EMTALA, the ACA & Liability in the ED

Graham Billingham, MD, FACEP
Chief Medical Officer, MedPro Group

Robert Bitterman, MD, JD, FACEP
President, Bitterman Health Law Consulting Group, Inc.
Learning Objectives

This presentation will enable participants to:

• Identify current hot and/or recurring ED risk issues and provide methods to eliminate or reduce litigation risk.

• Discuss the impact of the Affordable Care Act on the application of EMTALA and on the functioning of the hospital emergency department.

• Recognize the key issues related to EMTALA that need to be included in implementation and practice.
Outline

– Lay of the land
– Malpractice trends
– ED claims trends
– Emerging risk
– EMTALA
– Q&A
May You Live In Interesting Times

VIEWPOINTS

SALLY C. PIPES | Special to The Bee

Obamacare should be defunded — now

Last week, the Obama administration’s top lawyer, acting Solicitor General Neal Katyal, asked the Supreme Court not to honor Virginia Attorney General Ken Cuccinelli’s request to fast-track his Medicaid Services — has called the “jewel in the crown” of the law. In the past, Berwick has expressed admiration for government-run, single-payer health care systems — which control costs by rationing care. America’s

New rules push hospitals, doctors to work together

By Noam N. Levey
Los Angeles Times

WASHINGTON — The Obama administration proposed new regulations Thursday to encourage doctors and hospitals to collaborate more closely to improve patient care, a major goal of the sweeping health care law the president signed last year.

“Many have known for a long time that too many Americans fail to get the best care. It doesn’t have to be this way,” said Kathleen Sebelius, secretary of Health and Human Services.

Report Slams Digital Health Records

The Obama administration took vendors of electronic health records to task for making it costly and cumbersome to share patient information and frustrating a $30 billion push to use digital records to improve quality and cut costs.

The report, by the Office of the National Coordinator for Health Information Technology, reviewed 260 electronic health records, or EHRs, sold to hospitals, doctors and health plans.

Emergency-Room Visits Keep Climbing

Those on Medicaid turn to hospital care when doctor access is limited, new survey suggests.

Seeking Care

Three-quarters of 2,000 doctors surveyed in March have recent patients in the emergency room since January 2013.

Increased poorly

Decreased slightly

Increased slightly

Emergency rooms visits continued to rise through the second quarter of 2013, according to a survey by the American College of Emergency Physicians. A survey of 2,008 emergency department doctors found that nearly half of the doctors said they had seen an increase in emergency room visits.

Medical errors can now be used as a barometer of the quality of care. A study of 1,000 hospitals across the country found that 30% of patients had a medical error in the past year. The study found that medical errors were more common in hospitals that had a higher number of patients. Many doctors don’t record medical errors because the volume has been too high, and many times patients have been discharged from the hospital.

Dr. Jane Yeh speaks at an emergency room patient at OSF Saint Francis Medical Center in Peoria, Ill.

Inspectors General. Among providers who could offer adequate care, the median number of patients was between 500 and 1,000, according to ACGME.

“We’re seeing a huge backlog in the ER because the volume has increased,” and Bay Area, at Peninsula Peninsula, for many people with serious medical problems. The report notes the primary care specialist is facing a shortage of doctors and many times patients have been discharged from the hospital.
White House Officials have said that, as a result of ACA, the health care system will evolve into one of two forms: organized around hospitals, or organized around large physician groups.

Effects of the Affordable Care Act (ACA)

- More demand
- Less access
- Reimbursement declining
- Volume to value
- Consolidation on all fronts
- Measure satisfaction
- Measure quality
- Coverage expansion
- Medicaid expansion
- Insurance exchanges
- Increased regulation
- Different ACO models
- No tort relief

“Certainty of death. Small chance of success....
What are we waiting for?”
- Gimli, Lord of the Rings
A Rocky Start for the Affordable Care Act…

50% can’t afford the premium

52 changes to the law

40% EHR dissatisfaction

huge shifts in AR

HIGH-DEDUCTIBLE PLANS

<table>
<thead>
<tr>
<th>Reasons for not enrolling</th>
<th>Survey answers included the following options:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability</td>
<td>• I could not afford to pay the premium</td>
</tr>
<tr>
<td>Technical challenges</td>
<td>• I could not effectively shop</td>
</tr>
<tr>
<td>Plan selection</td>
<td>• I could not complete purchase</td>
</tr>
<tr>
<td>Plan comprehension</td>
<td>• I could not set up user account</td>
</tr>
<tr>
<td>Still deciding</td>
<td>• I could not find a plan that met my/ my family’s needs</td>
</tr>
<tr>
<td></td>
<td>• I could not understand/calculate my subsidy</td>
</tr>
<tr>
<td></td>
<td>• I am still deciding what product to buy</td>
</tr>
</tbody>
</table>

Note: November responses not shown because “affordability” was not provided as an answer choice in that survey, preventing trended comparison.

511 ACOs Identified... ACO lives tend to be concentrated in areas with a history of managed care.

Source: Geographic Distribution of ACO Covered Lives, Leavitt Partners, December 2013
We Have a Growing Math Problem

Defensive medicine driving an estimated 8-12% of all costs

1 in every 10 severe mental illness patients

PCP to patient ratio 1:10,000

High-deductible plans = huge drop in reimbursements
(Are you going to send grandpa to collections?)

30-50 million new patients

75,000,000 baby boomers in the next decade

Prediction: Moving older, more complex patients faster through the system, ordering fewer tests and consults, and not readmitting them will drive the frequency of patient visits.

New residents doing 20% fewer procedures
Supply can’t keep up with demand...

FTE Physician Demand: Impact of ACA

Projected Supply
Projected Demand

130K shortfall


Physicians are looking for a stable job...

**Employment Rate**

- High
- Independent
- Moderate
- Low

November 2011

March 2014
Private MDs are Shrinking

> 50% of MDs Are actively seeking to retire, sell, or close practice

Physician Practice Buyers

- Health Systems & Hospitals: 52%
- Physician Owned Groups: 19%
- Solo Practitioners: 18%
- Other: 10%

AHA Trend Watch Chartbook 2013; Deloitte 2013 Survey of U.S. Physicians
Primary Care is Shifting to PAs & Nurse Practitioners

>40% of PRIMARY CARE to be provided by Physician Assistants & Nurse Practitioners

Source: Jackson Health Affairs, November 2013; Merritt Hawkins 2014 Review of Physician and Advanced Practitioner Recruiting Incentives
Transparency in healthcare will change the business model

- Medicare fees paid
- Extreme price variation
- What defines quality?
- Who owns the data?
- Patients will own their records
- Customer satisfaction
- Verizon health care expenditure is $4 billion
- Lockheed has 27 clinics
- Boeing is shopping
- Health grades
## Top Concerns in the New World Order

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Hospital CEOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Uncertainty</td>
<td>• Financial challenges</td>
</tr>
<tr>
<td>• Reimbursement</td>
<td>• Physician alignment</td>
</tr>
<tr>
<td>• Loss of control</td>
<td>• Governmental mandates</td>
</tr>
<tr>
<td>• Compliance</td>
<td>• Quality measurement</td>
</tr>
<tr>
<td>• Technology</td>
<td>• Cost reduction</td>
</tr>
<tr>
<td>• Meeting expectations</td>
<td>• Technology</td>
</tr>
<tr>
<td>• Productivity</td>
<td>• Patient engagement</td>
</tr>
<tr>
<td>• Outcomes</td>
<td>• Population health management</td>
</tr>
<tr>
<td>• Utilization</td>
<td>• ACOs</td>
</tr>
<tr>
<td>• Satisfaction</td>
<td>• Patient safety and satisfaction</td>
</tr>
<tr>
<td>• MOC</td>
<td>• Personnel shortages</td>
</tr>
</tbody>
</table>

Source: American College of Healthcare Executives, 2013
Affordable Care vs. Restricted Access

“One of the goals of PPACA was to keep healthcare insurance prices low. However, to do that, insurers are leaving some of the nation’s top hospitals out of their covered networks. This is putting some families in a bind. Zoe Newton’s family is one of them”

“Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down”

— The Washington Post (November 21, 2013)
HSH: Utilization

Chart 3.1: Inpatient Admissions in Community Hospitals, 1991 – 2011

Chart 3.12: Total Hospital Outpatient Visits in Community Hospitals, 1991 – 2011

Chart 3.7: Emergency Department Visits and Emergency Departments\(^{(1)}\) in Community Hospitals, 1991 – 2011

The healthcare system's capacity to deliver mental health services has been shrinking.

Chart 32: Total Number of Psychiatric Units\(^{(1)}\) in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals\(^{(2)}\) in U.S., 1995-2010

Source: AHA Trend Watch Chartbook 2013
Hospital Consolidation – Source: Deloitte

Figure 4. The health system landscape

<table>
<thead>
<tr>
<th>Group</th>
<th>Description</th>
<th>Number of health systems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large health systems/national chains</td>
<td>• 10+ hospitals</td>
<td>80</td>
</tr>
<tr>
<td></td>
<td>• Multi-region or multi-state footprint</td>
<td></td>
</tr>
<tr>
<td>Mid-tier health systems</td>
<td>• 2-9 hospitals</td>
<td>273</td>
</tr>
<tr>
<td></td>
<td>• Local regional/metropolitan area footprint</td>
<td></td>
</tr>
<tr>
<td>Academic Medical Centers (AMCs)</td>
<td>• Academically affiliated</td>
<td>134</td>
</tr>
<tr>
<td></td>
<td>• Independent and multi-hospital systems</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Local regional/metropolitan area footprint</td>
<td></td>
</tr>
<tr>
<td>Small community health systems</td>
<td>• Independent</td>
<td>1,346</td>
</tr>
<tr>
<td></td>
<td>• Located in urban, suburban, and rural markets</td>
<td></td>
</tr>
</tbody>
</table>

Total: Non-government health systems 1,833

Figure 2. Top three health system acquisitions since the start of 2013

<table>
<thead>
<tr>
<th>Acquirer</th>
<th>Target</th>
<th>Dollar value of deal</th>
<th>Number of hospitals acquired</th>
<th>Date announced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Systems</td>
<td>Health Management Associates (HMA)</td>
<td>$7.6 billion¹</td>
<td>71</td>
<td>July 2013</td>
</tr>
<tr>
<td>Tenet Healthcare Corporation</td>
<td>Vanguard Health Systems</td>
<td>$4.3 billion²</td>
<td>28</td>
<td>June 2013</td>
</tr>
<tr>
<td>Catholic Health Initiatives</td>
<td>St Luke’s Episcopal Health System</td>
<td>$1 billion³</td>
<td>6</td>
<td>April 2013</td>
</tr>
</tbody>
</table>

Source: Deloitte

Figure 7. Projected consolidation: Number of health systems

- 2014: 1,833
- 2024E: 926

Figure 1. Average deal size for hospital acquisitions²

- 2007: $42 million
- 2013: $224 million

Source: Kinetic Associates, The Hospital Acquisition Report 2014
HSH: Financial Health

- Hospitals expected to face more than $300B in Medicare spending cuts through 2019
- Revenue growth well below historical levels being driven primarily by growth of outpatient services.

Source: AHA Trend Watch Chartbook 2013; Deloitte Going vertical Opportunities for hospitals to embrace post-acute care, 06-2014
Hospitals: integration beyond physician practices

- Post acute care integration with acute hospitals coming soon?
- 40% of Medicare acute care patients discharged to a post-acute care setting in 2011
- With U.S. population aging, demand for post-acute care will increase.
- Post-acute providers generally have stronger Medicare Margins than acute hospitals

**Figure 1** Average Medicare margins (2011)

- Skilled nursing facility: 23.0%
- Home health agency: 14.8%
- Inpatient rehabilitation facility: 2.6%
- Long-term acute care hospital: 6.9%

* Margins for only Skilled Nursing Facilities and service lines, not long-term care service lines that may be located in the same building. Source: Medpac. Health Care Spending and the Medicare Program. June 2013.

**Figure 3** Post-acute care: Long-term care, home health & rehabilitation


Deloitte Going vertical Opportunities for hospitals to embrace post-acute care, 06-2014; PricewaterhouseCoopers Q1 2014 US health services deals insights
Integrated Systems: Is the Glass Half Full or Half Empty?

**The Good**
- Streamline care transitions
- Decreased cost
- Prevent readmissions
- Evidence-based guidelines
- Narrow practice variation
- IT resources and $
- Measure outcomes
- Measure satisfaction
- Disease management

**The Bad**
- Hub and spoke problem
- Lack of due diligence
- Credentialing
- Disenfranchised MDs
- Different EHR systems
- Takes time: 6–8 yrs.
- Coverage issues
- Contract liability
- Few winners as of yet
Recent Conversations — The Law of Unintended Consequences

- Transfers.
- Formularies.
- Lab follow-up.
- Readmission wall.
- Traditional networks.
- High-deductible plans.
- EHR — Am I responsible?
- Why do they keep calling me a provider?
- Shared savings – contractual incentives
Stable frequency & severity continues to tick up

**Industry Tailwind**
(losses stable ... rising severity offset by fewer claims)

**NPDB Paid Claims By Close Year**

- **Counts**
- **Severity**

*Paid Claims*

*Paid Average*
Medical Malpractice Premium

MPL DWP by Segment

Billions


$0 $2 $4 $6 $8 $10 $12 $14

Source: SNL Financial
Are we through the bottom of the cycle?
Medical malpractice “super losses” on the rise

• Prevalence of high verdict amounts is growing
• The percentage of total dollars spent in claims for losses of $5 million annually was in the 7.5% to 10% range in the early 2000s.
• Now, that figure has moved up into the 15% to 25% range and is expected to increase.
• Definite creep in severity in the $5 million to $10 million band.”
• “There’s a sentiment in the US of general distrust with big business, so when your community hospital that you’ve known for 30 years becomes part of a much bigger national hospital corporation, you’re no longer suing your friend,” Keith said. “You’re suing some faceless name.”
• Source: Hiscox 2014
Long Term Care Risk

- Loss rates are increasing by 5.0%
- GL/PL loss rate limited to $1 million per occurrence is $2,030 per bed.
- Frequency is increasing by 3.0%
- GL/PL frequency is 0.93 claims per 100 occupied beds.
- Severity is increasing by 2.0% annually on an overall basis.
- GL/PL severity is $218,000 per claim limited to $1 million per occurrence.
- Source: AON : General Liability and Professional Liability Actuarial Analysis, November 2014
NPDB: Countrywide allegations

Percentage of Claims by Allegation Group, 2003-2012

- Diagnosis Related: 28%
- Surgery Related: 6%
- Treatment Related: 5%
- Obstetrics Related: 8%
- Medication Related: 3%
- Anesthesia Related: 5%
- Others: 19%

Diagnosis Related: Top Allegations

- Wrong or Misdiagnosis (e.g. Original Diagnosis is Incorrect): 62%
- Failure to Diagnose: 2%
- Delay in Diagnosis: 5%
- Failure to Order Appropriate Test: 3%

Average Indemnity by Allegation Group

- Obstetrics Related: $468
- Diagnosis Related: $332
- Anesthesia Related: $330
- Treatment Related: $271
- Surgery Related: $262
- Medication Related: $259
- Others: $256

Diagnosis Related: Average Indemnity

- Improper Management: $414
- Delay in Diagnosis: $380
- Failure to Diagnose: $355
- Failure to Order Appropriate Test: $319
- Wrong or Misdiagnosis (e.g. Original Diagnosis is Incorrect): $293

• About four of every 100,000 ED visits result in an allegation of malpractice.
• 47% of ED cases allege a failure to diagnose.
• 39% of ED cases alleging a missed diagnosis cite a judgment error related to ordering a test or image.
• 41% of diagnosis-related ED cases involve inadequate assessment leading to premature discharge.
• Community hospital-based nurses are named twice as frequently in ED malpractice cases as are nurses in academic medical centers.
• Medical malpractice indemnity costs approximately $8 per ED visit.
Source: 2011 CRICO Benchmarking Report

How often do Emergency Department patients sue?

70% OF CASES CITE EMERGENCY MEDICINE AS THE PRIMARY RESPONSIBLE SERVICE

Other services frequently deemed responsible in ED-related cases:

- Radiology
- Pediatrics
- OB/Gyn
- Medicine
- Surgery
- Psychiatry

PERCENT OF CASES
Diagnostic errors are the most common—and costly—allegation in ED cases.

<table>
<thead>
<tr>
<th>TOP ALLEGATIONS</th>
<th>CASES FILED</th>
<th>INDEMNITY INCURRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>MISSED OR DELAYED DIAGNOSIS</td>
<td>47%</td>
<td>62%</td>
</tr>
<tr>
<td>MANAGEMENT OF MEDICAL TREATMENT</td>
<td>28%</td>
<td>24%</td>
</tr>
<tr>
<td>MEDICATION-RELATED</td>
<td>7%</td>
<td>4%</td>
</tr>
<tr>
<td>SAFETY OR SECURITY</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>SURGICAL TREATMENT</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**Top Final Diagnoses in ED Cases**

<table>
<thead>
<tr>
<th></th>
<th>PERCENT OF CASES</th>
<th>AVERAGE INDEMNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORTHOPEDIC INJURIES</td>
<td>14%</td>
<td>$150K</td>
</tr>
<tr>
<td>STROKE</td>
<td>9%</td>
<td>$550K</td>
</tr>
<tr>
<td>ANEURYSM, EMBOLISM, THROMBOSIS</td>
<td>8%</td>
<td>$500K</td>
</tr>
<tr>
<td>MYOCARDIAL INFARCTION</td>
<td>7%</td>
<td>$600K</td>
</tr>
<tr>
<td>INFECTIONS</td>
<td>7%</td>
<td>$910K</td>
</tr>
</tbody>
</table>

Blood, skin, neurological, respiratory

Source: 2011 CRICO Benchmarking Report
Emergency medicine: Claims frequency & indemnity by allegation type

**Claim volume by allegation type**
- Diagnosis Related: 64%
- Medical Treatment: 22%
- Medication Related: 6%
- Other: 8%

**Indemnity dollars by allegation type**
- Diagnosis Related: 84%
- Medical Treatment: 9%
- Medication Related: 4%
- Other: 3%

*Diagnostic-related allegations* account for over half of all claims and more than three-fourths of all payments.

Source: MedPro’s coded claims data, 2001-2010
No single diagnosis accounts for more than 10% of either claims frequency or total dollars paid. However, failure to diagnose MI, CVA, aortic aneurysm, and intracranial bleeds together account for 25% of claims.

Source: MedPro’s coded claims data, 2001-2010
Contributing factors are broad areas of concern that may have contributed to allegations, injuries, or initiation of claims. These factors reflect issues that may be amenable to loss-prevention strategies. A claim may have several contributing factors identified, or none.

Source: MedPro’s coded claims data, 2001-2010
<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td>96,454</td>
<td>7,791</td>
</tr>
<tr>
<td>Paid</td>
<td>25,223</td>
<td>2,078</td>
</tr>
<tr>
<td>Paid %</td>
<td>26%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Total</td>
<td>$ 8.2 billion</td>
<td>$ 542 million</td>
</tr>
<tr>
<td>Ave.</td>
<td>$ 325,919</td>
<td>$ 260,960</td>
</tr>
<tr>
<td>Median</td>
<td>$ 200,000</td>
<td>$ 157,046</td>
</tr>
<tr>
<td>Largest</td>
<td>$ 13 million</td>
<td>$ 3 million</td>
</tr>
</tbody>
</table>

Source: PIAA DSP 2003-2012
How do we compare?

Figure 4. COMPARISON OF AVERAGE INDEMNITY PAYMENTS BY MEDICAL SPECIALTY (2003-2012) - 2012 DOLLARS -
Source: PIAA - Expense and Indemnity

Figure 6. AVERAGE PAYMENTS BY CLOSE YEAR FOR EMERGENCY MEDICINE CLAIMS (1988-2012) - 2012 DOLLARS -

<table>
<thead>
<tr>
<th>Year</th>
<th>Indemnity</th>
<th>Expenses</th>
<th>% Paid-to-Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988-1992</td>
<td>$221,401</td>
<td>$18,991</td>
<td></td>
</tr>
<tr>
<td>1993-1997</td>
<td>$274,836</td>
<td>$21,880</td>
<td></td>
</tr>
<tr>
<td>1998-2002</td>
<td>$298,191</td>
<td>$32,204</td>
<td></td>
</tr>
<tr>
<td>2003-2007</td>
<td>$366,675</td>
<td>$35,247</td>
<td></td>
</tr>
<tr>
<td>2008-2012</td>
<td>$361,647</td>
<td>$53,268</td>
<td></td>
</tr>
</tbody>
</table>
PIAA ED claims trends over 10 years

- Frequency = 4% of all closed claims
- Severity = 4% of total indemnity paid
- Ranks 8th out of 28 specialties
- 2007 ave. = $401,401  2012 ave. = $313,991
- In 2012 ave. expense $60k (closed); $80K (paid)
- 43% diagnostic error; 74% of total indemnity
- Dx: Chest pain, abdomen, pelvis, back, soft tissue
- 2012 – chest pain – ave. $679,042
- 29% of ED MDs had previous claims
- In 38% of claims the patient expired = 46% of total indemnity
- Top 10 presenting complaint in 2012 – chest pain, abd/pelvis, AMI, meningitis, pneumonia, back, multiple trauma, headache, N/V, respiratory arrest
- Others: delay in dx or rx, failure to supervise, medication error, procedures, consultation
Specific areas for review

Data security  Electronic communication  Electronic health records

Telemedicine  New technologies
EHR Liability: Is Metadata the Next Asbestosis?

- Time synchronization
- Audit trails/metadata
- Medical guidelines and best practices are not updated
- Alert fatigue/overload
- Too many “normal” indicators
- Abnormal areas are incorrectly documented
- Usable information is harder to find
- Document events before they actually occur
- Data entered for the wrong patient
Incorrect information in the EHR was a factor in 20%

- **Faulty data entry**: A patient’s height is 60 inches but is recorded as 60 centimeters, which distorts her body mass index (BMI).
- **Unexpected conversion**: The data is entered correctly, but the computer auto-converts it without the user noticing. For example, 2.5 changes to 25, which becomes a medication error when a clinician acts on the higher number.
- **Wrong file or field**: A user accidentally opens up the wrong patient file and orders medication or records vital signs for someone else. As Sato explains, “Because of the way EHRs are designed, you can get lost easily and enter information in an incorrect field or for an incorrect patient without realizing it.”
- **Repeated errors**: Mistakes in a patient record persist for years without being caught.
- CRICO
Role of the EHR in patient safety events

- 3,099 reports related to EHR
- 10% classified as “unsafe” condition
- 15 reports in “temporary” harm
  - Entering wrong medication data
  - Administering the wrong medication
  - Ignoring a documented allergy
  - Failure to enter lab tests
  - Failure to document an allergy

Medication related errors are the most commonly identified EHR errors

Major Allegations

- Medication-related
- Diagnosis-related
- Medical Tx
- Surgical Tx
- OB-related Tx
- Communication
- Breach of Confidentiality
- Pt. Monitoring
- Violation of Rights
- Anesthesia-related Tx

N=147 PL cases with an EHR-related contributing factor.
Total incurred includes reserves on open and payments on closed cases.
## Ambulatory setting dominates EHR cases

### Patient Type and Top Locations

<table>
<thead>
<tr>
<th>PATIENT TYPE</th>
<th>% OF CASES</th>
<th>% OF TOTAL INCURRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory</td>
<td>56%</td>
<td>46%</td>
</tr>
<tr>
<td>Inpatient</td>
<td>31%</td>
<td>39%</td>
</tr>
<tr>
<td>ED</td>
<td>13%</td>
<td>16%</td>
</tr>
</tbody>
</table>

### Ambulatory Locations

<table>
<thead>
<tr>
<th>AMBULATORY LOCATIONS</th>
<th># CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hosp clinic/MD office</td>
<td>56</td>
</tr>
<tr>
<td>Ambulatory/day surgery</td>
<td>9</td>
</tr>
<tr>
<td>Radiology</td>
<td>4</td>
</tr>
<tr>
<td>Physical med/rehab</td>
<td>2</td>
</tr>
<tr>
<td>Imaging</td>
<td>2</td>
</tr>
</tbody>
</table>

### Inpatient Locations

<table>
<thead>
<tr>
<th>INPATIENT LOCATIONS</th>
<th># CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s room</td>
<td>15</td>
</tr>
<tr>
<td>Labor &amp; delivery</td>
<td>9</td>
</tr>
<tr>
<td>Operating room</td>
<td>7</td>
</tr>
<tr>
<td>ICU (SICU, MICU, CCU)</td>
<td>5</td>
</tr>
<tr>
<td>Inpatient</td>
<td>4</td>
</tr>
</tbody>
</table>

### ED Locations

<table>
<thead>
<tr>
<th>ED LOCATIONS</th>
<th># CASES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>18</td>
</tr>
<tr>
<td>Offsite ED</td>
<td>1</td>
</tr>
</tbody>
</table>

N=147 PL cases with an EHR-related contributing factor.

Total incurred includes reserves on open and payments on closed cases.
EHR errors — By clinical severity outcome

Half of the EHR cases resulted in high injury severity

Injury Severity

PERCENT OF CASES

- High: 50%
- Medium: 38%
- Low: 12%

PERCENT OF TOTAL INCURRED

- High: 86%
- Medium: 14%
- Low: 0%

N=147 PL cases with an EHR-related contributing factor.

Total incurred includes reserves on open and payments on closed cases.

Severity Scale:
- High = Death, Permanent Grave, Permanent Major, or Permanent Significant
- Medium = Permanent Minor, Temporary Major, or Temporary Minor
- Low = Temporary Insignificant, Emotional Only, or Legal Issue Only
Source: PIAA – EHR Litigation Data

- 53% of the participants have already seen EHR-related claims.
- The top trends:
  - cut-and-paste practices
  - failure to review additional electronic records
  - failure to interface with other systems
  - allegations of HIPAA violations.
- Templates used by an EHR
  - too generic
  - not intuitive to use
  - over-reliance on the system
Alert fatigue and “work-around” dangers

The volume of alerts and notifications — such as allergies, medication interactions, reminders regarding vaccinations and immunizations — and the fact that many of them do not apply to every patient, may cause the provider to ignore them or “wo
<table>
<thead>
<tr>
<th>Time</th>
<th>Admission Code</th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:40</td>
<td>LUN</td>
<td>2355</td>
<td>Cal</td>
<td>28</td>
<td>Neuro Problem</td>
<td>S/P Assault</td>
<td>EKG Admit</td>
</tr>
<tr>
<td>05:00</td>
<td>Bis</td>
<td>94</td>
<td>GlA</td>
<td>38</td>
<td>Syncope</td>
<td>D OUT</td>
<td>Pelvic</td>
</tr>
<tr>
<td>21:15</td>
<td>Che</td>
<td>426</td>
<td>Abd</td>
<td>43</td>
<td>Abdominal Pain</td>
<td>Split Zone</td>
<td></td>
</tr>
<tr>
<td>08:55</td>
<td>B10</td>
<td>111</td>
<td>Vic</td>
<td>422</td>
<td>Bloody Stool ORSA</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>10:40</td>
<td>ODE</td>
<td>377</td>
<td>Bike Acc</td>
<td>53A</td>
<td>IVC</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>11:40</td>
<td>Roy</td>
<td>113</td>
<td>4DL</td>
<td>16</td>
<td>Hematuria</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>07:30</td>
<td>Lun</td>
<td>225</td>
<td>Hip Pain</td>
<td>89A</td>
<td>PNA</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>07:50</td>
<td>Lun</td>
<td>225</td>
<td>Lupus</td>
<td>89A</td>
<td>MSA's HR 133</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Complaint</td>
<td>MD</td>
<td>RN</td>
<td>PMD</td>
<td>Orders</td>
<td>Done</td>
<td>Dispo</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------------------------</td>
<td>-------------</td>
<td>----</td>
<td>-------------</td>
<td>--------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>F50</td>
<td>BG 88/75 1/2 amp d50 given per EMS</td>
<td>+++ (MO01) ++</td>
<td>AL03</td>
<td>Gagnier Richard</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>M44</td>
<td>palpitations</td>
<td>+++ (MO01) ++</td>
<td>AL03</td>
<td></td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>+++ (NK01) ++</td>
<td>VF01</td>
<td></td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F52</td>
<td>DKA</td>
<td>+++ (LT02) ++</td>
<td>+++</td>
<td>Ghosh Shantonu</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F76</td>
<td>Shortness Of Breath</td>
<td>+++ (LT02) ++</td>
<td>+++</td>
<td></td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F58</td>
<td>mvc</td>
<td>+++ (LT02) ++</td>
<td>+++</td>
<td></td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F83</td>
<td>Abdominal Pain, Side Pain</td>
<td>FZ01 (UN01) ++</td>
<td>KK01</td>
<td>Morris Geoffrey</td>
<td>CD*</td>
<td>DV</td>
<td>FULL</td>
</tr>
<tr>
<td>M40</td>
<td>Chest Pain</td>
<td>FZ01 (UN01) ++</td>
<td>KK01</td>
<td>Grable John</td>
<td>*</td>
<td>V</td>
<td>734</td>
</tr>
<tr>
<td>M62</td>
<td>Mva</td>
<td>FZ01 (ZH01) ++</td>
<td>CG01</td>
<td>Sawant Kalpana</td>
<td>*</td>
<td>D</td>
<td>328</td>
</tr>
<tr>
<td>M84</td>
<td>Shortness Of Breath</td>
<td>FZ01 (UN01) ++</td>
<td>AL03</td>
<td>Wegman Susan</td>
<td>*</td>
<td>V</td>
<td>OBSV</td>
</tr>
<tr>
<td>M50</td>
<td>no feeling in R arm</td>
<td>FZ01 (UN01) ++</td>
<td>SP01</td>
<td>Botelho Richard</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>M40</td>
<td>R/O SHUNT PROBLEM</td>
<td>FZ01 (UN01) ++</td>
<td>VF01</td>
<td>Payyapilli Thomas</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>M47</td>
<td>Blackout (Fainting, Syncope)</td>
<td>FZ01 (JG01) ++</td>
<td>VF01</td>
<td>Allen Jeffrey</td>
<td>*</td>
<td>V</td>
<td>OBSV</td>
</tr>
<tr>
<td>M49</td>
<td>low BG</td>
<td>FZ01 (UN01) ++</td>
<td>AL03</td>
<td>Glazer Gary</td>
<td>*</td>
<td>V</td>
<td>DCRN</td>
</tr>
<tr>
<td>F84</td>
<td>Falls, pt. doesnt recall events</td>
<td>FZ01 (NK01) ++</td>
<td>JZ01</td>
<td>Courtsal Charles</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F92</td>
<td>N, V</td>
<td>FZ01 (NK01) ++</td>
<td>JZ01</td>
<td>Akowuah Emmanuel</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F43</td>
<td>etoh/ drug withdrawal</td>
<td>FZ01 (MO01) ++</td>
<td>VF01</td>
<td>Pierce Deborah</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F72</td>
<td>NEW CONFUSION</td>
<td>FZ01 (MO01) ++</td>
<td>KK01</td>
<td>Peterson Kimberly</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>F44</td>
<td>Chest Pain</td>
<td>FZ01 (UN01) ++</td>
<td>+++</td>
<td>Grable John</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>M56</td>
<td>S/P LIVER TX, FEVER</td>
<td>ER01 (UN01) ++</td>
<td>JZ01</td>
<td>Clifford David</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
<tr>
<td>M41</td>
<td>SAH</td>
<td>ER01 (ZH01) ++</td>
<td>CG01</td>
<td>John Thompson</td>
<td>*</td>
<td>V</td>
<td></td>
</tr>
</tbody>
</table>
Final Case: Monitor

- 74 year old woman in ED for syncope
- Workup negative
- Admitted for monitoring
- Hospital full (becomes a “boarder”)
- Remains on bedside monitor w/telemetry
- 3:30am- blood drawn, patient fine
- 5:30am....
Why talk about data security?

- Stolen health information is more valuable than stolen social security numbers.
- Increasing numbers of healthcare providers are reporting privacy breaches.
- Growing automation and adoption of EHRs exacerbates the risk of privacy breaches.
Handheld and mobile devices: Risk

• One laptop is stolen every 53 seconds.
• 70 million smartphones are lost each year.
• 4.3% of smartphones issued to employees are lost.
• 52% of devices are stolen from the workplace.
• Types of threats include:
  o Data breach
  o Loss of intellectual property and trade secrets
  o Loss of personal information
  o Mobile malware
  o Web-based threats

Advisen Ltd. (August 2012). The liability of handheld and mobile devices.
Three-fourths of all cases related to cyber liability/privacy issues arise out of breach of confidentiality (disclosure of personal health information) or theft of patient records (either paper or electronic). Breach of contract/warranty cases involve failure of vendors to provide protection against “hacking” into system servers.

The “Other” category includes unique scenarios, such as stealing of patient lists for new business, attaching incorrect patient identification to billing records, etc.
Social media

• Email
• Texting
• Facebook: “friending”
• Twitter
• YouTube
• LinkedIn
• Google: public search
• Blogs
• Wall posting
Physicians selectively use social media

- 25% use social media daily.
- 6.8% use Twitter.
- 52% use online physician-only communities such as Sermo, Ozmosis, medical society membership sites, and Medscape Physician Connect.

What about online reviews of your practice?

Options to consider:

– Do nothing.

– Ask the webmaster to remove the post.

– Do NOT engage in an online debate!

– If you do respond, do not respond to online comments. It’s okay to script language to indicate you are committed to providing excellent patient care and encourage anyone with concerns to contact your office directly.
Risk of board investigation

Study published January 15, 2013, in the *Annals of Internal Medicine*:

– Surveyed 70 state medical and osteopathic boards.

– Participants assessed hypothetical vignettes of online physician behavior.

– Asked to classify each — likelihood of triggering an investigation, possible sanctions, etc.

# Investigation likely — High consensus

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Issue Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81%</td>
<td>Misleading information about clinical outcomes</td>
</tr>
<tr>
<td>79%</td>
<td>Using patient images without consent</td>
</tr>
<tr>
<td>77%</td>
<td>Misrepresenting credentials</td>
</tr>
<tr>
<td>77%</td>
<td>Inappropriately contacting patients</td>
</tr>
</tbody>
</table>
Investigation likely — Moderate consensus

73%
Depicting alcohol intoxication

65%
Violating patient confidentiality

60%
Using discriminatory speech
Investigation likely — Low consensus

46%
Derogatory speech toward patients

40%
Showing alcohol use without intoxication

16%
Providing clinical narratives without violation of confidentiality
Email checklist

Do you have a signed release and acknowledgement from the patient that includes:

- Requirement that for emergent or urgent concerns, communication will be via phone or in person?
- Notice of the provider’s right to refuse to make decisions or conclusions based on information obtained online?
- Notice that email communication is retained in the patient’s healthcare record?
- Notice that the patient has read and accepted the practice’s “online patient policies,” which include hold harmless language and terms of use?
- Email server encryption requirements, and a waiver if patients opt not to use an encrypted service?
## Case study — Texting

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Academic medical center used smartphones to enter orders.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case Overview</strong></td>
<td>Resident was in the process of discontinuing warfarin; at the same time, she received a party invitation via text message. The disruption caused her to forget to discontinue the medication.</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>Three days later, the patient had a bleeding crisis that required surgery.</td>
</tr>
<tr>
<td><strong>Key Issue</strong></td>
<td>Did personal use of mobile technology cause the distraction, which resulted in the adverse outcome?</td>
</tr>
</tbody>
</table>
Patient Portals

• Secure online website giving patients 24-hour access to PHI, including:
  o Prescription requests
  o Discharge summaries
  o Diagnostic test results
• Terms of use should be clear
• Access should be via encrypted, password-protected login process
• EHR audit trail should be utilized — validate who accessed patients’ records and when
• Goal should be to enhance provider–patient communication and to improve patient outcomes

http://healthit.gov/providers-professionals/faqs/what-patient-portal
Telemedicine becomes the norm

- State laws
- Medical boards
- Reimbursement issues
- Dermatology
- Radiology
- Psychiatry
- Emergency medicine
- Critical access hospitals
- Intensive care units
- International
- Military
- 30% of future visits
State licensing board regulations

- State regulations vary; some states address telemedicine directly, others indirectly, and some not at all.

- In the absence of direct or indirect guidance, doctors can assume that they likely need a license in the state where the patient is located.

  - Even doctors practicing within one state may need a special telemedicine license or permit, depending on state law.
Credentialing

• CMS regulations, The Joint Commission
• Credentialing by proxy
• Requirements
• Ensure that providers at distant sites are legally allowed to provide services to the originating site’s patients
Online prescribing

• Provider–patient relationship
• Adequate physical exam
• Accuracy of patient history
• State licensing board requirements
• Federal regulations
• Majority of legal actions that have been brought against telehealth providers are related to online prescribing
Emerging Risks

Is Metadata the Next Asbestosis?

New Standards for E-Discovery Shortfalls

APP scope

Social Media
Emerging Risks — Where Is the Puck Going?

- Telemedicine
- Social media
- Retail medicine
- International medmal
- APPs scope of practice
- Genetic testing
- EMR and metadata
- Infectious diseases
- New technology
- Cyber liability
- Choosing wisely
- Big data
- LEP
Changing Role: Employed Physician Risk

- Scope of practice
- Entrepreneurs
- Sunshine Act
- EPL, D&O, E&O
- HIPAA breach
- STARK law provisions
- Contract liability
- Referral network
- Due diligence
- Standards of care
- Follow-up liability
- Best practice guidelines
- Resident training
- Supervision — APPs
- Medication risk
- Social media
Take Home Lessons

- Employment doesn’t equal alignment
- Coverage doesn’t equal access
- Consolidation doesn’t equal coordination
- Shared savings doesn’t equal shared risk
- Plaintiff's bar is being more selective
- The market is soft and there is lots of capacity
- Severity continues to tick up
- However, there is a lot of pressure on frequency
- A small change in frequency will drive a lot of rate
- Nursing home severity will rise
- Hospital closures will climb
- This will take a decade to sort out
- It will never return to the way it was because the revenue model has changed and the younger providers will seek employment and work/life balance
EMTALA, the ACA, and Liability in the ED

Robert A. Bitterman, MD, JD, FACEP
Objectives

• Recognize risk of regulatory and civil liability in the ED; theme = delay of care
• Learn how regulations & ‘failure to follow your own rules’ establish liability
• Establish bright lines of responsibility
• Avoid grief
"I need a long rest? I just had one in your waiting room!"
Liability for Patients Waiting to be Seen

• Delay in triage
• Triage = new hot bed of litigation
• Adverse public relations
• Deaths in the ED waiting room
• Lack of sense of urgency
• Appreciate risks of triage
Failure to Adequately Triage

- Quality of nurses at triage – sick patients
- Training, experience, education
- Interpersonal / communication skills
- Advanced training in key areas
- ‘Brightest and the Nicest’
"Okay, you be the new, inexperienced intern, and I'll be the old nurse who tells you what to do, okay?"
Failure to Reassess Patients

• Abandoned in the waiting room
• Reassess when, how, where, why?
• Repeat vital signs how often?
• Guidelines vs. ‘mandatory’
• EMTALA vs. standard of care
Delay Due to Registration Process or Insurance Issues

- ‘Reasonable registration processes’
- No prior authorization
- Ask about insurance/co-pays
- Not delay access to MSE
- Not ‘unduly discourage’
Registration Recommendations

• Create parallel tracks
• Blind staff to insurance
• Use bedside registration
• Process - P & P
• Educate everyone
Delay in Evaluating EMS Patients

• Ignore EMS patients until ‘accepted’?
• CMS memos – obligation upon arrival
• Can still ask EMS to help, but must triage ‘immediately’ and ensure EMS capable of monitoring patient’s condition
Delay Due to EMS Diversion

• Arrington case – 9th Circuit
• Morales case – 1st Circuit
• Codified in CMS’s definition of ‘comes to the ED’
• Additional civil litigation
Delay of Medical Screening Exam

- Appropriate MSE means ‘prompt’?
- Constructive denial of ‘federal right’
- Scruggs case in VA
- Rockford PEDS case in IL
- FTFOR – FL, NJ, P&P
Delay of MSE in Minors

- Consent is a creature of state law
- Federal law preempts state law
- EMTALA controls intake of minors
- Never delay care of a minor
Miscellaneous Delays of MSE

- Disasters and epidemics, Ebola
- VIPs / private patients
- Chronic pain patients / drug seekers
- Police blood alcohols
- ‘Scheduled’ ED visits
Midlevel Providers in the ED

- ‘Qualified medical personnel’ - MSE
- Supervision issues
- FTFOR – policies and procedures
- Define role and set expectations
- Provide on-call services?
- EMTALA transfers
Failure to Follow Hospital Policy and Procedure

• Growing area of liability
• Scruggs case, Florida AAA case
• St. Joseph’s Hospital case in CA
• Repeat vital signs in ED or at discharge
• MSE QMP – PA vs. MD
• Chest pain protocols, etc ...
Hospital offers ER guarantee

Oakwood patients treated in 30 minutes or get movie passes.

By Mike Hudson

DEARBORN — Oakwood Hospital's emergency room is taking a page from the old Domino's Pizza marketing playbook: It is guaranteeing service within 30 minutes.

And if the doctor is late, you'll be treated to an apology — and free movie passes.

The unusual move is the latest marketing ploy in a fiercely competitive medical care market. Oakwood is advertising the guarantee on two billboards and in 60,000 fliers mailed to area residents.

The program, which will be extended to other Oakwood hospitals, is in response to long waits for emergency care.

"Twelve months ago we got a wake-up call from our customers saying they were waiting too long," said Corinne Victor, Oakwood's emergency services administrator. "They want to see a doctor, get treated and go home."

The guarantee won't compromise quality of care, officials say. Those most urgently in need of care will still be seen immediately.
Liability for Patients Who Leave

• LBE / LWBE / Elope
• AMA
• CMS’s warning
• Public relations issues
Left Before Exam - LBE’s

- Quality indicator
- Risk indicator
- Long waits breed hostility
- Hostility breeds lawsuits
Patients Who LBE or Elope

• Vital signs and triage data
• Evaluate charts in real time
• Lab or x-ray data review & communication
• EMTALA issue – denial of federal right and burden of proof
• System & documentation to avoid liability
Patients Who Leave AMA

- Failed relationship
- Communication skill
- Address the problem
- ‘Negotiate’ - bargain for time
- Involve the family, friends, dog
Patients Who Leave AMA

• EMTALA controls emergent cases
• Failure to obtain an ‘informed refusal’
• Competence / risks and benefits
• Physician involvement required
• Documentation critical
Against Medical Advice

• Process v. signature
• Alternative treatments
• Do not punish
• Welcome back
• Call back system
Liability for Patients Waiting for Admission

• Failure to monitor the patient
• Failure or delay in utilizing the ‘full resources’ of the hospital: CT, antibiotics, on-call physician consults
• Failure to admit to correct unit
• Failure of handoff/communication between EPs and admitting physician
Liability for Patients Waiting for Transfer

• Failure of on-call physicians to respond
• Failure to transfer promptly / appropriately
• Failure to reassess / stabilize at the time of transfer
• Failure of handoffs between EPs
Psychiatric Patients Waiting for Transfer

- Use of county mental health teams
- Role of on-call psychiatrist
- Ongoing care in the ED
- Review of old records, recent admissions
- Security, restraints, elopement issues
Psychiatric Patients Waiting for Transfer

• Handoffs between EPs
• Failure to reassess at time of transfer
• Voluntary vs. involuntary commitment
• Transfer documents / methodology
On-Call Physician Delay of Care

• EMTALA is the hospital’s on-call policy
• Hospital duty - hospital liability
• On-call physicians represent the hospital, not their private practice
• Agency issues
Too Busy to Respond?

• Office packed - too bad?
• Elective surgery - unacceptable?
• Emergency procedure - no problem
• Simultaneously on-call elsewhere?
Respond Within a ‘Reasonable Time’

- What is a ‘reasonable time’?
- Written down – in minutes?
- Phone response v. physical presence
- Who decides what’s reasonable?
On-Call System

- Method/structure irrelevant
- Resolution and unavailability P&P
- Written in medical staff R&R
- Response times enforced
Delay in ED Follow-Up Care

- EMTALA applies?
- Limit contractual duty
- Define duties of on-call physicians
- Board/medical staff commitment
- ED back-up system
Failure of On-Call System

• Hospital directly liable
• CMS terminates hospital
• OIG fines hospital and physician
• Patient sues hospital
• Hospital sues physician
Accepting Transfers

• Non-discrimination clause (g)
• Prohibits ‘reverse dumping’
• Amendment to the law
Accepting Hospitals

• What must accept?
• When can refuse?
• Murky legal mumbo jumbo
Accepting Transfers

• Hospital duty and liability
• Delegated to whom?
• Delay = ‘constructive denial’
• CMS / OIG – ‘responsible physician’
Transfer Acceptance System

- Need method/structure
- Use a ‘transfer center’ v. direct calls to the on-call physicians
- Role of the parties involved
- Represent hospital v. private practice
Transfer Acceptance System

• Documentation - form
• Record conversations?
• Educate everyone on acceptance team
When Must Accept Transfer

• Duty vs. option to accept
• Medically indicated transfers
• ‘Specialized capabilities or facilities’
• ‘Capacity’ – as defined by law
• ‘Appropriate transfers’
Specialized Capabilities or Facilities

• Undefined
• ‘You got it; they don’t.’
• Food chain analogy v. specialty hospital
• Affiliated hospital issues
Capacity

- Defined by CMS regulations
- ED closed to EMS?
- Can you ‘save’ an ICU bed?
- Trauma/specialty center exception?
- Potential capacity pitfall
Appropriate Transfers

- Undefined
- Condition of the patient
- Emergency medical conditions
- Must the patient be unstable?
Contingencies Not Allowed

- Pay for transfer or care
- Agree to take patient back
- Only if use our helicopter
- Mandate on-call consult before accept
- Obtain insurance authorization
No Territorial Safe Harbors

• Out of county or out of state
• Outside our referral area
• Skipped over closer hospital
• Outside boundaries of United States
• ‘I’m not on-call for your hospital.’
• ‘On-call’ for the USA?
Accepting Transfers

- Economics irrelevant
- Citizenship irrelevant
- Veteran status irrelevant
- Out-of-network irrelevant
- Physician not on staff irrelevant
- When ask about insurance?
Refusing Transfers

• Patient requested transfers
• Lateral transfers
• No ‘capacity’ or ‘capability’
• Not an ‘appropriate transfer’
• ‘Too encumbered’ to accept transfer?
• Documentation - form
Accept Inpatient Transfers?

- Controversial - even after CMS regs
- CMS sanctioned economic discrimination?
- Nondiscrimination clause
- Independent duty of accepting hospital?
- Want to be the test case at trial?
Accept Inpatient Transfers?

• CMS assumes/asks hospitals to accept inpatients in transfer ... but what about physicians?
• 6th Circuit Moses case ramifications
• Statutory interpretation
• Original intent
Definition of Inpatient

- Admitted for bed occupancy
- Inpatient hospital services
- Overnight stay expected
- Even if doesn’t happen
- Formally admitted
‘Inpatient’ Transfers Gamesmanship

• Legal definition of ‘inpatient’
• ‘Observation’ is not admission
• Park in ED or in ‘obs’ status
• On-call doc refuses to ‘admit’
Inpatients in DED

- Inpatient status, boarded in DED
- Direct admits via DED
- Not private patients in DED
- Not ‘observation’ patients
Accepting Hospital Actions

• Define capabilities
• Educate senders
• Educate acceptors
• Prearrange transfer agreements
• Monitor the system
LIFE, LIBERTY, PURSUIT OF HAPPINESS & BIG DAMAGE AWARDS
‘ED Was Too Crowded’ Defense

• System overload / physician overwhelmed
• Totality of the circumstances
• EMTALA mandate – no ability to control volume
• Jury not often sympathetic
How to Avoid Liability Due to Delay

• Communicate to patients and families
• Nurses with best clinical, interpersonal, & problem-solving skills in triage
• More frequent reassessments - and documented
• Recognize common pitfalls
Avoid Liability

• Bright lines of responsibility and liability
• Written and backed by leadership
• Policy and Procedure diligence
• Solve the problem
“Defer not time, 
Delays have dangerous ends.”
Questions?
Thank You

Robert A. Bitterman, MD, JD, FACEP
robertbitterman@gmail.com

Graham Billingham, MD, FACEP
Graham.Billingham@medpro.com