

YOUR PROFESSIONAL LIABILITY BROKER,



PROFESSIONAL LIABILITY CONSULTANTS

is pleased to be sending you, our *Cornerstone Quarterly Newsletter*.

Many of your colleagues may be in need of our assistance. Please have them give us a call at 800-508-1355.

Thank you,
Chris Zuccarini
President

If you would like us to remove you from your list please call 800-508-1355 and we will do so immediately

1500 LIBERTY RIDGE DRIVE . WAYNE, PENNSYLVANIA 19087 .
610-296-3700 . 800-508-1355 . FAX: 800-508-1354



PROFESSIONAL LIABILITY CONSULTANTS

A QUARTERLY NEWSLETTER

RISK MANAGEMENT: PATIENT REFERRALS OF SPECIALTY CARE: The need for coordination

As printed in the Risk Review a Publication of Princeton Insurance

COORDINATION OF CARE

Referrals to specialty consultants are among the many important things that primary care physicians (PCPs) must track in their day to day practice, both within the office and the hospital setting. Missed or delays in diagnosis and treatment, repeated or unnecessary testing, adverse drug reactions and a host of other problems can result from lack of communication and breakdowns in the coordination of care, and can all increase your liability exposure for failing to supervise a patient's case. These claims, which are occurring far too commonly, typically stem from poorly designed or implemented methods for ordering and keeping track of referrals and knowing whether a patient makes an appointment and keeps it, whether a consult on a hospitalized patient has taken place or whether the specialist has sent you a report.

We often hear PCPs complain that they do not always receive written communication of referral results from specialists when they refer patients. Conversely, and perhaps more troubling, is that PCPs do not always communicate necessary patient information to specialists when making referrals, and even when they do, the reason(s) for the referral are often absent. A study funded by the Agency for Healthcare Research and Quality (1) revealed similar results. This AHRQ study examined how physicians coordinate patient care for specialty referrals and the effects of these activities on specialist feedback, as well as physician's satisfaction with the specialty care of their patients receive. A total of 963 referrals from the offices of 122 pediatricians were reviewed. The results revealed that referral completion increased three-fold for those referrals in which the PCP actually scheduled a patients' appointment with the specialist and/or sent information to the specialist compared to those for which neither activity occurred; satisfaction ratings of referring pediatricians increased significantly by any specialist feedback, especially feedback by both telephone and letter; and elements such as presence of patient history, suggestions for future case, follow-up arrangement, and plans for co-management of patients by the specialist and PCP. All of these components positively improved physician ratings of the quality of specialist feedback.

(1) "Coordination of Specialty Referrals and physician Satisfaction with Referral Care," by Dr. Forrest, Gordon B. Glade, MD, Alison E. Baker, M.S., et al. Archives of Pediatric and Adolescent Medicine, May, 2000

NEW JERSEY COURT RULING :UPDATE

Most New Jersey physicians, if not all, have heard about the case involving a trucking company where the court ruled that the personal assets of the person involved in the case were at risk due to the carriers insolvency. Since the Guaranty fund will only cover the first \$300,000 of a claim even though limits issued by the insolvent carrier were much higher.

The NJ Supreme Court in Johnson v. Braddy, et al affirmed the Appellate Division decision whereby "a policyholder whose insurer becomes insolvent is personally liable for judgments in excess of the \$300,000 maximum coverage provided under the NJ Property Liability Insurance Guaranty Act." The Supreme Court decided this on 2/1/06 in the "absence of a statutory directive to the contrary". The Court added - "in light of the potentially catastrophic effect that this ruling may have on responsible citizens who have purchased insurance to protect themselves and the victims of accidents in which they are involved, this issue is commended to the Legislature for such remedial action as it deems appropriate." The NJ Hospital Association and the NJ Medical Society submitted amicus curiae briefs.

We will watch and see what the legislature does.

GUIDELINES FOR ORDERING CONSULTATIONS WITH SPECIALISTS

When referring a patient to a specialist, be cognizant of the consultative process;

- Whenever possible speak personally with the consultant, before the patient is seen, especially in “urgent” situations.
- Avoid leaving a request for a consult with an answering service; however, if absolutely necessary, be sure to follow up to ensure consultation requested was received.
- Explain to the patient why the consult is being requested and document this discussion in the medical record.
- Develop a standardized format or ordering consults. Information should be provided, as to:
 - a. Relevant patient history, including working diagnosis, what test/diagnostic studies have been performed and current medications.
 - b. The type of consultation being requested, such as whether the request is for:
 - i. Consult for opinion only
 - ii. Consult and recommend treatment
 - iii. Consult and treat specific problem
 - iv. Consult and assume total care of patient
 - c. The urgency of the consult, such as:
 - i. Urgent; consultation needed immediately
 - ii. Not urgent; please see patient within _____hours/days
- If ordering a consult on a hospitalized patient, provide complete information on the consultation order forms, per hospital policy.
- The written request for consultation, and the reason for the consult, should be documented in the requesting physician’s plan of care
- Whenever possible, speak with the consultant after the patient is seen. Carefully read the consultant’s written report to assure that all of the information assumed in the consulting physician’s diagnosis/impression is accurate. Leave nothing to chance.

GUIDELINES FOR SPECIALIST FEEDBACK

Direct communication helps to establish clear responsibility for monitoring or follow up and avoids the false reliance of one physician upon the other that the patient is being followed. Failure in communication between the PCP and specialist as to who will monitor and follow-up with the patient on the continuing basis is a common source of liability exposure. Recommendations include:

- Answer a consult in timely fashion
- Speak with the PCP before and after the consult
- Respond to the consult according to the type of consult requested, as listed above
- Explain to the patient your role in his/her care
- Avoid inflammatory verbal or written remarks about subsequent care and treatment

- Provide the patient with feedback as to your findings and their therapeutic options and whether further studies or follow-up are indicated explaining why there’re needed
- Do not consult another physician without first conferring with the PCP

CONCLUSION

While often a time-consuming and inadequately reimbursed process, referrals necessitate the need for diligent communication and coordination of care across multiple settings and providers. Consultants must be performed following a systematic process and in a timely manner to maintain continuity of care, enhance patient care and satisfaction, and to help prevent serious adverse consequence that would impact all those involved in the care, especially the patient.

DOCTORS FOR MEDICAL LIABILITY REFORM

Reprinted with the expressed permission of the Medical Liability Monitor

Doctors for Medical Liability Reform has unveiled an interactive national map with state-by-state data showing how the medical liability crisis is harming patients’ access to quality healthcare across the country. At www.ProtectPatientsNow.org viewers can access up-to-date information on lawsuit abuse and reform.

RISK MANAGEMENT:

SECURITY OF PERSONAL HEALTH INFORMATION – RECORDS STORAGE & MANAGEMENT

By Donna Knight, Princeton Insurance Healthcare Risk Consultant

Does your practice place the security of patient personal health information in jeopardy? Through policies and procedures your practice can protect health records against loss, defacement, tampering or use by unauthorized individuals. Essential to records storage and management are procedures and staff training that address storage, access, and security of records. Health records policies should identify who had keys and training on access, security and the log-out process for records.

Secure storage can be a problem in some practices where the physical environment is an issue. The storage system and space must be adequate to protect the physical integrity of the record and prevent loss, destruction, and unauthorized use. The storage method selected is dependent on the amount of storage required and the physical environment. According to the American Health Information Management Association (AHIMA), if the office is to be in an open environment, the shelves or file cabinets must be lockable and kept locked whenever staff is not in attendance. If there is a storage room used for health record information open shelf filling can be used as long as all doors or access to the room are locked.

Storage rooms should be kept organized with adequate shelving, lighting and security. Multiple use storage rooms in which multiple staff members have access or keys must have a separate area that is caged and locked to protect the security of confidential records and documents. The storage room environment should not cause damage to the records and documents (such as moisture or rodents).

Storage areas outside of the main practice office, such as areas for inactive health records, should be locked with access limited to only those who need access. When storage boxes are used, they should not be stacked on top of each other. Boxes should be placed on shelves to facilitate easy retrieval of records and documents. Boxes should be placed off the floor and 18 inches below sprinkler heads. It is acceptable to use storage boxes, but it would be optimal to use metal files or cabinets.

Procedures should be kept in place to protect against internal security breaches. Whether paper or electronic health records are utilized, the greatest risk of sabotage comes from a practice's employees and former employees. Other policies and procedures to have in place pertain to practices with satellite offices. There should be procedures for transport, security, confidentiality, and tracking of records. In addition, special procedures that address precautions and secure storage should also be taken with regard to health records and other relevant health materials involved in litigation or potential litigation.

Records storage and management also includes policies that address record retention. It is in that best interest of your practice to retain health records in a safe and secure environment as long as possible. The practice's documented policies and procedures should outline when records can be destroyed, as well as when and where the destruction will take place. This can help avoid allegations that records were destroyed deliberately or maliciously. The policies and procedures should include:

- When the records will be destroyed (record type- length of retention)
- Where records should be stored (onsite or offsite)
- Who is responsible for deciding what keep and when to purge
- How records will be destroyed – document the process with a log that lists which records have been destroyed, when and how (shredded, pulping, or burning to preserve confidentiality).

PRIMARY CARE IN THE US

Reprinted with the expressed permission of the Medical Liability Monitor

Primary care in the US could fall apart without immediate reforms, according to the American College of Physicians. Dropping incomes coupled with difficulties juggling patients, soaring bills and policies from insurers that encourage rushed office visits mean that more primary care doctors are retiring than are graduating from medical school. The group is calling for revision to reimbursement policies of Medicare and private insurers to emphasize preventive medicine.

RENDELL VETOES JOINT & SEVERAL LIABILITY REFORM

In a stunning reversal of his 2002 campaign promise to support reform of Pennsylvania's unbalanced joint and several liability doctrine, Gov. Rendell vetoed SB 435 late last week (3/24/06). The veto brings to an end the chance of reenactment of the 2002 proportional liability law that was struck down on a technicality by Commonwealth Court last summer. It further guarantees that the system of holding any defendant in a liability lawsuit liable for 100 percent of the damages will continue. The governor's veto was a huge blow to longtime effort to bring balance and fairness to Pennsylvania's liability system. Options for an override of the governor's veto are limited and it is unclear at this point whether joint and several liability reform is dead.

Using a storage company

If a storage company is utilized for inactive health records, the practice should review their written policies on the security and safety of confidential records and documents. The written contract or agreement should outline the storage company's responsibility is securing documents and protecting documents from loss or destruction. It should also

identify how the practice will access records, the time frame for obtaining records and the process to access records in an emergency situation. The practice should maintain a list of all patient health records and other documents retained at the storage company.

How long should I retain health records?

State statute requires health records to be retained for seven year after the last patient contact, plus add two years for the statute of limitation to initiate a lawsuit. However, under some circumstances, it is possible that a lawsuit could be filed against a healthcare provider in accordance with the Federal False Claims Act up to 10 years after care is rendered and claim is submitted for payment. For this reason, it is recommended that physician offices dealing with Federal beneficiaries, such as Medicare and Medicaid, retain medical records for 10 years. In the instance of minors that sustain injuries at birth, the New Jersey Medical Malpractice Tort Reform law indicates a statute of limitations to initiate a lawsuit prior to the minors 13th birthday. Otherwise, the records of minors should be retained for 23 years (until their 21st birthday plus the statute of limitations to initiate a lawsuit which is 2 years).

The storage environment

Maintaining records in a secure environment also pertains to provisions for emergency situations. For example, records should be protected from fire through the utilization of sprinkler systems or use of noncombustible containers. Fire extinguishers and smoke detectors should be installed in all areas. A plan should be in place to deal with water damage (flood, sewage back-up, sprinkler damage, etc), fire power failures (electronic medical records and clinical information systems). If a record is damaged by water from the sprinkler system or flooding, the records may need to be processed to restore and preserve the content of the record.

There are special considerations for those practices that utilize electronic health records. As of April 2005, the final HIPAA security standards for electronic health information went into effect. The rule requires appropriate administrative, technical, and physical safeguards to protect the privacy of protected electronic health information. Once of the procedures includes policies that outline authorized and unauthorized use and access, including disciplinary actions for misuse or promotion of misuse by others; and confidentiality of passwords. Safeguards should also prevent alteration or tampering with previously entered data.

Maintaining records at home

A note of caution to physicians that utilize home computers to access patient's health information: security safeguards should be implemented on home computers as well. Instances of breaches in health information security have occurred through vulnerabilities in unsecured electronic health information systems on physician's home computers utilized by family members. Computer systems should have virus protection, firewalls and a program that limits access to another user's information. Another method of assuring security is to have a separate computer for other family members.

Whether the practice utilizes paper or electronic health records, when a practitioner retires or a group practice dissolves the healthcare provider remains liable for the security of health records. Therefore, the provider must make appropriate plans to protect the security of the information the health records contain. Security can be accomplished by identifying a location, either within the physician's residence or in an off-site locked location.

FOUR IN 10 MALPRACTICE CASES GROUNDLESS

By **ALICIA CHANG, AP Science
Writer, Wed May 10, 7:33 PM ET**

About 40 percent of the medical malpractice cases filed in the United States are groundless, according to a Harvard analysis of the hotly debated issue that pits trial lawyers against doctors, with lawmakers in the middle. Many of the lawsuits analyzed contained no evidence that a medical error was committed or that the patient suffered any injury, the researchers reported. The vast majority of those dubious cases were dismissed with no payout to the patient. However, groundless lawsuits still accounted for 15 percent of the money paid out in settlements or verdicts.

The study's lead researcher, David Studdert of the Harvard School of Public Health, said the findings challenge the view among tort reform supporters that the legal system is riddled with frivolous claims that lead to exorbitant payouts. "We found the system did reasonably well in sorting the good claims from the bad ones, but there were problems," he said. However, the American Medical Association, which favors caps on malpractice awards, called the study proof that a substantial number of meritless claims continue to slip through the cracks, "clogging the courts" and forcing doctors to waste time defending them, association board member Dr. Cecil Wilson said in a statement.

TORT REFORM IN NEW JERSEY UPDATE:

There have been several pre-filings for introduction and introduction of various bills in January and February of this year. They are in various stages of presentation. The bills include the following:

A419: Cap on noneconomic damages in medical malpractice actions arising from emergency care at \$250,000. This is no doubt a reaction to the National Report card which was published in January of 2006

A494: Provides standards for expert witnesses in medical malpractice actions against physicians;

A721: Establishes a Special Medical Malpractice Part in the Superior Court. Of note - matters to be heard by Judge without a jury.

A1083: Reduces statute of limitations for medical malpractice liability actions to four years;

A1088: Concerns medical malpractice procedures and liability. (This actually outlines how a case proceeds)

A1498: Requires payment of Medical Malpractice policy proceeds in certain circumstances; (Of note- this bill states that the legislature finds that citizens have been victims of medical practitioners who have criminally and sexually assaulted them. Citizens cannot collect damages because practitioner might be insolvent or med mal liability policy excludes coverage for criminal acts. Bill states it is "patently unjust for medical malpractice liability insurers to avoid paying damages for medical malpractice otherwise covered by their policies simply because the malpractice involved a criminal act." Legislature says this is contrary to public policy and therefore "declared to be the public policy....that in proven cases of medical malpractice in which the medical practitioner has perpetrated a criminal act upon the patient, proceeds of the malpractice liability insurance policy should be available to the injured person, and the insurer should be indemnified by the practitioner for payment to the injured person..."

A1634: Revises standards for expert witnesses in Medical Malpractice actions;

A1868: Establishes premium assistance fund and task force concerning Medical Malpractice Liability Insurance

A2424: Establishes Medical Malpractice Liability Insurance Premium Increase Review Panel in Department of Banking and Insurance;

S593: Establishes limits for certain damages in Medical Malpractice Actions;

S671: Establishes Medical Malpractice Court

S847: Caps Noneconomic damages in med mal actions arising from emergency care at \$250,000.

We'll have to wait and see the outcome.

FOUR IN 10 MALPRACTICE CASES GROUNDLESS (CONTINUED)

The findings were published in Thursday's New England Journal of Medicine. The study found 3 percent of claims analyzed were filed by patients who had no injury. Of the claims that involved injuries, two-thirds were caused by medical error. But the remaining injury claims, or 37 percent, lacked evidence of a medical mistake, and most of those — 72 percent — were thrown out or otherwise resolved without a payout to the patient.

Altogether, the Harvard researchers reviewed 1,452 malpractice claims randomly selected from five insurance companies. The cases were resolved — meaning they ended in a verdict, a settlement or a dismissal — between 1984 and 2004. The claims resulted in a combined \$449 million in verdicts and settlements. The researchers examined medical records, depositions and court transcripts to determine if the patients were injured and whether the injury was due to a medical error. In one instance, a young woman with no family history of breast cancer underwent routine breast exams for four years and came back with a clean bill of health. But doctors later found she had breast cancer that had spread to other parts of the body. The researchers determined the case did not involve medical error because proper procedures were followed. The woman filed a malpractice claim and received an undisclosed settlement. The study also confirmed that defending a claim is expensive and long, taking an average of five years to resolve. It also found that for every dollar awarded to patients, about half went to cover lawyers' fees and other expenses.

Chris Mather, a spokeswoman for the Association of Trial Lawyers for America, said the study was biased because data was taken from insurers, which sometimes are the defendants in malpractice suits. The debate over malpractice litigation simmered in Congress this week when Senate Democrats defeated a pair of Republican-backed bills aimed at limiting how much pain-and-suffering damages juries can award in malpractice cases. Similar legislation already passed the House. George Annas, a Boston University bioethicist who had no role in the study, said he was not surprised by the findings. Many personal injury attorneys receive a contingency fee — meaning they get paid only if they win — and will not go to court with a baseless lawsuit, Annas said. "There's really no motivation to bring a frivolous lawsuit," he said. "It's not worth their time and effort." Among the findings:

- An overwhelming number of malpractice claims (97 percent) involved a severe disability or death. Seventy-three percent of all of the injury claims that were due to medical error were settled with a payment.
- In about a quarter of cases where a groundless claim was settled, the average payout was lower than that given to a legitimate claim (\$313,000 versus \$521,000).