of documenting erroneous information. Even in the face of a negative outcome, good documentation can provide an accurate recount of the practitioners thought process and support their rationale for choices regarding the management of a patient's care. This type of information may be the linchpin in defending care, even if a complication arises.

It is imperative that practitioners understand a medical record must not be changed or altered, with or without the intent to deceive, particularly following notice of a lawsuit. Following notification of a suit, some practitioners are tempted to insert additional information into the record to provide a sense of totality and completeness. Upon review, a practitioner may discover there is information that should have been included in the medical record. In some instances, practitioners feel compelled or are tempted to further explain the treatment rendered and/or their decision for rendering same. In other instances, practitioners attempt to cover mistakes made with respect to their treatment or their failure to perform or recommend a particular type/method of treatment. Regardless of the reason, a medical record should never be altered. Poor documentation does not automatically equate to bad medical care or a departure from the standard of care. On the other hand, discovery of altered records are never viewed favorably and are often times seen as self-serving and deceitful.

This is not to say additions can never be made. Additions can be made, however, they must be done with the greatest of care. Information inserted into a record at a later date must be clearly identified as an addendum. The addendum must then be signed/initial with the date and time it was created. This simple practice can assist in avoiding the appearance of impropriety and the consequences for altering a patient's medical record. A practitioner must remember that while the physical medical record belongs to them, the content of the record belongs to the patient.

It is a misconception that "altering" a medical record must be done with the intent to deceive. In reality, record alteration can manifest itself in a variety of ways.

Alterations to a patient's chart or care record can consist of the later addition of information which accurately reflects the patient's condition, complaints and treatment, as well as the practitioner's conversations, recommendations, and plan at the time of contact with the patient. Despite the truthfulness or accuracy of the information, notes that are "back dated" (whether an entire entry or a notation to make an existing note more complete) to provide the appearance as though they were written at the time of treatment, is impermissible. This is a dangerous practice that at the very least, can lead to inaccuracies and the appearance of impropriety.

Alterations need not go to the heart of the treatment provided or the standard of care, to call into question the veracity of an entire medical record. In fact, the detection of a seemingly minor alteration, that has no bearing on a departure, can make a suit that is medically defensible, indefensible. Indeed, the defense of a matter may no longer focus on liability and whether the practitioner departed from the standard of care, but rather when and why the practitioner altered the medical record. Invariably, it is inferred that the practitioner has attempted to conceal care which did not comport with good and accept standards of medical care. Consequently, alterations challenge the true nature of a patient's treatment, the timing of the treatment, and on occasion, whether the treatment described within a record was even rendered. Thus, a practitioner may be forced to settle a case, even in the absence of a departure from the standard of care or casual link to the patient's injury, based solely on an alteration to their record. Undeniably, alterations speak directly to the heart of a practitioner's credibility and integrity. The thought is, if the practitioner has altered one portion of the record, it casts a dark cloud of doubt as to the truthfulness and accuracy of the remainder of the entries.

Alterations can also consist of corrections to errors or inaccuracies. If an error is discovered it *may* be corrected. Conversely, whether the error *needs* to be corrected is an entirely different consideration. The potential for a negative inference should be weighed against the necessity of the correction. If a practitioner must correct an error, a single line should be placed through the erroneous information and it should be initialed with the date and time. It is imperative that the practitioner does not entirely obscure/"black out" the information, as this may be seen as deceptive. Even when prudently corrected, the practitioner must take heed and be prepared to cogently explain the basis for making the correction. Additionally, once a malpractice action has been commenced, corrections or additions to a record should not be made without first conferring with legal counsel. Again, the benefits of the correction or addition may be overshadowed by the appearance of impropriety. One could most certainly argue that an addition or correction to a record where a patient has suffered

a bad outcome or complication ostensibly placed the practitioner on notice of a potential suit. Thus, any change in a record following suit may appear completely self-serving.

Altered medical records may be disseminated in a variety of ways and for a variety of reasons. Records may be provided to another practitioner/provider for further care or a second opinion. They may also be exchanged for purposes of billing or insurance reimbursement. Moreover, they may even be exchanged to support an ancillary claim for benefits, such as disability, which at the time provided, have no connection to a future action sounding in medical malpractice or the quality of care rendered by the practitioner. These are just a few examples of ways in which a record can be copied and shared before the practitioner is even on notice of a suit.

Furthermore, many practitioners and hospitals have departments or individuals dedicated to responding to requests for medical records. Consequently, the practitioner may not be aware that their records have been exchanged. Hence, records may be exchanged months or years before an alteration is made. A finding that information was added or changed months or years following treatment, regardless of its accuracy or truthfulness, on its face, appears deceptive and self-serving.

Practitioners may be under the false impression that if it's not written, it did not happen. While it is preferable to have information memorialized in a patient record, a practitioner, in the absence of a written note, may still rely on their custom and practice. Absent a specific recall, a practitioner may attest to what he or she would have done, said, recommended, etc. based upon their custom and practice in like circumstances. Again, although reliance on custom and practice is not equivalent to a solid medical record, it is far better than the discovery of an alteration.

Regardless of intent, the ramifications of an altered medical record can be catastrophic. The consequences are numerous and may include the inability to defend/the need to settle a matter otherwise defensible; disclaimer of coverage by the malpractice carrier; as well as fines, sanctions, suspension and/or revocation of the practitioner's license. The New York State Department of Health appears to be growing less tolerate of practitioners who fail to maintain accurate records. New York State Education Law §6530 defines professional misconduct. Specifically, Education Law §6530-32 states, in pertinent part, that a licensee can be found guilty of professional misconduct, resulting in penalties, for "[f]ailing to maintain a record from each patient which accurately reflects the evaluation and treatment of the patient." Consequently, evidence of record alteration can be a proverbial death sentence to one's professional career.

The New York State Department of Health, Office of Professional Medical Conduct may also require exchange of a patient's medical record in connection with an investigation. New York Public Health Law §230.10(I) states "[t]he board or its representatives may examine and obtain records of patients in any investigation or proceeding by the board acting within the scope of its authorization." In addition to requiring a copy of the patient's record within 30 days of receipt of the request,[1] the practitioner is also required to execute a certification. Pursuant to the certification, the physician certifies that the records provided are complete, true and exact copies of the patient's record "during the regular course of business and were made at the time of such event as recorded or written." When a record has been altered, absent a clear indication that it is an addendum or correction of an error, the practitioner can no longer truthfully execute the certification. Exchange of a record at the request of the Department of Health without providing an executed certification undoubtedly raises a red flag as to the accuracy of the medical record. This can only serve to hinder a practitioner's ability to defend themselves during the course of the investigation.

Record alteration may also lead to an application seeking a remedy for spoliation of evidence once a suit has been commenced. At times the opposition may seek to strike the answer of the practitioner arguing that the addition of information into a record, without designating it as an addendum, is similar to the destruction of evidence. Although the striking of a parties pleading is typically reserved for matters with evidence of willful or contumacious conduct[2] the New York Court's have consistently held that, "when a party negligently loses or intentionally destroys key evidence, thereby depriving the non-responsible party from being able to prove its claim or defense, the responsible party may be sanctioned by the striking of its pleading."[3] An argument may be advanced that a patient is unable to offer evidence central to the prosecution of their claim if a record has been altered. Such a drastic measure would, of course, be affected by the nature of the alteration and whether there is evidence that the alteration was made with the intent to defraud of conceal information.

Conclusion

Preparation of cogent notes following treatment of the patient is imperative. If information crucial to a patient's care and treatment has been left out or erroneous, careful consideration must be made as to whether an addition or correction should be made. The best manner in which to include such information is to author an addendum or correct the error. In both instances denoting when the addition or correction was made is essential. This practice will ensure additions and corrections to a record are designated as such and are the best way to avoid the appearance of impropriety. Although adhering closely to the suggestions set forth above with respect to properly amending or correcting medical records may not thwart commencement of a medical malpractice action, a solid and detailed medical record is the quintessential first step in mounting a defense.

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[1] Education Law, § 6530-28.
[2] Molinari v. Smith, 39 A.D.3d 607, 834 N.Y.S.2d 269 (2nd Dept. 2007).
[3] Baglio v. St. John's Queens Hospital, 303 A.D.2d 341, 755 N.Y.S.2d 427 (2nd Dept. 2003).

Tracey A. Reiser, a senior associate in the law firm of Kaufman Borgeest & Ryan LLP, handles the defense of hospital and medical professionals in malpractice matters. Additionally, she represents medical professionals in licensing matters before the Department of Health.

LEGISLATIVE UPDATE

New York State Adverse Event Reporting

Revisions to the New York State Patient Occurrence Reporting and Tracking System (NYPORTS) have been implemented as a result of a collaboration between the Department of Health (DOH) and stakeholders to more closely align the system with national reporting trends through significant, but not complete adoption of National Quality Forum (NQF)'s Serious Reportable Events (SRE)'s.

Statutory changes to Public Health Law (PHL) Section 2805-1

PHL Section 2805-1 has been revised to allow the Department of Health (DOH) the ability to conform to NQF reporting definitions and to share NYPORTS de-identified findings. These statutory revisions allow the DOH to share data with researchers with the goal of robust data analysis and information sharing with hospitals within New York State.

The summary of changes are as listed below:

- The term "incident reporting" is changed to "adverse reporting"
- The definition of "hospital" is expanded to include diagnostic and treatment centers
- DOH may add, modify or eliminate reporting requirements, after consultation with experts in the interest of patient safety consistent with NQF standards
- DOH is directed to analyze event reports, root cause analyses (RCA), and corrective action plans to determine patterns of systemic failure and identify methods to correct these failures and communicate findings with facilities
- DOH is authorized to release de-identified analyses and findings to hospitals and to the public, as well as data for research purposes in the interest of patient safety with the Commissioner's approval

Changes to Reporting Adverse Events

Significant changes to NYPORTS adverse event reportable codes became effective July 5, 2011. DOH began collecting a subset of the 29 NQF SRE's. The subset includes NQF codes that are most similar to prior NYPORTS events and have the potential to yield significant risk reduction strategies through analysis. The remainder of NQF events have been placed on hold until further notice.

Health Insurance Exchange

Governor Andrew Cuomo announced the submission of a Governor's program bill that will establish a Health Benefit Exchange to comply with the Affordable Care Act (ACA) passed by Congress and signed into law in 2010.

Under this program bill, New York will operate its health exchange, in lieu of the federal government, to better address the nuances and complexity of the New York insurance market. The goal of this legislation is to establish a centralized exchange that will service the individual consumer and small business operators with the purchase of health plans, qualified dental plans and public health coverage programs.

The Exchange will be established as a public benefit corporation managed by a Board of Directors including the Commissioner of Health and State Medicaid Director. The Board will work with an Advisory Committee, who represents those impacted by the Exchange sector, to drive the direction of the Exchange in order to meet the need of the consumers.

The Exchange is required to be self sustaining by January 2015 with federal funds supporting the initiation, and operations through December 2014. New York has begun its funding by participating in grant initiative monies.



Risky Business

"When Common Sense is Uncommon"

By: Pamela Monastero, MBA

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Newsletter, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to Pamela.monastero@nychhc.org or mail to AHRMNY utilizing the RISKY BUSINESS form which can be found on our website at AHRMNY.org. The form permits confidentiality.

COMMON SENSE TIPS FOR STAFF:

This quarter's column focuses on the impact of technology on health care and in risk management.

Over the course of the past several years, the Risk Management Quarterly has published several articles addressing the electronic medical record (EMR). While most risk managers will likely agree that the EMR and modern technology can be a solution, it also can create other unanticipated issues.

Years ago, risk managers dealt with concerns about lost/missing paper records, fetal monitoring strips or x-ray films that were unread by radiology, record alterations, notes written out of sequence or added along the borders of progress notes, critical values that went unheeded, etc. Most of us hoped that technology such as the EMR, digitized imaging of radiology studies and fetal monitoring strips would be a magic bullet to solve some of these issues. Unfortunately, what solves one problem, undoubtedly creates another.

Since all EMRs are not created equally, some of the specific issues outlined may not apply to all facilities. Listed below are some technology-related issues reported to us from health care professionals and we encourage our members and readers to write in and let us know what your experiences have been with technology so we can continue to expand the list and educate our peers.

- Event time vs. documented time: some EMRs automatically record the date/time a note is written but allow the provider to document the 'event or bedside' time in a field. How does your chart print of the EMR display the time? When reviewing the note on line, how does your EMR display the time of event and/or time of documentation?
- How are critical values reported electronically? Some hospitals report that there is an abnormal queue set up for each ordering provider and results are sent there. How are your providers notified and does anyone check (monitor) that providers regularly check the critical value reports or 'delete' viewed items from their queues?
- Navigating the EMR can be troublesome. Some systems permit the user to view the EMR like a 'book' (similar to the paper chart) and see notes documented sequentially. In our readers' experience, providers tend to read each others' notes less in the EMR setting than with the paper chart.
- Retrieving lab or radiology results from the wrong admission. We have received information that in some EMRs, older results cannot be 'grayed out' with newer results displayed in different colors. Sometimes providers click on the wrong date or year and therefore act on out-of-date information.
- We all remember the days when a provider made an erroneous diagnosis that carried throughout the admission in the paper chart because subsequent providers took that note to be 'gospel.' In the EMR, it appears to be an epidemic and not just in terms of one diagnosis, i.e. "patient has diverticulitis." Sometimes whole notes or paragraphs are reiterated, even when the information is incorrect because providers add to the notes of other providers without correcting or addressing prior misconceptions or errors.
- Amending notes is another issue. If notes are amended or corrected, how does the chart print of the EMR present the data? In paper charts, the incorrect note would be in sequential order bordered by other notes. In the EMR environment, is only the amended note printed or do both notes appear?
- Drop down menus—do they make sense? Are there contradictory terms contained in menu selections? What are the safeguards? Ease of selection is a problem because you are a click away from making a dangerous mistake.

LESSONS LEARNED:

1. The EMR has almost made the risk manager's job more difficult. There are now audits to check, amended/corrected notes to check and cross check against the time they were written—sometimes reviewing a chart can feel like a CSI episode! Depending on which EMR a hospital utilizes, it can be a daunting task for risk managers to determine what happened when.
2. Providers not reading each others' note remains a patient safety and liability exposure issue. Forced functions such as 'no pass fields' or 'mandatory reading' might be the answer to this.
3. Are chart prints truly transparent in terms of providing a clear picture of what transpired and when? Is certain information available only via an audit process?
4. What measures can be put into place (i.e. forced functions, no pass fields, limited narrative, etc.) to mitigate problems?
5. Is your facility's audit process broad enough to monitor the virtual EMR and the actual EMR to ensure it meets the needs of the stakeholders?

LONG-TERM AND CONTINUING CARE (LTC) PARTNERSHIPS IN THE WAKE OF MEDICAID REDESIGN

Health care across all settings in the continuum has been experiencing a dramatic unparalleled financial challenges and upheaval. The causes are various multiple but largely due to proposed and demonstrated changes in reimbursement, demands of regulatory bodies and other patient or resident expectations. Reportedly, long-term care and continuing (LTC) services comprise the largest portion of Medicaid expenditures in most states, serving as a motivator for states to develop innovations that would help hold the line on expenses.[1]

The topic of Medicaid Reform and its impact on health care services was a timely key topic of the June 10, 2011 Annual Conference. So much so, the Discharge Planning presentation by co-presenters Lydia R. Galeon, Senior Vice President, Business Development and Long-Term Care and Jay Gormerly, Vice President, Planning, Research and Innovation of Metropolitan Jewish Health Services (MJHS) addressed opportunities with proposed legislative Medicaid Reform at the June 10, 2011 AHRMNY Annual Conference. The presentation captured the reality of the effect on Medicaid Redesign/Reform (MRT) on discharge planning and the 'business' of LTC services.

The presentation clarified the 'bundling' concept of funding and heightened the awareness of the effect that Medicaid Reform will have not only in the LTC arena but the all health care entities in the health care continuum. The distribution of funds for health care will foster 'partnerships' of LTC and acute are facilities. Partnerships will be the key to viability of healthcare entities.

In addition to proposed reform challenges, LTC organizations will need to account for shifts in the paradigms of the consumer base and the need for health care services will challenge the industry. The shift is not only in the age of the clients but also the proposed amount of client s to serve as there is anticipation for the 'baby boomers' who are shopping for their future.[2] The surveillance by regulatory agencies to maintain the 'drive' for age appropriate centered care is high as are the expectations of the LTC consumers.

In-line with the shift in the demographics of the LTC consumer, the shift in paradigm of the health care services provided. The 'old' LTC continuum was defined facilities as nursing homes for the aged and the hospitals provided rehabilitation services, acute care and mental health needs. The MJHS presenters demonstrated that the shifts in the health care paradigms are apparent in the new paradigm of LTC. The 'new' paradigm identified the growth of the LTC organization with health care services that include disease and case management, wellness programs, palliative care and respite care, hospice, outpatient therapy, home care. Hospital services will include sub-acute/acute hospitalization and long term hospitalization.[3]

MRT also fosters a competitive edge for many LTC organizations. Many have learned how to market their facility and services to attract clients and partnerships. For example, many facilities have replaced the word or idea of "geriatric" from their organization's name and have opted to market themselves as "centers" for "rehabilitation and/or nursing services." Suggestions for a competitive edge include re-evaluation of your health care business model; evaluation of who you are as an organization and what you do well; identification of partnerships in the community and acute care facilities and promotion of outreach efforts with social service agencies and departments.

The MJHS speakers shared five *"take home"* points which reinforce the need for partnerships in the age of health care reform, and safe 'hand-off' of discharged patients to the community. The take home points include:

- MRT has provided a window of opportunity for all levels of health care, us Hospitals and Homecare agencies, to achieve competitive advantage in open markets;
- Business practices will require need change , as a result some revenue reductions out of MRT, but these changes are an out-growth of a process that has been under way for years;
- MRT is an impetus for making the changes now, but not the reason. Healthcare as businesses need to change the models of care in order to reflect a changing environment and increase coherence;
- Many of these changes and transformations will be in partnership with other providers and represent first steps toward change;
- Transitional Care and the planning of those discharges as a partnership will be a large leverage point for our public health system. [4]

Conclusion

In the wake of health care and Medicaid Reform/Redesign, all levels of entities in the health care continuum will need to collaborate in order to extend our expertise beyond the walls of our facility, share information, share access to information and increase each other's understanding of the full continuum of care when meeting the demands of public health.

Endnotes

[1] D.I. Shostak and P.A. London. State Medicaid Expenditures for Long-Term Care 2008-2027,: Report prepared by Strategic Affairs Forecasting for America's Health Insurance Plans, September 2008.

[2] Risk Management Pearls Long-Term & Continuing Care 2010; American Society for Healthcare Risk Management of the American Hospital Association (ASHRM) Chicago, Ill.

[3] AHRMNY 2011 Annual Conference, 'Creative Discharge Planning' presentation by co-presenters Lydia R. Galeon, Senior Vice President, Business Development and Long-Term Care and Jay Gormerly, Vice President, Planning, Research and Innovation of Metropolitan Jewish Health Services (MJHS)

[4] Ibid.

Should you have any suggestions or questions regarding this column; or topics of interest for future Long-Term Care columns please e-mail any suggestions to the AHRMNY Publication Committee "Editors" at ahrm@optimum.net

INSURANCE UPDATE

By: Robert Marshall

The newly created New York State medical indemnity fund (MIF) will be fully operational on or about October 1, 2011. It is reported by the Greater New York Hospital Association that the establishment of the fund could reduce hospital malpractice costs by as much as $320 million statewide while also producing meaningful premium relief for obstetricians.

What impact will the Neurological Impairment Fund have on physician's medical malpractice premium?

The medical malpractice insurance marketplace for physicians in New York is highly regulated by the New York State Insurance Department. Malpractice rates for licensed and admitted carriers are set annually each July 1st by The Department of Insurance. As of this writing rates have yet to be promulgated by the State for the licensed and admitted insurers. The largest licensed and admitted carriers in the State are Medical Liability Mutual Insurance Company, Physicians Reciprocal Insurers, Academic Health Professionals Insurance Association, and Hospital Insurance Company, Inc.

Risk Retention Groups who also offer physician malpractice policies in New York State, and whose rates and underwriting rules are not regulated by The New York State Insurance Department can use their discretion in adopting credits.

What impact will the Neurological Impairment Fund have on the Hospital's malpractice premiums?

Hospital's who purchase a primary level (typically defined as $1m of coverage) of Hospital Professional Liability Insurance Coverage will likely see little impact on their insurance premiums in 2011. Since premiums are typically developed by insurers using a ten (10) year historical trended and developed claim history, the impact, if any, on premium levels will likely be experienced in future years if the Fund impacts frequency and/or severity of claims. Most insurers are taking a "wait and see" approach prior to offering credits this year. But, this position, as well, can be impacted by competitive pressures and specific by hospital.

What impact will the Neurological Impairment Fund have on the Hospital's self retained exposures (self insured trust and/or captive)?

Jim Stergiou of SG Risk Consultants, a leading actuarial consulting firm for many hospitals in New York, opines that the Fund could have an impact on severity of future claims if you consider the following assumptions:

Based on specific client data and overall industry statistics Obstetric claims represent on average approximately 40% of all Hospital Professional Liability claim costs with ranges in any given year of 20% to 70%. Approximately 2/3rd of these claims result in a neurological event from birthing. Of these events, it is expected that 50% of the dollars incurred will be assigned to the Neurological Impairment Fund.

Hospital with deliveries will potentially see a reduction in prospective loss costs and funding levels in the area of between 6% and 14% going forward. In addition, ultimate costs on all open OB claims on past years should be reduced, because the MIF will also apply to all open, eligible claims

What impact will the Neurological Impairment Fund have on the Hospital's Excess reinsurance or stand alone excess policies?

Hospital's who purchase excess reinsurance or standalone excess insurance policies should be able to negotiate lower premium levels if they can show a statistical correlation to reduction in severity of Obstetric related payouts to neurologically impaired infant cases. Qualified actuaries and insurance/reinsurance brokers can assist the Hospital in structuring and negotiating these contracts with a variety of various insurers/reinsurers in the Domestic, Bermuda and London Insurance markets.

CONSIDERATIONS FOR DEPLOYING TOUCHSCREEN TECHNOLOGY AT THE BEDSIDE

By: Brian Yarnell

The convergence of traditionally consumer-oriented technology and clinical applications stands to revolutionize the patient experience in hospital and long-term care settings. Conscientious deployment of cutting edge technology platforms and applications will certainly have a positive impact on quality of care and patient safety. However, effectively implementing and maintaining some of the advances seen in the consumer world in a clinical setting is not without its pitfalls. This article examines some of the considerations to successfully leveraging touchscreen technology at the bedside.

Using Touchscreens at Patient's Bedsides

It's clear that touchscreen technology is one of the most pervasive trends in our personal lives, and for good reason. A touchscreen interface removes significant obstacles to interaction with technology. I'm sure every one of us has family members and friends that would have never sent an email or joined the latest social media craze if it weren't for getting their hands on an iPhone.

As the healthcare industry moves aggressively towards both meaningful use of information systems like EHR's and the adoption of new cutting-edge technologies like workflow management systems, there is a significant risk of alienating both providers and patients. Simple, intuitive interfaces like the now familiar touchscreen stand to reduce these barriers.

In fact, our research has shown very encouraging evidence of adoption rates within elderly and Limited English Proficiency (LEP) patients when technology is delivered using this medium. In a study of geriatric, non-English speakers, we experienced nearly 100% of subjects reporting that they could make requests via touchscreen without any difficulties and could readily learn to use the system.[1]

Considerations for Deployment

While the decision to deploy touchscreen technology in a clinical setting should be an easy one, there are a few challenges to overcome.

Hardware Selection

The variety of selections for touchscreen devices is staggering and shows no sign of becoming more homogenous. This means that there is a substantial risk that the device you select today may be obsolete in a matter of months. There is a rule-of-thumb used in many industries that the usable life of technology about 36 months. In the case of emerging technology like touchscreen devices, this is almost certainly shorter.

So- what can you do to mitigate risk? The most important thing you can do to protect your investment is avoiding "vendor lock-in"—essentially becoming married to a hardware or software vendor due to high switching costs. Be very wary about selecting any touchscreen system that explicitly ties together hardware and software. As hardware progresses, you want to be able to consider all options for an upgrade instead of being locked into the options presented by your incumbent vendor. Obviously, the same thing goes for software. Make sure that any software you select has the flexibility to run on multiple platforms, preferably standard off-the-shelf models.

Keep Devices from Walking out the Door

It goes without saying that touchscreen devices are enticing items and should be secured appropriately. This presents a particular challenge considering the limitations of deploying devices at the patient's bedside. Remember that mounting anything to the bed itself is probably a bad idea from a patient safety standpoint and even if it didn't impact patient safety, it is really inconvenient for care providers that may have to adjust bed rails or move patients around. Also be aware that while many touchscreen device are wireless, most will still need a power cord that also poses a risk to patient safety. Unfortunately, the best solutions that we've seen also tend to be a bit more pricey—articulated arms with integrated cord management.

a power cord that also poses a risk to patient safety. Unfortunately, the best solutions that we've seen also tend to be a bit more pricey—articulated arms with integrated cord management.

What about when the devices actually do walk out the door? Despite your best efforts to secure a touchscreen device at the patient's bedside, the chances are high that the draw to take one of the devices home will eventually overwhelm whatever physical security you have in place. If this happens, you need to be 100% sure that no sensitive data goes with it. Be mindful that the systems you select do not store data locally on the device.

Keeping it Clean

Based on the simple fact that touchscreen devices are constantly being touched, they are certain to accumulate germs. It's important to verify that the device you select can be properly sanitized, especially if you're using off-the-shelf hardware. Screen protectors are a wise investment, but make sure that the ones you select are not adversely affected by your standard cleaning solution. Once you have identified how to best clean the touchscreen devices without destroying them, it's important that you make this part of the standard operating procedure in your facility.

Placing a touchscreen device at the patient's bedside can certainly encourage better patient/provider communication, but there is a downside. When you have patients and providers sharing the same device, there is a risk of spreading germs to the provider's hands. Proper hand sanitization procedures are really important in this situation. Another solution is to select a platform that does not force patients and providers to share the same unit. This might involve separate dedicated interfaces for care providers at strategic locations in the hospital or the addition of a mobile interface so that each provider has a personal device.

Standalone vs. Networked Devices

There are many applications for touchscreen devices at the patient's bedside, ranging from translation services and patient request management to the dissemination of educational content and health records. In any application of this technology, it's critical to assess the total impact the platform will have across the organization. Any device that claims to be a standalone solution is probably not well equipped to leverage the organizational efficiencies of your facility, while devices that depend largely on other hospital systems need to be examined closely to determine the amount of effort to implement.

In most cases, you will experience a higher return on investment (ROI) from networked devices because they expand the footprint of existing systems and allow your organization to receive additional value from previous expenses. While the ROI of a more integrated system is potentially higher, be aware that there is a significant increase in the upfront investment. With initiatives like Meaningful Use on many executives' minds, there is a very rational tendency to require that all platforms talk to each other. Selecting systems that are interoperable will certainly make this an easier conversation, but be aware that it still takes time and money to make different platforms speak the same language.

Lessons Learned

The unfortunate truth is that no technology will exist in a clinical setting just because it's cool, patients like it, or there might be some nebulous impact on patient safety and quality of care. It's important to make sure that the implementation of touchscreen technology for patients (or any other technology initiative) has a significant and measurable return on investment. In many instances the addition of detailed workflow management utilities, dedicated provider interfaces and a reporting engine to improve visibility for management helped move the platform from a neat idea to a viable long-term solution.

As you engage in your own projects to implement innovative technology at the bedside, remember that the goal is not just to give the patient a cool new toy to play with. Investments should focus on better engaging patients in their own care and helping care providers do their jobs more effectively and efficiently.

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[1] Kaufman, D.K., and Shine, A. Evaluating the Usability of a Novel Bedside Monitoring Device: Final Report. Unpublished report, Transcendent International, May 2, 2011.

Biography

Brian Yarnell is the Director of Product Management at LanguageMate. He has been involved in the creation of technology platforms for more than ten years, creating innovative systems in Healthcare, Digital Media, Manufacturing and Business Intelligence. At LanguageMate, Brian focuses on transforming the concepts developed in collaboration with the National Institutes of Health (NIH) into viable commercial offerings. LanguageMate has been the recipient of more than a dozen grants focused on addressing disparities in patient care across the entire healthcare continuum.

Should you have any suggestions or questions regarding this column; or topics of interest for future emerging technology columns please e-mail any suggestions to AHRMNY Publications Committee "Editors" at ahrm@optimum.net

SUMMARY OF AHRMNY'S ANNUAL EDUCATIONAL CONFERENCE

The conference began with a presentation, **"Benchmarking Data and Overview on Radiology Risks"** by Sharon Groves, Assistant Vice President, Risk Management and Russell Creed, Vice President, Actuarial and Analytical Services at BerkleyMed. From 2007 through 2009, BerkleyMed has experienced an increase in hospital radiology claims. Significant risks in radiology include exposure to radiation, contrast media, MRI, interventional radiology and communication and documentation. Radiology claims comprise 5% of all hospital professional liability claims and the total claims frequency is increasing. The average cost of a radiology claim in NY is $296,647. The most likely allegation is diagnostic error and the most likely outcomes are cardiac event and death. Promoting a culture of safety in Radiology and monitoring clinical and administrative quality process and outcome indicators relevant to radiology services were discussed.

"Creative Discharge Planning" was presented by Douglas K. Stern, Esq. of Abrams, Fensterman Fensterman Eisman Grennberg Formato and Einiger, LLP and Lydia R. Galeon, Senior Vice President, Business Development and Long-Term Care and Jay Gormerly, Vice President, Planning, Research and Innovation of Metropolitan Jewish Health Services. A hospital must take appropriate action when it wants to discharge a patient that has no immediate alternate resources and no valid legal residency or citizenship status. PRUCOL (Permanently Residing within the United States under the Color Of Law) must be considered. In 2001, the New York State Court of Appeals held that aliens who are PRUCOL are entitled to full Medicaid benefits. The PRUCOL "Alien" refers to an alien who is permanently residing within the U.S. with the "knowledge and permission or acquiescence" of the Department of Homeland Security (DHS) and whose departure the agency does not contemplate enforcing per 10 NYCRR 360 *et. Seq.* PRUCOL is not a status conferred upon an individual as a legal "immigration" status, but it is a public benefits eligibility status. The patient's legal status can be obtained from inquiry of the Medicaid agency and/or inquiry of DHS. Discussions also highlighted the opportunity of *"Partnerships"* among health care providers during health care reform and Medicaid Redesign. These partnerships, among acute care hospitals, Long-Term and Continuing Care (LTC) facilities and community based entities, will prove essential to the successful transition of patients to the next level of care in the health care continuum.



Sharon Groves



Russell Creed



The Creative Discharge Planning Panel
Lydia Galeon, Jay Gormely and Douglas Stern

Dennis P. Whalen, Executive Vice President of HANYS presented "**Medicaid Redesign Team and the Future of Medicaid and Healthcare in New York."** Governor Cuomo has proposed the largest Medicaid cuts in history. The NYS DOH Medicaid Reform Team has made several recommendations to save $2.3 billion for the state. These recommendations include: provider rate reductions, cap on future Medicaid spending with an enforcement mechanism, patient-centered medical homes, care management for Medicaid population, controls on personal care and home health, control on utilization of certain optional benefits, regulatory streamlining and reform and medical malpractice reform. Federal healthcare reform impact on NY Hospitals and Health Systems will be a revenue decrease of $15 billion over ten years. The three keys to the healthcare delivery system include quality, health information technology and clinical integration. The healthcare leadership opportunities include reframing the future of organizations with the need to consider integration, mergers and consolidation to survive; exploring new arrangements with physicians; attention to operational efficiencies and quality improvement; and a strong link with communities to enable communication about change.

The honored guest speaker, New York State Senator, Kemp Hannon, Chairman of Senate Health Committee reviewed current initiatives including **Medicaid Redesign Team and Accountable Care Organizations and the Medical Indemnity Fund.** He indicated that meaningful discussions are taking place, during these various stages of implementation; however, there is a long way to go and work to be done.

The Educational Conference concluded with a **Risk Management Panel** that discussed Risk Management "Hot" Topics. The panel included: John V. Campano, Esq., Vice President, Risk Management, Associate General Counsel, New York-Presbyterian Hospital; Jean Carlson, Sr. Associate Director, Risk Management, Bellevue Hospital Center; and Margaret Davino, Esq., Partner, Kaufman Borgeest and Ryan, LLP. "Hot" Topics posed to risk management colleagues included disclosure and self reporting of medical errors; root cause analysis (RCA); promoting a *'Just Culture'* environment and accountability in a healthcare system and the challenge of meeting the need for 24/7 Risk Management Services. The panel discussed the challenges of disclosure and self-reporting of medical errors in a punitive environment as evidenced by OPMC, DOH, and OMH. The reality is that there is a lack of clear consensus regarding selection of cases for root cause analysis (RCA) and how to conduct the RCA. The challenge of 24/7 Risk Management Services continues; however recommendations including creating a "Top 5 List" of most commonly asked questions with the answers can help risk management staff more easily field questions.



Dennis P. Whalen and Jon Rubin



New York State Senator, Kemp Hannon

Risk Management Panel



Jean Carlson



John V. Campano



Margie J. Davino

The panel addressed the process of challenges and the dilemmas of promoting a *'Just Culture'* environment within a healthcare system that engages accountability of all staff. The process encompasses many of the topics addressed such as disclosure, RCAs as well as the duty by the healthcare facility to the clinician and/or physician.

Electronic medical records (EMR) are legible, can reduce medication errors with computerized provider order entry (CPOE), and improve tracking of lab and test results. However, there are new risks/liabilities associated with the EMR that include templates. Templates facilitate the *"cloning"* of documentation notes from an earlier encounter; default settings providing fewer opportunities for clinicians to add information with important details. An unanswered question is what the burden or duty will be on staff if the EMR generates an alert and staff does not act on it. In-line with health information and records is the HITECH Act which strengthens civil and criminal enforcement of HIPAA to address privacy and security concerns regarding electronic transmission of health information.

Lastly, Accountable Care Organizations bring new risk concerns, such as, is it a separate entity with its own risk and insurance? Also, physician integration often involves employment of physicians and if physician integration involves captive PCs, are they insured under the hospital policy? These topics join the multiple of "Hot" Topics and challenges for healthcare risk managers. The conference was enjoyed and well received by all.



Grace Langan (center) – Recipient of AHRMNY's First Distinguished Service Award with Jon Rubin (Current President) and Peggy Sullivan (Past-President)



Retiring Board Members Sam Senders, Lisa Bronikowski and Judy Block (not pictured) were presented with honorary plaques for their years of dedicated service to the Organization



Lunch and Award Ceremony

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