The Keyboard is (also) Mightier than the Sword

BY BO THOMPSON, JR., YATES, McLAMB & WEYHER, L.L.P.

Defending healthcare providers against claims of medical malpractice is a dynamic, but very rewarding endeavor. Staying current with changes in the delivery of health care to patients is one challenge. Understanding broader cultural trends, which have created new sources of evidence that may help or hurt our ability to defend cases, is equally as challenging. The marked increase in patients’ use of electronic devices to transmit real-time updates about their interactions with the healthcare system to family, friends and co-workers is a recent cultural phenomenon that falls into this second category. For the reasons summarized below, physicians and their practices need to be aware of the pervasive trend of generating “statements” about patient care electronically. The fundamental reason we all need to understand the sources of, and manage the creation of electronic statements made about patient care, is because these electronic statements can be used in court just like hard copy writings or scribbled handwritten notes can be used as trial evidence.

From the healthcare providers’ perspective, despite a moderate increase in the use of computerized medical records, most providers’ written “footprints” about patient care have remained roughly the same as in the record still kept by hand. In any given chart, whether electronic or paper, we still expect to see the same basic statements about a patient as we have in the past—progress notes, physician orders, nurses’ notes, and radiology and consultation reports. One reason that the overall volume of providers’ statements about patient care has not substantially increased is because patient privacy regulations severely restrict providers’ ability to generate statements about patient care, particularly if such statements are not created in or routed directly to the patient’s office or hospital chart. Most providers do not create content relative to their care of patients outside of the patient’s chart, unless they engage in ancillary communications over the internet—“blogging,” “twittering,” e-mailing, etc.

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From the patients’ perspective, the reality is completely different. Patients have, historically, had no chart in which to record and memorialize their own thoughts and impressions about the care in issue. This has changed as patients’ take advantage of newly-developed technology designed to help people communicate all kinds of information quickly and with relatively little expense (e-mails, text messages, blog postings, etc.). Thus, patients’ “footprints,” with respect to statements made about health care, have expanded exponentially in the past couple of years. Importantly, patients are not bound by rigorous confidentiality constraints. Confidentiality is, typically, the patient’s privilege to keep or to waive. This freedom, coupled with rapidly expanding access to the internet at home, in the hospital, at local internet cafes, and on personal communication devices (Blackberries, for example), gives patients the ability to generate statements about their health care experience. Patients and their families are unquestionably taking advantage of the technology.

As suggested above, a significant number of people today are connected in real time by e-mail and internet information sources. When a loved one or close friend faces serious health problems, whether inpatient or outpatient, people appear very willing to trade a personal phone call for more frequent, electronic updates on how the patient is getting along—all transferred over the internet. Recipients of these electronic updates tacitly or expressly acknowledge that drafting one e-mail addressed to multiple recipients reduces avoidable stress on the patient and/or the designated messenger by eliminating the need to verbally repeat complicated and emotionally draining medical details over the phone to dozens of family and friends. Most frequently, the communication is in the form of a mass e-mail, though lately we have seen hospital and non-profit websites serving as an organized information hub allowing patients to post frequent updates to those who wish to follow a particular patient’s course (Caring Bridge is but one example). Although I am absolutely not predicting the demise of the ultra-sacred physician-patient confidentiality privilege, it appears the taboo of sharing personal medical information with close family and friends is waning when it comes to publishing these electronic updates.

From a litigation standpoint, this rapid explosion of electronic statements generated by patients has to be taken seriously. Statements made by patients contemporaneously with the delivery of the health care often directly relate to hotly disputed issues once litigation commences including:

1. The patient’s version of the sequence of events leading to direct contact with the healthcare system;
2. The patient’s rationale for choosing one provider or facility over others;
3. The planning, execution, interpretation and follow up of initial examinations, diagnostic tests and studies;
4. The provider’s proposed treatment options after diagnosis including, necessarily, the patient’s interpretation of the informed consent discussions;
5. The patient’s understanding of the success or failure of procedures after execution, including detailed explanations given by the provider or others in the healthcare system for the perceived success or failure;
6. Statements made by healthcare providers at every level about the patient’s care or prognosis (from a practice group’s temporary receptionist to the chief of a tertiary care specialty department) from the moment the patient encounters the system to the time of discharge;

7. The patient’s feelings, questions, concerns, gratitude and/or displeasure about the processes and outcome;

8. Subsequent descriptions of the patient’s subjective assessment of improvement or continued deficit; and

9. What subsequent treating physicians have said about a previous physician’s care.

For those of us defending claims against providers, the information contained in patients’ electronic statements to friends and family is substantively important irrespective of whether the statements are medically accurate and irrespective of whether the statements are consistent with the notes, information or chronology contained in the providers’ medical chart. The electronic statements are also important from a technical side, as we can easily glean from embedded information contained in e-mails the exact computer and internet location from which the e-mail was sent as well as identify potential witnesses (the recipient list) that may have additional information that would help defend the case.

Many physicians reading this note may be on one or more of their patients’ “recipient” lists, which raises a set of questions outside the focus of this article.

What can providers and practices do to obtain these valuable patient statements if a lawsuit is filed? North Carolina rules permit people involved in a medical malpractice lawsuit to “discover” or to obtain copies of most “statements” made by either the patient or the provider prior to the court trial. Statements historically included the medical chart and letters between the provider and patient, but now include e-mails and other electronic statements between the two of them. This also includes most statements made by the provider or the patient to third parties (family, friends, colleagues, or co-workers). Thus, a provider would be entitled to obtain a copy of every electronic statement written by the patient who updates their close friends and family about their ongoing medical care.

A person’s request to obtain a copy of all “statements” before trial usually works both ways, though. Providers and practices need to be prepared for a reciprocal request from the patient’s attorney for the physician’s electronic communication (to the extent such statements exist outside of the patient chart).

For providers and their practices, it is important to identify the frequency and means by which physicians, nurses, and office staff members communicate about patient care electronically.

This includes identifying if and how general office events are discussed electronically, particularly if the events described can be retrospectively associated with a specific date. For example, a practice’s staff member’s personal webpage update describing the “bad day at the office” could be obtained and potentially used in litigation if the “bad day” could be tied to the date of a patient’s less-than-desirable outcome.

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Similarly, a physician’s internet “blog” might be used in court—even though patient-specific information had been carefully removed—if it is later determined that the physician was, in fact, “blogging” about the patient now claiming medical malpractice.

To the extent physicians use e-mail within their practices to obtain or to explain coverage, or to seek another physician’s opinion, those statements may need to be handed over to the patient during the course of the malpractice litigation.

In short, prospectively having a full understanding of a physician’s or practice’s electronic communication is a critical aspect of managing a medical practice in 2009. Once litigation is contemplated, courts are more frequently imposing costly and sometimes case-determinative procedural penalties if electronic statements (including, but not limited to, e-mails) pertaining to the patient are destroyed or become unavailable—even inadvertently. This is similar to the serious problems providers faced in the past if all or part of the actual medical chart was lost or destroyed. The presumption in court, if evidence is lost, is that the information contained in the missing pages was harmful to the person who lost the evidence. The potential court sanctions for failing to preserve evidence (either handwritten or electronic) apply to patients and physicians alike.

In summary, important considerations exist well before litigation counsel is assigned to defend a specific claim of malpractice that can, if appropriately addressed in advance, maximize providers’ and practice groups’ posture when seeking the valuable contemporaneous statements generated by their patients-turned-claimants. In most cases, this means identifying how frequently providers and their practices generate electronic statements relating to patient care and prepare an appropriate plan for preserving the statements in the event a claim arises.

Bo Thompson is a defense attorney with Yates, McLamb & Weyher, L.L.P. in Raleigh. He is licensed to practice law in the State and Federal courts in North Carolina. He can be reached at bthompson@ymwlaw.com, though legal questions coming from other jurisdictions should be directed to an attorney licensed in that area.

Stimulus 101: The $19 Billion Healthcare IT Giveaway and How Your Practice Can Benefit

BY LEIGH BURCHELL, DIRECTOR OF GOVERNMENT AFFAIRS, ALLSCRIPTS

When President Barack Obama signed the American Recovery & Reinvestment Act on February 17, 2009, his primary goal was to stimulate the lagging U.S. economy. But by signing the “stimulus bill” into law, Obama also provided the means for every physician in America to affordably enter the digital era of medicine by implementing an Electronic Health Record (EHR).

The health IT component of the legislation—the HITECH Act—appropriates $19 billion to encourage healthcare organizations to adopt and effectively utilize EHRs, and to establish regional health information exchange networks, all while ensuring that the systems deployed safeguard critical patient data.
The Act represents an enormous opportunity for healthcare providers. After decades of slow but steady progress towards converting our paper-based record system into an electronic one, we are taking a monumental leap forward.

But just what does the new law mean for a given specialty group? How can you take advantage of the billions in new funding that will be available as early as 2011? And what will happen if you fail to seize the opportunity presented by the new law?

**Details of the $19 Billion**

The HITECH Act can be broken down into two sections—one providing $2 billion immediately to the Department of Health & Human Services (HHS) and its sub-agency, the Office of the National Coordinator for Health IT (ONCHIT), and a second that sets aside $17 billion for healthcare providers who can demonstrate their use of a certified EHR.

In the Act’s first section, the Secretary of HHS is directed to spend $300 million of the $2 billion fund to establish more health information exchange (HIE) initiatives across the country, as well as helping existing HIEs to progress in connecting providers electronically. Additionally, the Act allocates $20 million to ensure that health information standards are consistent in all settings.

**Areas singled out for investment include:**

- Further development of standards related to interoperability and privacy
- Building infrastructure for the advances of telemedicine
- Expanding health IT in public health departments
- Establishing a Health IT Research Center and regional Health IT Extension Centers to offer information to healthcare providers on best practices, vendor selection, implementation, training, etc.
- Providing funding for federal grants via the Agency for Healthcare Research and Quality (AHRQ), Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC), as well as grants to states and state-designees that will help healthcare organizations with up-front funding for EHRs

The second part of the Act calls for $17 billion in incentive payments to physicians and hospitals. The government is focused on two primary goals in this legislation:

1. Moving physicians who have been slow to adopt EHRs to a computerized environment, and;
2. Ensuring that patient data no longer sits in silos but is, instead, actively exchanged between providers to ensure that patients receive informed care.

The majority of the funds within the HITECH Act are for payments that will reward physicians and hospitals for effectively using a robust, connected EHR system. There is a program designed for those who see large volumes of Medicaid patients, and another for those who accept Medicare.

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In order to qualify for the incentive payments, both physicians and hospitals have to demonstrate “meaningful use” of an EHR—a standard that is currently under development by HHS, but which will include, at a minimum, three key elements:

1. Use of an EHR with ePrescribing capability that meets current HHS standards;
2. Connectivity to other providers to improve access to the full view of a patient’s health history, and;
3. Ability to report on their use of the technology to HHS.

It is important to note that, because the government wants to spur quick action, all of the incentives include payments for up to five years, but provide the largest payments early in the program. The incentive payments begin in 2011 to ensure providers have time to adopt and learn to use the EHR. Physicians who fail to adopt an EHR will eventually be penalized through lower Medicare and Medicaid payments. The penalties begin in 2015.

**Specifics of the Physician Opportunity**

There are two separate incentive programs for physicians: one provided by Medicare and another by Medicaid.

- **Medicaid:** If more than 30 percent of a physician’s patients pay with Medicaid (20 percent for pediatricians), then they are eligible for payments of up to $64,000 over five years. The incentives will be calculated through a formula that factors in the exact Medicaid mix of their patients, as well as amounts ranging from $25,000 in the first year to $10,000 in subsequent years.

  Please note: Under the Medicaid program, nurse practitioners and mid-wives can file for incentive payments. Physician assistants (PAs) who lead and practice in a rural health clinic, or a federally qualified health center, do also qualify to file for incentive payments.

- **Medicare:** Physicians who do not have a large Medicaid volume, but do accept Medicare, can earn up to $44,000 over the five years. Additionally, physicians operating in a “provider shortage area” will be eligible for an incremental increase of 10 percent, though those delivering care entirely in a hospital environment, such as anesthesiologists, pathologists and ED physicians, are not eligible for any incentives.

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• **Fee reductions:** Providers who do not demonstrate meaningful use of an EHR by the end of 2014 will see, in their 2015 fee schedules from Medicare, a decrease of 1 percent. An additional decrease will be affected in 2016 and 2017 down to a total of 97 percent of the regular fee schedule. The Secretary of HHS can reduce the fee schedule even further, by a maximum of 5 percent beginning in 2018, if the nationwide EHR adoption rate remains below 75 percent.

**Standards, Certification and Privacy Expansion**

The Secretary of HHS is required by the Act to review all existing standards, determine the initial set of standards that will apply to the “meaningful use” criteria for product certification, and implementation specifications. All of this must be completed before the end of 2009.

Finally, as part of the HITECH Act, a very strong emphasis was placed on further protecting patient health information under Federal privacy and security laws (HIPAA).

**Primary changes included:**

- Defining which actions constitute a breach (including some inadvertent disclosures)
- Imposing restrictions on certain disclosures, sales, and marketing of protected health information
- Requiring an accounting of disclosures to a patient upon request
- Authorizing increased civil monetary penalties for HIPAA violations
- Granting authority to state attorneys general to enforce HIPAA violations

What’s the bottom line for physician groups? Industry experts agree that, to gain maximum financial incentives, groups need to begin planning the rollout of EHR systems as soon as possible. While many of the details of the Act remain need to be worked out—including the complete definition of “meaningful electronic health records”—providers can not afford to wait for all of the details to be ironed out before moving forward. To gain the maximum amount of Medicare and Medicaid incentives, physician groups must have a qualifying records system in place by 2011.

**Bottom line:** If you want to be at the front of the line to collect the incentive payments and move your practice onto the electronic healthcare highway, the time to start driving is now.

Allscripts uses innovation technology to bring health to health care. More than 160,000 physicians, 800 hospitals and nearly 8,000 post-acute and homecare organizations utilize Allscripts to improve the health of their patients and their bottom line. The company’s award-winning solutions include electronic health records, electronic prescribing, revenue cycle management, practice management, document management, medication services, hospital care management, emergency department information systems and homecare automation. Allscripts is the brand name of Allscripts-Misys Healthcare Solutions, Inc. To learn more, visit [http://www.allscripts.com](http://www.allscripts.com).

**Medical Mutual Website Update**

**Where do you go if you want to…**

- view your policy?
- add or remove a provider?
- view financial transactions and invoices?
- generate a COI?
- access valuable risk management resources: online CME programs, the latest toolkits, educational materials and consent forms?
- find out what to do if you have a malpractice claim?
- read the latest issue of MedNotes?
- consult with your HR|Expert?

To find the answers, please visit us at [http://www.medicalmutualgroup.com](http://www.medicalmutualgroup.com)—of course!

Click on “Member Services” on our home page where you will find helpful features and improved navigation. Policyholder Services will make managing your account a whole lot easier.

If you’re not a registered member, simply click on “sign up” now, to complete a member registration form—it’s quick and easy.

**Questions?** Please see the “Contact Us” box on the right side of the Policyholder Services pages, or you may call us at 800.662.7917.

**Please note:** Only authorized practice representatives are granted access to Policyholder Services and members only resources. Policyholder Services is not currently available to practices represented by outside agents.
E-Communications: Beware of the Risks and Liabilities
BY AMY YOUNG, SENIOR RISK MANAGER

Electronic communication has its advantages. Messages can be sent and received instantaneously. E-mail is inexpensive to use and creates a permanent record of the communication. Many practices are now using e-mail to communicate with their patients. However, the use of e-mail carries some risks and liability concerns that should not be ignored. The Risk Management Department at Medical Mutual is concerned about this issue and will be including our risk advice on electronic communication in the upcoming release of the Risk Management Handbook. The following is a preview of the chapter on electronic communication. We hope you will find it to be practical, useful, and relevant.

Electronic communication must never replace the face-to-face contact of the physician-patient relationship. If used, it should only supplement and enhance the relationship. The least risky way to utilize e-mail communication with patients is to limit the content of your messages to administrative issues such as appointment confirmations, address changes, and other non-clinical matters.

The American Medical Association (AMA) (http://www.ama-assn.org) has an excellent guidance document on electronic communication. Medical Mutual fully supports their advice, which is excerpted here:

**AMA Ethics Policy**

E-mail can be a useful tool in the practice of medicine and can facilitate communication within a patient-physician relationship. When communicating with patients via e-mail, physicians should take the same precautions used when sending faxes to patients. These precautions are presented in the following considerations:

- E-mail correspondence should not be used to establish a patient-physician relationship. Rather, e-mail should supplement other, more personal, encounters.

- When using e-mail communication, physicians hold the same ethical responsibilities to their patients as they do during other encounters. Whenever communicating medical information, physicians must present the information in a manner that meets professional standards. To this end, specialty societies should provide specific guidance as the appropriateness of offering specialty care or advice through e-mail communication.

- Physicians should engage in e-mail communication with proper notification of e-mail’s inherent limitations. Such notice should include information regarding potential breaches of privacy and confidentiality, difficulties in validating the identity of the parties, and delays in responses. Patients should have the opportunity to accept these limitations prior to the communication of privileged information. Disclaimers alone cannot absolve physicians of the ethical responsibility to protect patients’ interests.
Proper notification of e-mail’s inherent limitations can be communicated during a prior patient encounter or in the initial e-mail communication with a patient. This is similar to checking with a patient about the privacy or security of a particular fax machine prior to faxing sensitive medical information. If a patient initiates e-mail communication, the physician’s initial response should include information regarding the limitations of e-mail and ask for the patient’s consent to continue the e-mail conversation. Medical advice or information specific to the patient’s condition should not be transmitted prior to obtaining the patient’s authorization.

Before engaging in any type of electronic communication, it is extremely important to have patients sign an e-mail consent form. Please contact the Risk Management Department at 800.662.7917, if you would like to obtain a sample e-mail consent form.

The AMA has also developed practical guidelines on the use of e-mail. A few of the main points are listed below:

**Communication Guidelines**

- Establish a turnaround time for messages.
- Do not use e-mail for urgent matters.
- Inform patient about privacy issues.
- Patients should know who besides the addressee processes messages during addressee’s usual business hours and during addressee’s vacation or illness.
- Retain electronic and/or paper copies of e-mail communications with patients.
- Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- Instruct patients to put the category of transaction in the subject line of the message for filtering.
- Request that patients put their name and patient identification number in the body of the message.
- Configure automatic reply to acknowledge receipt of messages.
- Send a new message to inform the patient that the request has been completed.
- Request that patients use the auto-reply feature to acknowledge reading of the message.
- Develop archival and retrieval mechanisms.
- Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use the blind copy feature.
- Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- Append a standard block of text to the end of e-mail messages to patients. It should contain the physician’s full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- Explain to patients that their messages should be concise.
- When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to call or come in to the office.
- Remind patients when they do not adhere to the guidelines.
- If patients repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

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Additionally, you must ensure that your e-mail system is secure. We do not recommend the use of internet e-mail programs such as Yahoo, Google, or Hotmail. Such systems do not provide adequate security.

Electronic communication with patients requires strict adherence to the above-listed policies and procedures. If you are not able or willing to commit to the necessary actions, it may be prudent to maintain more traditional forms of communication.

Note: The AMA guidelines are updated periodically. Access the website frequently to obtain the most recent information. The website is http://www.ama-assn.org. Search for "electronic communications".

Does Your Employee Handbook Include an Electronic Communications Policy?

BY JILL SCHULTZ, MPA, SPHR, HUMAN RESOURCES ADVISOR, HR|EXPERTS

Because we rely so heavily on technology, an electronic communications policy should be part of your employee handbook. Such a policy serves as a guideline for employees and provides an important safeguard for companies against liability due to misuse and abuse of electronic communication services and equipment by its employees. Having a clear communications policy in place that informs employees of expectations and how company-owned communications systems may be monitored will help diminish any privacy concerns by employees.

The following bullet points illustrate the types of provisions you may want to include in your electronic communications policy.

When designing your policy, take into account the types of communications equipment and systems you have in your office and how these devices and systems are used by your employees. It is also recommended that you have an attorney review your policy to be sure it is in compliance with all federal and state employment laws.

- **Define the company’s communications equipment and services**
  Communications equipment and services include mail, electronic mail, courier services, facsimiles, telephone systems, computer networks, on-line services, computer files, cellular phones, bulletin boards, etc.

- **Establish that the communications services are the property of the company**
  All company communications services and equipment, including the messages transmitted or stored by them, are the sole property of the company.

- **Establish no right to privacy regarding the use of company communications services**
  The company may access and monitor employee communications and files as it considers appropriate.
• **Establish disciplinary action should improper use occur**
  Improper use of company communications services and equipment will result in disciplinary action, up to and including termination.

• **Define improper use**
  All electronic communications systems should be used primarily for company business. Personal communications must be held to a minimum and at no cost to the company. Improper use includes any misuse as described in this policy as well as any harassing, offensive, demeaning, insulting, intimidating, or sexually suggestive written, recorded, or electronically transmitted messages.

• **Employee Acknowledgement and Consent**
  Require that employees sign that they have received, read, and understood the company’s electronic communications policy and that they consent to the company accessing, monitoring, using, and disclosing any communication or information on its electronic information systems. The consent should also include a statement by the employee that they waive any privacy rights in such communications or information. State also that failure to agree to and comply with this policy may result in discipline, up to and including termination.

### Compliance Alert

**BY DAVID SOUSA, JD, MBA, SENIOR VICE PRESIDENT AND GENERAL COUNSEL**

**Q:** From Red Flags Rules, to Expanded HIPAA Regulations, to State Identity Theft Laws: Are You Protecting Your Practice From Fines, Penalties and Patient Lawsuits?

**A:** Probably Not!

The federal government has declared that all healthcare providers who extend “credit” to a patient (“credit” being broadly defined as allowing the deferral of payment for your services), must, by November 1, 2009, develop and implement written identity theft prevention programs. The failure to do so may, in the face of stolen patient identifying data (name, social security number, or health insurance information), result in federal fines of up to $2500 per violation, and subject your practice to a private lawsuit brought by your patient where recoverable damages under state laws can exceed five figures. Please review all relevant information at the Federal Trade Commission’s web site (http://ftc.gov/redflagsrule) to understand what you need to do to comply. The American Medical Association has also developed and released timely resources to its membership on this issue.

Go to http://www.ama-assn.org and type in “Red Flags Rules” in the search box in the upper right hand corner. They offer a succinct summary of how the Rules apply to your practice, what you must do to reach compliance, and even have a sample policy which you can download and use: “AMA identity theft prevention and detection and Red Flags Rule compliance.”

Identity theft can occur in ways you may not have even imagined:

1. Un-shredded patient charts being discarded into normal trash and being stolen by data thieves who rummage through your trash dumpster;

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2. A transcription service to whom you transfer dictation over the internet and which experiences a security breach in its computer servers allowing search engines to “reach into” its data files and publish patient chart information over the internet;

3. A well-intending front desk receptionist repeating a name, social security number or the health insurance information of a patient within earshot of others who sit in the waiting room and record and sell such information, and;

4. The dishonest employee who takes and sells such information to willing buyers.

ALL of these examples have occurred among our pool of insureds within the last two years. Will you be next?

Make certain that the outside vendors who clean your offices, dispose of your trash, do your transcription, host your electronic medical records, service your information technology hardware and software, and screen your employees, are under written contract with you. Be certain that each such contract protects you and your practice from identity theft by including indemnification language that provides that, if their negligence results in identity theft and your group being fined and/or sued, they will indemnify you and hold you harmless from all damages that you incur.

Sample language follows that will need to be tailored by your personal counsel to fit your contracts:

“Both parties agree to defend, indemnify and hold harmless the other from and against all claims, expenses, liabilities, losses, costs, and damages, including reasonable attorney fees, resulting from, or alleged to have resulted from, solely the other’s breach of this AGREEMENT. Notwithstanding the foregoing sentence, it is expressly understood that CONTRACTOR has the exclusive and sole responsibility to protect from any unwanted third-party disclosure, intended or unintended, the personal information, including, but not limited to, Protected Health Information of any patient of PROVIDER resulting from, or alleged to have resulted from, patient privacy or security breaches based on, or originating with or in, the systems, services and products provided by CONTRACTOR, as each is defined in this AGREEMENT, and shall defend, indemnify and hold harmless PROVIDER from and against all claims, expenses, liabilities, losses, costs, and damages, including reasonable attorney fees based on all such disclosures. The indemnity described in the preceding sentence of this section includes, but is not limited to, violations and alleged violations of the Fair and Accurate Credit Transaction Act, HIPAA and any state Identity Theft Laws.”

Finally, be certain that all such vendors carry sufficient liability insurance to stand behind—and fund—the mishaps which they make that impose liability on you.

Title XIII of the American Recovery and Reinvestment Act of 2009, also known as “HITECH”, and generally publicized as the “Economic Stimulus Package,” greatly expanded obligations under HIPAA. With varying effective dates, the changes include:

1. Expanded monetary penalties now capping at $50,000 per violation and $1,500,000 per calendar year;

2. Expanded obligations for your Business Associates (BA’s), which may necessitate revisions to your existing and future BA agreements, and;
3. New obligations to individually notify patients and the local media if there has been a security breach of protected health information—such as theft of a laptop, hand held device or computer hard drive containing patient information.

Please see “New HIPAA rules get tough on security breaches,” in the May 8, 2009 online issue of Medical Economics for a nice summary of these changes.

Times are changing. Assure that your practice is ahead of the curve regarding these important compliance matters.

Claims Case Review

BY NAOMI TSUJIMURA, RN, BSN, CCRN, MEDICAL CARE ANALYST

On 7/14/03, the patient, a 60 year old married male who was a high level executive with a national trucking firm, presented to the insured primary care practice with complaints of fever, sinus symptoms, cough and chest congestion. The patient reported a medical history significant for depression and occasional pipe- and cigar-smoking.

The patient was seen by a locum tenens physician at the practice. During the patient exam, the patient reported that his symptoms had persisted for several weeks despite the use of an over-the-counter antihistamine and a prior prescription for a Medrol dose pack.

The locum tenens physician diagnosed the patient with a chronic cough possibly due to postnasal drip. She took a chest X-ray in the office. She did an initial read and noted that the film was within normal limits. She advised the patient that the X-ray would be over-read by a radiologist and that he would be contacted if anything out of the ordinary was found. She prescribed Allegra D and referred the patient to an ENT. The patient said he knew an ENT and that he would make his own appointment.

The patient saw his ENT on 7/15/03. At this visit, he gave a history of chronic sinus problems, postnasal discharge, cough and burning in his chest. The ENT diagnosed chronic sinusitis/possible GERD. He prescribed Prevacid and ordered a CT scan of the sinuses. The patient was to return in three weeks to review the results of the CT scan. The ENT never sent a copy of his consultation note to the patient’s primary care group and the primary care practice was unaware of the patient’s visit of 7/15/03.

On 7/18/03, the locum tenens physician received and reviewed the chest X-ray report from the over-reading radiologist. The report noted that there was an area of increased density superimposing the ninth rib which could represent a minimal infiltrate or atelectasis. The over-reading radiologist noted: “In view of previous treatment, CT correlation might be appropriate at this time.”

The insured locum tenens physician requested that an office LPN, who was new to the practice, call the patient regarding the need for a follow-up chest CT scan.

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The LPN called the patient and informed him that he would need a follow-up “CT scan”. The patient told the LPN that he was already scheduled for a CT scan on 7/23/03.

The LPN made the following notation in the chart: “Patient notified that he needs CT. Patient stated already scheduled 7/23/03. Order faxed to hospital.” This notation was followed by her signed initials in the chart. No further clarification was made with the patient regarding the type of CT scan that was ordered. The hospital had no record of ever receiving a faxed request on the patient and a chest CT scan was never ordered and never done. The locum tenens physician left the practice on 8/03/03.

On 7/23/03, the patient underwent a CT scan of his sinuses at his local hospital. This was read as an essentially normal paranasal sinus CT scan with small, scattered bilateral maxillary and mucosal retention cysts. On 7/25/03, the ENT’s office called the patient with the results of the CT scan. No changes were made in the patient’s treatment plan and he was advised to follow up with the ENT on an as-needed basis.

The patient was not seen again by any healthcare provider until 4/07/04. At that time he was seen at a different primary care practice; however, the physician he was seeing had left the prior practice where he was seen by the locum tenens physician. The patient’s old chart had been sent to the new practice.

The patient presented with complaints of fatigue. At that time, the physician increased his dosage of his Effexor. The patient was seen for several other acute care visits throughout 2004 and into 2005.

On 3/23/05 the patient presented with complaints of chest congestion and a dry cough. The patient was diagnosed with bronchitis and prescribed Augmentin. He returned on 4/01/05 with continuing complaints of congestion and was prescribed Prednisone. On 4/19/05 he presented again with complaints of SOB, wheezing, and chest tightness. He was diagnosed with reactive airway disease and prescribed Advair. He returned again to the practice on 4/28/05 with continuing complaints of chest tightness and burning in his chest.

An X-ray was taken on 4/29/05 and showed a 3 cm mass in the right lower lobe. It was later noted that the mass was in the same area as the previously noted infiltrate seen in 7/03. A CT scan was done on the same day and was significant for a “3.8 X 3.1 cm mass in the right lower lobe likely related to primary bronchogenic carcinoma.”

In 6/05 the Mayo clinic confirmed a diagnosis of stage III B squamous cell carcinoma of the lung. Surgical treatment was not an option. The patient underwent chemotherapy but ultimately succumbed to his cancer in February of 2006. He was survived by his wife of 30 years, two adult children, and two grandchildren. A sizable out-of-court settlement was reached on behalf of the locum tenens physician and the original primary care practice.

**There are multiple risk management take-away points from this case:**

1. During the discovery process of this lawsuit, the plaintiff’s own experts conceded that the standard of care did not require that the findings of the initial chest X-ray of 7/14/03 be followed with a chest CT scan.
However, these same plaintiff experts were adamant that if a physician orders a test, such as the chest CT scan ordered by the locum tenens physician on 7/18/03, then the standard of care does require that the practice/physician follow-up on any ordered testing.

At the time this patient was treated, the primary care practice had no means for tracking outstanding radiology studies.

A tracking system can be as simple as a log/notebook where requests for testing are entered and the receipt of results and subsequent review by a physician are also entered. A scheduled review of the log can show what results are outstanding and what testing requests may require follow-up by the practice.

2. In addition to having a tracking system, does your practice have a process in place for who maintains the tracking system? Do you have key personnel who have been instructed and trained on how to order outside testing?

In this case, the LPN was new to the practice, and unfamiliar with some of the group’s policies and procedures. She noted that the patient told her that his “CT scan was already ordered.” She made a notation in the chart and didn’t pursue the matter with any other senior staff members.

The LPN later testified that she had no recollection of this discussion with the patient. The patient expired before his testimony could be taken regarding his memory of the discussion with the LPN. Was the LPN aware that the CT scan ordered was a chest CT? Did she communicate this to the patient? Was the patient aware that the CT scan that the physician wanted to order was a chest CT scan, and not a sinus CT scan?

3. The specialty physician, in this case the ENT, never sent record of the patient’s office visit or subsequent testing to the patient’s primary care practice. Even though the patient “self-referred” to the ENT of his choice, that physician still needs to assure that a record of the visit is sent to the patient’s primary care physician.

Had the ENT sent a copy of his consultation and the CT scan of the sinuses to the primary care practice, it is possible that a physician or staff member would note that the chest CT was never ordered/obtained.

4. The locum tenens physician testified that she would have expected the chest CT results at the office within one to two weeks; however, her contract ended within this one to two week time frame. Had her contract not ended, she testified that she would have been “looking” for the results.

Locum tenens physicians provide a valuable service to both medical practices and the patients they serve. If your practice utilizes locum tenens physicians, then you need to schedule an “exit interview,” wherein the departing locum tenens physician can review patient records and any outstanding studies, labs, radiology, or otherwise, with a member of the practice.

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5. The patient transferred his care to another practice less than one year after his July 2003 visit. When the patient transferred his care, his old record was sent to his new primary care provider. Had his physician taken time to review his most recent office visits, the lack of the follow-up chest CT may have been found.

When a patient comes for an office visit, do you take a few moments to review the patient problem list for new or “open” problems? Do you review the most recent visits and check for any testing results? A review of this patient’s chart in April of 2004 could have resulted in follow-up testing that would have diagnosed his cancer one year earlier.

This case represents a constellation of numerous missed opportunities by multiple providers. The presence of a basic tracking system and sound office procedures within all of the three practices—the original primary care practice, the ENT practice, and the second primary care practice—could have resulted in a much different outcome for the physicians, the practice and, most importantly, the patient.

New Retirement Provision for MMIC Insureds
BY SHARON MUSSELMAN, ARM, ASSISTANT VICE PRESIDENT, UNDERWRITING

Medical Mutual is pleased to announce the addition of a new retirement criteria for our insureds. Effective July 1, 2009, our policy was revised to allow our insured physicians who have been with the Company for five or more years and have reached the age of 62 to receive a free extended reporting endorsement (tail coverage), and to continue the practice of medicine on a limited basis.

Prior to this change, our policy defined retirement as, “the complete and permanent withdrawal from the practice of medicine.” This new provision recognizes the desire of many of our insureds to continue to provide medical services in some limited capacity after retiring from their standard practice.

As a policyholder of Medical Mutual Insurance Company of North Carolina, your policy now provides you the ability to obtain either a partial or complete waiver of premium for an extended reporting endorsement (tail coverage) under either of the following conditions:

1. Either you must be 55 years of age or older, and have been insured with the Company for at least five consecutive years immediately preceding your retirement, or you must have been insured continuously by the Company for ten years immediately preceding your retirement, regardless of your age (complete waiver); and:

   • You must, at the time of your retirement, hold a license in good standing issued from your state medical board; and

   • Your retirement must meet your policy’s definition of retirement, defined in your policy as “…the complete and permanent withdrawal from the practice of medicine.”
If you have not been insured continuously by the Company for the last five years, but are 55 years of age or older (partial waiver), you will qualify to have 20% of the cost of your extended reporting endorsement waived for every full year you were continuously insured immediately preceding your retirement;

2. **NEW:** You are at least 62 years of age and have been insured with the Company for at least five consecutive years immediately preceding your retirement, and you are either retiring completely and permanently from the practice of medicine, or you are retiring from your current practice with the intent of engaging in the part-time practice of medicine (less than 80 hours per month) in a substantially different practice arrangement than your current one, and do not require continued coverage with Medical Mutual Insurance Company of North Carolina.

If you have any questions regarding the retirement provisions of your policy or how your future retirement plans fit into these criteria, please contact your underwriter at 800.662.7917. We would encourage you to have these discussions before final decisions are made to ensure that your plans fall advantageously within these policy provisions.

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**Your Loyalty...Your Reward: The Legacy Fund**

**BY JIM KAY, VICE PRESIDENT OF SALES AND MARKETING**

We have received thousands of registrations for our new Legacy Fund program and we thank you for your participation. If you have not had the opportunity to sign up for your tax-deferred member savings account, we hope you will take a few minutes to visit our website at [http://www.medicalmutualgroup.com/legacyfund](http://www.medicalmutualgroup.com/legacyfund) to enroll in our innovative new program.

*The Legacy Fund* creates individual savings funded in tax-deferred accounts for the benefit of our member physicians in North Carolina and Virginia. As indicated in *The Legacy Fund* informational packet mailing that you received in May, a portion of the initial aggregate allocation of $6.25 million will be credited to an individual member savings account, referred to as a Legacy Fund account, for each qualifying physician. These accounts could grow with future contributions and interest until distributed to the member physician upon a qualifying event.

The dedication of our physician owners to practicing quality medicine and developing a collaborative partnership with us has made Medical Mutual one of the most financially sound professional liability insurance companies in the nation. Your ongoing commitment to keep claims under control along with your continued loyalty has, and will continue to have, a direct impact on the financial success of Medical Mutual. *The Legacy Fund* allows us to share our financial success with you, our physician owners.

Enroll now to participate in Medical Mutual’s *Legacy Fund*. Your reward for your commitment and loyalty awaits you. Take advantage of this completely company-funded, tangible, cash distribution opportunity.

For more information, please contact your Legacy Fund Coordinator, Colleen Larsen, at colleen.larsen@mmicnc.com or 800.662.7917, ext. 7563.

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Michael Brohawn accepts the Administrator of the Year award from Medical Mutual’s David Sousa

**NCMGM Names Administrator of the Year**

Michael Brohawn, Practice Administrator for Wake Emergency Physicians, PA (WEPPA) was named the 2009 Administrator of the Year at the North Carolina Medical Group Managers’ (NCMGM) Annual Spring Conference. This award honors a medical practice administrator for exceptional leadership, management proficiency and enhancing the effectiveness of health care delivery in North Carolina. The award, sponsored by Medical Mutual, also provides a stipend of $2,000 for continuing education.

Approximately 250 people were in attendance at the NCMGM Spring Conference in Myrtle Beach.

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**NCMGM 2009 Fall Conference**

September 16–18, 2009
*Weathering the Season of Change*
Pinehurst Resort
Pinehurst, NC
Register online at:
[http://www.ncmgm.org](http://www.ncmgm.org)
NCMS Employee Benefit Plan Promotes Wellness in the Workplace

The North Carolina Medical Society Employee Benefit Plan (NCMS Plan), marketed exclusively by MMIC Agency, Inc., a Medical Mutual company, focuses on wellness in an effort to educate participating employers and employees about practical ways to improve their health. Through this partnership, we can encourage healthier lifestyles and control costs with wellness programs that work.

A wellness program in your practice should begin with a strong and supportive foundation—one that is comprehensive and consistent with your message of wellness. We encourage you to educate your employees about the resources available through your health insurance carrier, but also consider some of these very practical ideas for creating a culture of wellness in your workplace.

Tobacco-Free Workplace
As a healthcare provider, your practice shares a common goal with the NCMS Plan—the goal of promoting health and well-being. A great way to achieve this goal is to implement a tobacco-free workplace policy at your practice.

There are a wealth of free resources available to assist you and your employees. In addition to resources available to NCMS Plan clients, Quit Now NC! (http://www.quitnownc.org/hcworksites.asp) is a great resource for model policies and a template for a 12-month timeline to a tobacco-free practice. This site specifically targets healthcare facilities, so it is particularly relevant.

Healthy Vending Options
Do you have a vending machine in your office filled with potato chips, candy bars, and pastries? How about soda machines with sugar-filled soft drinks? Creating a culture of wellness requires changes both large and small. Studies show that when given healthy options, employees are more likely to make changes in their diet and lifestyle. Try adding light juices, flavored waters and only diet soft drinks. Don’t forget about the pharmaceutical and other sales representatives that so generously bring lunch and snacks for you and your employees. Don’t be shy about asking them to take your “culture of wellness” into account when providing food.

Policies that Support Wellness
One policy that can easily be modified to highlight your practice’s emphasis on health and wellness is your leave policy. What types of leave are acceptable under your current policy?

Vacation, sick, and bereavement leave are common, but what about wellness leave. In a formal policy, consider allowing, and even encouraging, employees to take wellness leave for their annual physical exams including colonoscopies, mammograms, and routine physicals. Perhaps it’s simply another way employees can use the sick leave they already accrue. Sure, it may be more time out of the office, but the benefits of a well employee far outweigh the short term loss of time on the job. You may be surprised how many employees do not get the check ups they should because they do not feel it is supported by their employer or that it could be an unacceptable use of leave.

For more information about the NCMS Plan and its wellness programs visit: http://www.ncmsplan.com/pages/wellness.html, or call 800. 662.7917.

2009 NCMS Annual Meeting: Succeeding in Frightening Times
NCMS members are invited to attend:
The 155th NCMS Annual Meeting and House of Delegates
October 30th – November 1st
Raleigh Marriott City Center

With the Annual Meeting falling during Halloween weekend, prepare to be spooked with this year’s theme, Succeeding in Frightening Times. Meeting highlights are as follows:

- The NCMS Foundation’s Community Practitioner Program’s 20th Anniversary Celebration
- A Practice Manager’s Lunch & Learn featuring a legislative recap of issues that have impacted practices
- HOD call for resolutions
- 2nd Annual Photo Contest: 12 finalists’ photos on display—vote for the winning image
- A “Wicked” Welcome Reception to kick off the weekend
- Two CME sessions, including “Medical Staff BOOT Camp” and the “Dispelling the Horrors of HIT”
- Important health policy discussions that will impact health care in this state and beyond
- Halloween fun for adults and children

2009 Annual Meeting materials are available online. Download a brochure now or register for the meeting at http://www.ncmedsoc.org/annualmeeting.
NEW Resource Offered by HR|Experts

Introducing HR|Experts’ Member List Serve

The List Serve is an e-mail discussion group that enables you to ask your peers at other Medical Mutual member companies for advice and/or recommendations while also sharing the best practices of your organization.

What could you learn from your peers? Sample discussion topics to date include:

- Job Descriptions
- Patient Flow Sheets
- Continuing Education Policies
- Red Flags Policies

When you register for HR|Experts, you are automatically enrolled in the List Serve as a benefit of the free services offered by HR|Experts. If you are not receiving the List Serve e-mails, simply send an e-mail to Jill.Schultz@callhrexperts.com. Once registered, you will receive a verification e-mail with information about submitting and answering List Serve questions, as well as managing your preferences within the List Serve system (including how to opt out if you choose).

If you are already enrolled in the list serve and you wish to submit a question to your peers, send your question in an e-mail to hrexperts-members-list@lists.callhrexperts.com. Remember to include a “Subject” in your e-mail so others can see and follow the discussion topic/thread. As an added feature, all discussion topics are saved in the List Serve archive—so if you think your question has already been asked, you can search the archives and find prior responses!

Please contact Jill Schultz at Jill.Schultz@callhrexperts.com if you have questions about the Member List Serve.

We hope you will take advantage of this program, and we look forward to meeting your practice’s Human Resources needs.