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INSIDE

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EMTALA Violations Persist as Hospitals Cope With Overload

The Emergency Medical Treatment and Labor Act (EMTALA) was passed in 1986 after several well-publicized instances in which patients died after being turned away from hospitals because they could not pay for treatment, and it imposes fines of up to $50,000 and disqualification from Medicare.

That is plenty of time for healthcare organizations to implement compliance programs and the penalties are severe enough to warrant attention, so why do EMTALA violations still occur? It's rarely because hospitals are simply trying to dump patients, compliance experts say. There are several factors at work, from lingering uncertainty about specific compliance requirements to real-world difficulties like overloaded EDs and behavioral health issues that can clash with efforts to follow the rules.

A review of investigations by the Office of the Inspector General (OIG) of the Department of Health and Human Services, including cases settled from 2002–2015, found that in that period there were 192 settlements with fines against hospitals and physicians totaling $6,357,000. Ninety-six percent of the settlements were against hospitals, and the rest against physicians. *(An abstract of the review is available online at: https://bit.ly/2Hc11CV.)*

THE MOST COMMON SETTLEMENTS WERE FOR FAILING TO SCREEN, ACCOUNTING FOR 75%, AND FAILING TO STABILIZE, CITED IN 42.7% OF THE CASES.

The most common settlements were for failing to screen, accounting for 75%, and failing to stabilize, cited in 42.7% of the cases. Inappropriate transfer and failing to transfer each

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EDITORIAL QUESTIONS
Call Editor **Jill Drachenberg**, (404) 262-5508

accounted for 11.5% of the violations, while hospitals failed to accept an appropriate transfer in 13%. The settlements claimed patients were turned away from hospitals for insurance or financial status in 15.6% of the cases.

Just under 7% of violations involved patients in active labor. An on-call physician refused to see the patient in 6.3% of the cases.

More Violations Not Reported

Those numbers may only reflect part of the problem with EMTALA compliance, says **Charleen Hsuan,** PhD, assistant professor of health policy and administration at Pennsylvania State University in University Park. Her research indicates that receiving hospitals often suspect an EMTALA violation but do not report it.

EMTALA violations occur because there are still strong financial pressures to avoid costly patients, even though clinicians and risk managers try not to be unduly swayed by those concerns, she says. Another primary factor is that EMTALA is not simple, at least not when it comes to applying it in real-world situations, she says.

Hsuan's research indicated that there is consistency in how clinicians are trained in EMTALA compliance.

"There are a lot of moving pieces to it. There are a lot of assumptions being made about who actually provides the EMTALA training, with some of those interviewed saying the hospital association takes care of it but the association saying no, the hospital handles its own EMTALA training," Hsuan says. "That's important to figure out right away, the hospital's assumptions about who knows what about EMTALA. Medical schools tell us that they don't even cover EMTALA, except maybe for the emergency medicine specialists."

There also can be conflicting priorities between physicians and risk managers, she says. Physicians are concerned about malpractice and may turn away patients, thinking they are protecting themselves if they are unable to provide the best care to the patient, or if the patient otherwise is a malpractice risk.

"Physicians often are surprised to learn that they can be held personally liable for an EMTALA violation and can even lose their Medicare certification. It's not just the hospital that can be held responsible," Hsuan says. "That's a point the hospital should repeat to physicians, emphasizing that this problem affects both hospitals and physicians."

EXECUTIVE SUMMARY

Hospitals continue violating EMTALA despite years of compliance efforts and the threat of severe penalties. In most cases, the hospital does not intend to dump patients.

- ED overcrowding and behavioral health issues can complicate compliance efforts.
- The number of violations may be higher than reflected in OIG data.
- Receiving hospitals should discuss suspected violations with the transferring hospital.

Some hospitals are implementing EMTALA best practice procedures such as routing all transfers to a specified person, such as the ED director, who can ensure compliance, Hsuan says. That can help when individual ED physicians may not be as familiar with EMTALA requirements and might refuse transfers inappropriately. Those policies often are implemented after a hospital is cited for an EMTALA violation, she says.

Another best practice is to clarify the screening process for specific conditions.

"Hospitals sometimes get into trouble when the patient has come in 10 times before and has a history of being drunk or abusing substances, and the clinician assumes it's the same thing this time. They don't implement the usual screening process, and it turns out that this 11th time the patient actually was suffering from something else," Hsuan says. "The hospital can make clear that the appropriate screening process applies every single time, no matter the history with the patient and even when you think you know what's really going on."

Contracted physician groups should be required to show that their doctors are trained in EMTALA, including on-call specialty groups, Hsuan says. Hospitals also can take a more active role in ensuring that physicians participate in refresher sessions and updates on EMTALA, she says.

Physicians definitely are feeling more financial pressure than ever and that affects their EMTLA compliance efforts, says **Jay Jagannathan**, MD, a neurosurgeon in Troy, MI. His practice provides on-call specialty coverage at trauma centers in Michigan, and he says some hospitals are known for trying to avoid Medicaid and other patients who could be a financial burden. That is a reasonable business decision, considering lean reimbursements and other financial demands, but it sometimes runs counter to EMTALA, he notes.

Limited bed space is another factor that physicians often run into when trying to make appropriate transfers, particularly with patients who need specialized services like neurological intensive care, he says.

"It often comes down to having appropriate triage units so those beds can be made available, and having good open lines of communication between hospital administration and the specialists about what those capabilities are," Jagannathan says. "Being in a field where fairly minor changes in time can make dramatic differences in patient outcome, we put a high value on processes that eliminate any unnecessary delay. About a once or twice a month I see delays that could have been prevented with better mechanisms in place by the hospital."

Social factors must be considered when assessing EMTALA compliance, says **Candy Campbell**, DNP, RN, CNL, CEP, FNAP, assistant professor, MSN-CNL maternity lead, at the School of Nursing and Health Professions at the University of San Francisco in California. Some facilities face great pressure to accommodate the needs of communities with high rates of homelessness, substance abuse, and other social ills, she notes. *(See the story on page 55 for more on how homelessness affects EMTALA compliance.)*

EMTALA can be abused by those who are seeking a way off the streets or pain medications, she notes. People learn that hospitals are not allowed to turn patients away without a screening, and combined with malpractice fears that prompt a workup for any complaint, that means many EDs will be crowded with people who have ulterior motives, she says.

In addition, some hospitals face a glut of trauma patients from gang violence and other criminal activity, which means some patients will be denied care because they are more stable than the trauma patients who need the available beds and resources.

"These are multifaceted problems, and we're doing our best with EMTALA to make sure hospitals don't take advantage of poor people," Campbell says. "The intent of the law is admirable, of course, but there are so many factors that complicate compliance. As a medical person, I question how many of these instances are really violations of the law, and how many of them are people just trying to bilk the system? I don't know."

EMTALA may appear to be simple and straightforward, but it becomes less so when applied to an individual patient, says **Kevin Klauer**, DO, EJD, FACEP, chief medical officer for hospital-based services and the chief risk officer for TeamHealth, an organization based in Knoxville, TN, with more than 20,000 clinicians nationwide.

In particular, Klauer says hospitals sometimes focus only on transfers and give short shrift to the other components of EMTALA.

"If you've not recognized someone's emergency medical condition and you haven't provided the appropriate stabilizing treatment, but you've discharged them, that can be an EMTALA violation," he notes.

The intake process also is important, he says. It must treat people equally and not produce a delay in the screening or treatment process to

obtain financial information, he says.

The continuing increase in patient volume at EDs across the country is creating "the perfect storm for more EMTALA violations," Klauer says.

"Part of EMTALA is that you be afforded a timely medical screening examination. You can't wait hours because they might decompensate," Klauer says. "If you have a busy day and your waiting room is overrun, the hospital is full, and you're boarding, you're going to have delayed medical screening examinations. Everyone who walks out because they're tired of waiting could file an EMTALA complaint."

Technical Violations, Not Dumping

EMTALA violations sometimes occur through "technical" violations. says **Callan Stein**, JD, partner in the Boston office of Barrett & Singal. These are not situations of "patient dumping," which the statute was enacted to prevent, but rather situations where everyone involved — the patient, the transferring hospital, and the receiving hospital — agrees on a course of action but the technical requirements for an EMTALA-compliant transfer are not met, usually because of exigent circumstances.

"For example, I worked on a case where a patient presented to a hospital in active labor with twins and requested a transfer to a neighboring hospital where her obstetrician worked. The hospital agreed to transfer the patient and the neighboring hospital agreed to receive the patient, but because of the urgency of the situation, the transferring hospital's emergency department did not consult with a physician before transferring the patient as required by EMTALA," Stein says. "Thankfully there was no harm to the patient or the babies, but this still constituted a violation of EMTALA, albeit a technical one."

Stein does not believe that EMTALA violation arose because of confusion with the law. The hospital risk manager recognized fairly quickly after the transfer that it was technically not compliant with EMTALA, he says. But even though the ED staff had been trained on proper transfer procedure, the specific and exigent circumstances of this case resulted in the violation, he says.

Details Matter

While the core obligations of EMTALA are well understood by most hospitals, the devil is in the details, says **Travis G. Lloyd**, JD, partner with the law firm of Bradley Arant Boult Cummings in Nashville,

Confusion, Competing Priorities Behind EMTALA Violations

Most hospitals violating EMTALA intend to comply with the law but fall short because of confusion about requirements and competing priorities between doctors and hospitals, according to research led by **Charleen Hsuan**, PhD, assistant professor of health policy and administration at Pennsylvania State University in University Park.

Hsuan and her colleagues interviewed hospitals, hospital associations, and patient safety organizations to determine how violations occur even though the law should be well understood. In addition to uncovering some of the reasons, they found that the number of EMTALA investigations probably reflects only a portion of the actual number of violations, with those interviewed citing many reasons not to report their suspicions. *(An abstract of the study is available online at: https://bit.ly/2Hp9uQO.)*

The researchers identified the following reasons hospitals might not comply with EMTALA:

- financial pressure to avoid Medicaid and uninsured patients;
- difficulty understanding all aspects of the act;
- referral burden at recipient hospitals;
- reluctance to report other hospitals to maintain good relationships with those institutions;
- conflicts between physician and hospital priorities.

Physicians sometimes resist accepting patients that they don't think they can properly care for, citing malpractice concerns, the study says. That can result in an EMTALA violation for which the hospital is most likely to be held responsible.

To address how many of the study's participants mentioned not wanting to report fellow hospitals to government regulators, Hsuan suggests creating a more informal mediation process.

Financial issues could be addressed by more closely aligning Medicaid/Medicare payment policies with EMTALA, the researchers suggested. ■

TN. Many key terms like "emergency medical condition" and "medical screening examination" and key concepts like appropriate stabilization and transfer are defined in ways that give hospitals and practitioners discretion to make appropriate clinical judgments, he says. But, invariably, questions arise at the margins of those definitions.

In addition, many hospitals have struggled with managing patients who present with behavioral health issues, Lloyd says, noting how a South Carolina hospital made headlines last year when it entered into a $1.3 million settlement with OIG to resolve allegations that it had failed to properly handle behavioral health patients presenting at its ED. According to the settlement agreement, the hospital allegedly held behavioral health patients in its ED without having an on-call psychiatrist evaluate them or admitting them to the hospital's inpatient behavioral health unit.

"In each instance, the patient was involuntarily brought to the hospital's emergency department, often by law enforcement," Lloyd says. "While the hospital had an inpatient behavioral health unit, the unit had a policy of only admitting patients that are voluntarily committed. Instead of admitting the patients, the hospital allegedly held them for extended periods of time in the emergency department while it tried to stabilize them or have them transferred."

Urgent Care Problematic

There also continues to be uncertainty about the application of the law to urgent care centers, particularly those owned by hospitals, Lloyd says. In many instances, the analysis comes down to whether the urgent care center is held out to the public as a place that provides care for emergency medical conditions on an urgent basis without requiring an appointment, often a highly fact-intensive inquiry, he says.

If it is so held out, the facility constitutes a "dedicated emergency department" for EMTALA purposes and will be subject to the law's substantive requirements, he explains.

"One of the major competing priorities is specialist availability. CMS [Centers for Medicare & Medicaid Services] has made clear that it expects a hospital to strive to provide adequate specialty on-call coverage consistent with the services provided at the hospital and the resources the hospital has available," Lloyd says. "Meeting this requirement can be difficult for small hospitals located in rural areas as well as large hospitals with highly specialized service offerings. In addition, arrangements through which hospitals pay physicians to provide call coverage must be carefully structured in view of fraud and abuse laws, like the Stark Law and Anti-Kickback Statute."

In the wake of an EMTALA incident, hospitals and risk managers should carefully consider whether there are any process changes that should be made to avoid or reduce the likelihood of future incidents, Lloyd says. Surveyors investigating EMTALA complaints likely will ask what the hospital has done to prevent it from happening again. Follow-up efforts often involve targeted training.

Document Training Efforts

Risk managers should seek to coordinate with medical staff leadership to get physician buy-in on these training efforts, Lloyd says. Administrators and risk managers should document their follow-up to best position the hospital to respond to surveyors' requests.

Recent changes to the Affordable Care Act and increasing costs of health insurance could lead to more EMTALA dilemmas, since EMTALA's "big picture" purpose is to stop hospitals from refusing to treat patients who either have no insurance or the "wrong" insurance, notes **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix. Violations continue to occur, even after monetary penalties for noncompliance were doubled in 2017 for four primary reasons, Owens says.

First, while the purpose of EMTALA may sound straightforward and self-evident, Owens says the ETMALA law and regulations impose a series of highly prescriptive, fairly technical steps that hospital ED staff must take in connection with examining, treating, and transferring patients seeking emergency services.

"Sometimes these specific technical requirements make sense, and sometimes they are inconsistent with the on-the-ground activities of an emergency department. Noncompliance with any of these requirements can give rise to a violation," Owens says. "In the hubbub of a busy emergency department, technical compliance sometimes gives way to treating patients and the need to keep moving."

The on-call requirement in EMTALA still generates problems, Owens says. Under the regulations, hospitals must maintain lists of specialists on the medical staff who can come to the hospital to supplement the skills of the ED practitioners in screening and

stabilizing patients. Many hospitals have attained compliance with the list requirement by paying physicians to serve on call or employing physician specialists and including on-call services in their contracts.

"All that said, physicians still frequently see on-call service as a burden to be resented. If the hospital's system allows these specialists to decide whether or not to accept a patient seeking transfer to a higher level of care, they may fail to follow regulatory requirements when making such decisions," Owens says.

EDs are challenged when patients arrive with a constellation of physical, behavioral, and substance abuse problems. Harried ED personnel may treat the physical complaints but miss or ignore the behavioral health issues, especially if the hospital lacks behavioral health inpatient capabilities, Owens notes.

Conversely, ED personnel may conclude that a patient is drug-seeking rather than legitimately seeking emergency services, and miss real physical or behavioral emergency medical conditions. Conclusions based on prior experiences with a patient or other understandable reasons can lead to a decision not to treat a patient who really needs treatment, she says.

"All this leads to the final reason why EMTALA violations continue to occur: EMTALA has never done anything but treat the symptom while ignoring the underlying problems. The increase in numbers of people with insurance coverage may assist in compliance by keeping patients from using the ED as a primary care provider," Owens says. "The erosion of the Affordable Care Act likely will reverse that trend. And in the behavioral health and substance abuse areas, appropriate resources simply do not exist at all or in adequate numbers to care for patients in many, many United States communities."

Communicate Before Reporting

Shifting to hospitals the burden of assisting these patients does not do anything to augment available resources, Owens says. Behavioral health and substance abuse care, as well as ongoing efforts to augment the lives covered by insurance, must continue and increase if hospitals are going to be able to consistently comply with EMTALA, she says. *(See the story on this page for Owens's advice on how to improve compliance.)*

Lloyd notes that the EMTALA regulations provide that, in the event a hospital has reason to believe that it may have received an improperly transferred individual, it must promptly report the matter to CMS

Four Steps for Improving EMTALA Compliance

Compliance with EMTALA will continue to pose challenges until systemic problems like the treatment of behavioral health patients can be addressed, but in the meantime there are steps that can help a hospital avoid being penalized for violations.

These suggestions are offered by **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix:

1. If possible, route requests for transfer into the facility through administrative channels rather than directly through the on-call physician. If the receiving hospital rather than the transferring facility contacts the accepting on-call physician, the chance of mistakes should diminish.

2. Plan ahead for high census periods, focusing on areas of major risk: delays, stabilization, and transfer. Make sure sufficient resources are devoted to the ED, including personnel in the waiting rooms to assist and reassess waiting patients.

3. To deal with behavioral health issues, get help. To the extent possible, bring in behavioral health professionals to handle or assist with emergency medical examinations and commitment processes. Develop relationships with the nearby behavioral health facilities, if they exist. Work out transfer processes so that transfers can be effected without undue delays.

4. When receiving hospital personnel see evidence of an improper transfer, do not turn down the patient. That itself can create EMTALA exposure. Instead, investigate the situation later, when the patient is safe. Because assumptions about the transferring hospital may turn out to be incorrect, a call to the transferring hospital when "dumping" concerns arise can be very productive. If a receiving hospital concludes that a transfer has been improper, it is required to contact CMS; a call to the transferring hospital may supply information that obviates the need for a CMS report. In any event, that call may open a line of communication to improve transfer cooperation in the future. ■

or the state survey agency within 72 hours. Failure to report improper transfers potentially subjects the receiving hospital to termination of its provider agreement.

"Although there's a short fuse on the reporting obligation, a receiving hospital that suspects an improper transfer should contact the transferring hospital to get all of the facts. Through that diligence, the receiving hospital may conclude the transfer was, in fact, proper," Lloyd says. "Regardless of whether the receiving hospital validates its initial concern, the hospital should document its analysis as it may be asked to explain its decision-making to surveyors."

Jagannathan says more one-to-one communication between physicians could smooth many EMTALA transfers. He keeps a list of physician contacts at the state's academic tertiary care centers where he is most likely to transfer patients for specialized care, and says ED physicians should try to know their counterparts at other facilities.

Owens also encourages more communication between hospitals when there is concern over a transfer. More of that communication could improve the relationship and diminish future EMTALA concerns, she says.

"I can't tell you how often I have heard community hospital personnel complain about being turned down when seeking to transfer patients to big city specialty centers, and then have heard the big hospitals complain that the community hospitals transfer unnecessarily," Owens says. "Better communications can make a big difference here. The key is to have these discussions when patients are not stuck in the middle." ■

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Patients Sometimes Game EMTALA System

EMTALA compliance is greatly complicated in communities with significant homeless populations, says **Candy Campbell**, DNP, RN, CNL, CEP, FNAP, assistant professor, MSN-CNL maternity lead, at the School of Nursing and Health Professions at the University of San Francisco.

Campbell has worked with nurses at San Francisco hospitals who tell of frequently encountering homeless people who present to the ED with vague complaints that must be investigated, even though the clinicians understand that the person is really there to escape the weather and get a meal. Though the nurses and physicians are sympathetic, catering to those patients for the sake of EMTALA compliance takes up valuable resources and delays care to other patients, she explains.

Campbell recently heard a nurse relate her experience with a man who presented to the ED during flu season, complaining of symptoms consistent with diabetic complications, prompting the need for tests. While the patient waited, the nurse gave him a box lunch and a bed bath. When she reported that his tests indicated no diabetic issues, the man pulled his pants down and urinated on her, saying that must mean he had a urinary tract infection.

"So she was duty bound to ask about it, and he knew what to say, complaining about the itching and how he couldn't help himself when he urinated on her. For the sake of EMTALA, he got to stay again while he was worked up for a urinary tract infection that he did not have. It's a misuse of generosity, and it's sad."

Clinicians do their best to be compassionate in such instances, she says, but they also are pressured to free up resources for more needy patients.

"She knew what was going on, right from the start. He wasn't fooling her," Campbell says. "But if she had told him she was sorry, she didn't have time for this and he had to leave, that would have been called an EMTALA violation." ■

Study: Diagnostic Accuracy Still Largest Claims Risk

Diagnosis-related events are the single largest root cause of medical professional liability claims, according to a recent analysis from Coverys, a medical malpractice insurer based in Boston. They account for 33% of medical professional liability claims and 47% of indemnity payments, the report says.

Coverys analyzed more than 10,500 closed medical liability claims from 2013 to 2017 to determine the root causes of diagnosis-related allegations. The analysis determined that testing is involved in more than half of all diagnosis-related malpractice claims. Testing issues, including failures in ordering, performing, receiving/transmitting, and interpreting test results, account for more than 50% of diagnosis-related claims.

Adverse events involving cancer were most prevalent, followed by infection, cardiac/vascular conditions, fracture/dislocation, and myocardial infarction.

Most diagnostic errors occur in outpatient settings, according to the report, with 24% of diagnosis-related claims taking place in the ED and urgent care facilities but 35% of diagnostic errors occur in non-ED outpatient settings, such as physicians' offices or clinics. *(The full report is available online at: https://bit.ly/2qlmVtz.)*

The missed or delayed cancer diagnoses are largely acts of omission, which makes the claim particularly difficult to defend, notes **Robert Hanscom**, JD, vice president of business analytics with Coverys.

> "WE KNOW THAT TIME IS VERY LIMITED AND EVERYTHING IS FRENZIED FOR THE PHYSICIANS, BUT THEY STILL NEED TO BE GETTING DIFFERENTIAL DIAGNOSES."

"They didn't make the diagnoses, so they don't even know anything is wrong until weeks or months later when they are served with a lawsuit. By then they don't remember the case well, if at all, and they don't know what the circumstances were or why they may not have made that diagnosis at that point," Hanscom says. "Despite all the systems we put in place for monitoring care and documenting what happens with a patient, there is a dearth of information about these missed or delayed cancer diagnoses."

The claims analysis shows the risk of physicians yielding to the pressure of a heavy workload by rushing the decision-making process, Hanscom says. Physicians must take the time to consider all the possibilities.

"We want providers to not get caught in traps where they shortcut the diagnostic process from the cognitive side. We know that time is very limited and everything is frenzied for the physicians, but they still need to be getting differential diagnoses," Hanscom says. "Even if they're pretty sure of a diagnosis, they need to always be asking what else could this be. In many of these cases, we see a narrow diagnostic focus in which they home in on what they think this is, and that becomes fact."

Even the best physicians can be derailed by poor processes, Hanscom says, such as an electronic medical record not showing the patient's entire history. Failure to follow up on test results also can result in inaccurate diagnoses, and patient referrals to other specialists may get lost in the system, he says.

Diagnosis errors are cropping up more in outpatient settings partly because more care is being provided on an outpatient basis, but Hanscom says there is more going on than simply a proportional increase in claims. Outpatient settings tend to have fewer risk management resources available, and that results in more claims, he says.

Radiology poses a challenge because there can be variability in how they read tests, Hanscom says.

EXECUTIVE SUMMARY

Diagnosis failures still pose the biggest risk for malpractice claims. A recent review found that they account for 33% of medical professional liability claims.

- Testing is involved in more than half of those claims.
- Adverse events with cancer patients are especially common.
- Most diagnostic errors occur in outpatient settings.

Providers should take steps to reduce that variability as much as possible, he says.

"Radiologists tend to write lengthy reports that are sometimes not clear. They may say there is something that looks kind of suspicious and should be followed up, but it's buried in there at paragraph four of page two," he says. "For the primary care physician to find that and figure out he should do something, that can be a real challenge. Radiology has put it in the report so they think they're covered, but if the physician doesn't recognize that something should be done, they both get named in the lawsuit. The plaintiff's attorney doesn't make a distinction over who is more responsible for the communication failure." ■

SOURCE

- **Robert Hanscom**, JD, Vice President of Business Analytics, Coverys, Boston. Phone: (800) 224-6168.

Report: Nurse Practitioners Pose Malpractice Risk Similar to Physicians

When it comes to medical malpractice risks and the strategies for minimizing liability, risk managers should look at nurse practitioners (NPs) almost the same as physicians, according to a recent analysis of claims data.

However, requirements for physician supervision are one area that requires additional attention.

A review of closed claims by The Doctors Company, a malpractice insurance provider in Napa, CA, found that while top NP risk areas are fairly equivalent to those of physicians and can be addressed by similar strategies, many NP risk factors can be remedied if physicians are clear about NP laws and regulations within their state and support the NP in providing care within the scope of practice.

NPs are projected to make up almost one-third of the family practice workforce by 2025, notes **David B. Troxel**, MD, medical director of The Doctors Company. NPs have become increasingly popular in recent years because they allow a physician practice or hospital clinic to see a higher volume of patients while also allowing doctors to focus on more complex care.

"This is a key area for risk management because a lot of doctors are so focused on using nurse practitioners as extenders that they don't always follow as closely as they should the scope of practice requirements and limitations," Troxel says. "Each state has its own regulations defining what they can and cannot do, so it becomes very important for physicians and risk managers to understand what the role of the nurse practitioner can be in your own state."

Troxel notes that though claims frequency has been gradually declining for physicians in recent years, it has been rising for NPs. That may simply be a result of the increasing use of NPs over the past decade, and the NP claims frequency is still low, he says.

"They still get sued less often than physicians, and when they get sued the payout involving a nurse practitioner is statistically much lower than that for a physician," Troxel says. "The risk for having a nurse practitioner is really quite low, and the steps to take for making that risk even lower are quite simple."

EXECUTIVE SUMMARY

Nurse practitioners face malpractice risks similar to those of physicians. Hospitals should provide similar types and levels of education in risk management.

- Nurse practitioners will soon make up almost one-third of the family practice workshop.
- Diagnosis-related claims are most common, followed by medication-related claims.
- Physician supervision requirements can create liability risks.

Similar Risk Management Approach

The Doctors Company studied malpractice claims involving NPs over a six-year period, comparing them to claims against primary care physicians. The analysis excluded claims in which the patient was seen by both an NP and the supervising physician. The most common claim allegations were similar for both groups, suggesting that risk

management strategies also should be similar, Troxel says.

Physicians had more claims for medical management allegations, which Troxel says is not surprising because they treat more complex patients than NPs.

Diagnosis-related claims and medication-related claims were the most common in both groups, but many nurse practitioner malpractice claims can be traced to clinical and administrative factors, the study found. Those factors include a failure to adhere to nurse practitioner scope of practice.

Other factors specific to NPs include an absence of or deviation from written protocols, and inadequate physician supervision.

"Many of these factors can be remedied if physicians are clear about the nurse practitioner laws and regulations within their state and support the nurse practitioner in providing care within the scope of practice," the report authors wrote. "There should be agreement on the level of supervision that will be exercised by the physician, including the number and frequency of charts to be reviewed and co-signed. Additionally, nurse practitioners and supervising physicians should agree on specific conditions that, when identified by a nurse practitioner, warrant assessment by the supervising physician." *(The study is available online at: https://bit.ly/2EAN2ko.)*

The research indicated that claims involving NPs were generated by failures by both the NP and the supervising physician, Troxel notes. Inadequate physician supervision was at the root of many NP claims, but another prominent factor was the NP's delay in obtaining a consult from the supervising physician or a specialist, or failing to make a referral to another doctor.

"This all gets down to how a physician practice is managed and how aware they are of what a nurse practitioner can and cannot do," Troxel says. "It is relatively easy to understand your state requirements and communicate that to NPs in your practice, but somebody has to actually do it. The problem is that many physicians, especially in small practices where they don't have much administrative staff, don't have the time to take a few hours out when they hire someone and go over all these things. Over time they get comfortable with a nurse practitioner, grow confident in how they perform, and they drift away over time, letting them operate more and more independently."

That is why it is important for the physician and NP to agree on specific conditions or situations that require the physician's input, Troxel says. That may be as specific as a list of potential diagnoses for which the physician must always see the patient, he says, and a good working relationship will have the NP feeling comfortable enough to always ask the doctor for advice rather than feeling reluctant to impose on his or her time.

By the same token, the physician must be open to such consults and not discourage the NP from asking for input when necessary, Troxel says. Physicians look to NPs to improve their efficiency and better manage the patient load, but substantial liability risk is created if the doctor gives the impression that the NP should not waste his or her time with patient consults, he says. Better to err on the side of caution and encourage the NP to speak up when in doubt.

"NPs tend to be very much liked by patients and having them in the practice can be an excellent experience for the physician," Troxel says. "The key is being aware of the scope of practice and having a structure in place to help the nurse practitioners work to the best of their abilities while still including the doctor when appropriate." ■

SOURCE

- **David B. Troxel**, MD, Medical Director, The Doctors Company, Napa, CA. Email: dtroxel@thedoctors.com.

Reduce Paper Records to Decrease Data Breaches

Healthcare organizations seeking to reduce the risk of data breaches should reduce how much protected health information (PHI) they put on paper, while also stepping up "holistic" risk management efforts, according to a recent report.

Those steps can help address a unique aspect of data breaches in healthcare organizations. The 2018 Protected Health Information Data Breach Report from Verizon indicates that healthcare is the only industry where insiders accounted for the biggest threat to sensitive data. Fifty-eight percent of healthcare data breaches were attributed to employees, the report says.

Verizon analyzed 1,368 security incidents across 27 countries, finding that 33.5% of threat actions were from error and 29.5% were misuse. Physical threats accounted for

16.3%. Hacking and malware, the methods that tend to get the most media attention, accounted for only 14.8% and 10.8%, respectively.

Paper records were most often involved in errors. In error incidents involving unintentional actions directly compromising information, 38.2% were caused by misdelivery and 17.2% were attributed to disposal error.

Employees also abuse their access privileges. Of all incidents involving unapproved or malicious use of organizational resources, two-thirds came from privilege abuse, the report says.

"Access to a great deal of sensitive information is necessary for healthcare professionals to successfully carry out their duties. But along with that access comes the relatively easy ability to abuse it," the report authors wrote. "Due to HHS regulations, ransomware outbreaks are to be treated as breaches (rather than data at risk) for reporting purposes. That poses the question: Is it that healthcare organizations are doing a poor job of preventing ransomware attacks, or does it only appear that way because they are required to report them all and other industries aren't?"

In social attacks, which involved hackers targeting privileged individuals to gain access, 70% involved phishing and 11.7% involved pretexting. The researchers describe pretexting as "when the criminal emails, calls, or otherwise engages an employee in a conversation with end goals such as duping the employee into providing them with their username and password or other sensitive data."

The Verizon report is available online at: http://vz.to/2FvldiW. ■

Doctors Maintaining Certification Less Likely to Face Discipline

Physicians who maintain board certification within 10 years of their initial certification are more than two times less likely to face state medical board disciplinary actions than those who do not, according to recent research.

Maintenance of certification (MOC) has a strong association with risk of disciplinary action, the study in the *Journal of General Internal Medicine* reports. Previous research had suggested that physicians who pass initial certification exams administered by the American Board of Internal Medicine (ABIM) after medical training are five times less likely to face disciplinary actions than doctors who do not become board certified.

"ABIM data indicates that a vast majority of internists pass the certification exam after training and periodic MOC exams through their careers. Even more ultimately pass on subsequent attempts," according to an ABIM statement accompanying the report. "To explore whether there is an association between MOC exam performance and risk of disciplinary actions from state medical boards, ABIM researchers studied MOC exam results and any reported disciplinary actions for nearly 48,000 general internists who initially certified between 1990 and 2003."

Research findings include the following:

- The risk of disciplinary action against physicians declines as scores on the MOC exam increase. The researchers say this indicates that more medical knowledge is associated with fewer disciplinary actions.
- Thirty-five percent of total disciplinary actions in the study population can be attributed to not having passed the Internal Medicine MOC exam.
- Poor exam performance is associated with more severe disciplinary actions.
- There was no difference in disciplinary rates associated with the amount of continuing medical education (CME) required for state medical licensure.

The researchers conclude that completing CME alone, in the amounts required for state licensure, does not reduce the risk of disciplinary actions.

- Researchers estimated that the number of patients potentially cared for by physicians with disciplinary actions could total hundreds of thousands to a few million.

An abstract of the report is available online at: https://bit.ly/2GQPae1. ■

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CME/CE QUESTIONS

1. **In a review of EMTALA investigations by the Office of the Inspector General of the Department of Health and Human Services, including cases settled from 2002–2015, what percentages of the settlements were against hospitals and physicians?**

   a. 96% hospitals, 4% physicians
   b. 76% hospitals, 24% physicians
   c. 46% hospitals, 54% physicians
   d. 24% hospitals, 76% physicians

2. **According to research by Charleen Hsuan, PhD, why do physicians sometimes violate EMTALA by refusing care to certain patients?**

   a. The physician is too busy.
   b. The physician has a history of bad interactions with the patient.
   c. The physician does not think he or she can provide adequate care to the patient.
   d. The physician has been instructed by administrators to refuse the patient.

3. **According to analysis from Coverys, diagnosis-related events account for what percentage of medical professional liability claims?**

   a. 20%
   b. 33%
   c. 65%
   d. 81%

4. **What did a review of closed claims by The Doctors Company find about risk management concerns facing nurse practitioners?**

   a. They are very similar to those facing physicians.
   b. They are unique and physicians do not face similar concerns.
   c. They face few liability risks because all the responsibility is on supervising physicians.
   d. They face more liability risks than physicians.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Inability to Break Up Blood Clot Results in $6.6 Million Jury Verdict

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News: In early 2012, a young woman sought care at a hospital for the treatment of an anemic disorder. She underwent a surgical removal of her spleen to treat the disorder. During postoperative recovery, the patient suffered from stomach pain and fever. These symptoms were caused by an undiscovered blood clot in her system that was restricting blood flow to her intestines. The patient returned to the ED several times before any treatment was provided, but at that point it was too late and the clot could not be broken apart, limiting her functionality.

The patient sued the hospital and several physicians, arguing that they were negligent in failing to timely diagnose her blood clot. The case proceeded to a trial that lasted several days and resulted in a verdict in favor of the patient for more than $6 million. That amount is subject to the state's tort reform laws and will therefore be reduced.

Background: In March 2012, a 23-year-old nursing school student was admitted to a hospital for the removal of her spleen to treat an anemic disorder. After the surgery, the patient experienced stomach pain and a fever and stayed in the hospital for an extended period. A CT scan was performed, but the treating physicians failed to recognize the portal vein thrombosis. The patient was admitted to the ED twice before she was ultimately diagnosed with the clot on April 15, 2012.

The physician who eventually discovered the blood clot used several methods to treat the clot, but none were effective because it was "too old." Due to the medical complications, the patient was forced to temporarily drop out of nursing school but did complete her degree and secured employment at a hospital. However, the blood clot remains in her system, and the related complications forced her to switch to part-time employment status.

THE PATIENT RETURNED TO THE ED SEVERAL TIMES BEFORE ANY TREATMENT WAS PROVIDED, BUT AT THAT POINT IT WAS TOO LATE AND THE CLOT COULD NOT BE BROKEN APART.

The patient filed suit in March 2014 against four doctors and the hospital, but the patient dismissed the hospital from the lawsuit several months later. A confidential settlement was reached with one of the doctors in 2017.

The case proceeded to a jury trial against three doctors: a surgeon, a radiologist, and a general surgeon who performed the splenectomy. The jury deliberated for two days and returned a verdict in favor of the plaintiff. The award totaled $6 million, including past medical expenses, future medical expenses, loss of earning capacity, past physical pain and mental anguish, future physical pain and mental anguish, past physical impairment, and future physical impairment. However, this amount will be significantly reduced due to the state's tort reform act.

As to additional specific findings, the jury determined that the surgeon and the radiologist were negligent in their failure to diagnose and treat the patient's portal vein

thrombosis, a blood clot in the vein that brings blood from the intestines to the liver. The jury found the general surgeon who performed the splenectomy to have acted within the appropriate standard of care.

The jury also found the patient 10% negligent after hearing evidence she had refused to be administered a prophylactic blood thinner after the clot was discovered. She agreed to be administered three other blood-thinning medications, but none were successful in breaking up the clot. As a result, the clot remained in the patient's system.

What this means to you: This case highlights the necessity of timely and accurate diagnoses. Portal vein thrombosis is a blockage or narrowing of the portal vein by a blood clot. The portal vein is the blood vessel that transports blood from the intestines to the liver. Most people with portal vein thrombosis have no symptoms, but some individuals experience the accumulation of fluid in the abdomen, an enlargement of the spleen, and severe bleeding in the esophagus. The spleen is enlarged because of increased pressure in the portal vein caused by its blockage or narrowing. This increase in pressure in turn causes an increase in spleen size, or splenomegaly. The blockage or narrowing of the portal vein also causes esophageal varicose, a dilation and twisting of the esophageal veins as well as the veins in the stomach, called the gastric varices. As a result, these veins can bleed considerably in some patients.

With this knowledge, physicians can diagnose portal vein thrombosis with patients who experience bleeding in varicose veins in the esophagus or the stomach, an enlarged spleen, and/or conditions that create a risk of developing portal vein thrombosis, such as umbilical cord infection in newborns or acute appendicitis. Further, physicians can use blood tests to determine the functionality level of the patient's liver as well as whether the liver has been damaged. However, since these tests do not always reveal portal vein thrombosis, physicians who receive normal results should use Doppler ultrasonography. This can reveal a restriction or obstruction of blood flow in a patient's portal vein. In some patients, it may be necessary to conduct MRI or CT scans to reveal the patient's blood flow.

Timely and accurate diagnosis is only the first step, and must be followed by appropriate treatment to conform to the standard of care. If a patient is diagnosed with portal vein thrombosis, the treatment depends on several factors: the rapidity with which the disorder develops, the age of the patient, and the comorbidity of other disorders such as portal hypertension and bleeding from varicose veins. If the clot causes vein blockage suddenly, physicians typically will use thrombolysis. This procedure involves the use of a drug that dissolves clots, such as tissue plasminogen activator. If instead the blockage develops slowly over time, physicians use an anticoagulant, such as heparin, to prevent clots from emerging or increasing in size. This method is not used when clots suddenly develop because anticoagulants will not dissolve existing clots.

Physicians often will treat portal hypertension and bleeding from the esophagus simultaneously with the thrombosis treatment, and there are multiple techniques available to treat esophageal bleeding. Ultimately, the methods for treatment must conform to the applicable standards of care in order to protect from claims of malpractice; when multiple different appropriate treatment options exist, physicians should discuss these with the patient along with advantages and disadvantages of each method, and document it as further protection from a claim by the patient that he or she was insufficiently advised to make an informed decision.

Finally, what was critical in this case was the failure of the surgeon and subsequent ED physicians and staff to recognize, acknowledge, and diagnose postoperative complications. Stomach pain and fever are symptomatic of the body responding to something abnormal. When this occurs in a healthy person, that person may seek medical attention if symptoms persist. When a patient who has just undergone major surgery presents with these symptoms, it is the duty of healthcare practitioners to use appropriate investigative resources to uncover the source of the problem. If no definitive diagnoses can be made, experts should be consulted. A medical professional who instead chooses the path of least resistance by sending an injured or suffering patient home with analgesics rather than addressing and curing the root of the problem is more likely to be subsequently pursued for failing to provide appropriate care. Diagnosis and treatment must be prompt as this case demonstrates that certain conditions evolve over time, subsequently precluding or reducing treatment options. In that case, a medical provider's delay in proper diagnosis or proper treatment not only may constitute negligence, but it may increase the harm suffered by the patient and increase the resulting damages in any litigation. ■

REFERENCE

Decided on Feb. 15, 2018, in the 234th District Court in Harris County, Texas; case number 201417076.

State Supreme Court Reverses $22 Million Malpractice Case

News: In 2008, a woman began a series of three epidural steroid injections, the first two of which were administered without complication. The patient was scheduled to receive the third injection on Sept. 16, 2008. When the procedure began, the physician administered two sedatives and positioned the patient facedown on the surgical table. Shortly after, a monitoring instrument alerted the physician and his support staff that the patient had started to lose blood oxygen saturation.

The physician rejected his support staff's requests to resuscitate the patient and to transport her to an ED. The procedure lasted a short time, but the patient was left with low blood oxygen levels for sufficient time to cause severe brain trauma and quadriplegia for the remainder of her life. The estate was successful in the initial trial, but the state's supreme court reversed the verdict in 2018 because the jury was improperly instructed on liability.

Background: An anesthesiologist and pain management specialist began treating a patient for chronic back pain in 2008. This treatment included two epidural steroid injection procedures (ESIs) that were administered without complications. On Sept. 16, 2008, the patient arrived at the surgery center for a third ESI. The physician took the patient's vitals, administered a pain reliever and a sedative, and placed the patient face down on a surgical table. Shortly thereafter, the physician administered propofol (a different sedative) and started the procedure. The patient's blood oxygen saturation level at this point was recorded at 100%.

After the procedure began, the pulse oximeter sounded an alarm, indicating a drop in the patient's oxygen level. A surgical technician tried to turn up the oxygen several times, but each time was told by the physician to return to the imaging machine she was operating. A nurse turned up the oxygen being administered to the patient at the physician's direction. The nurse began performing a jaw thrust maneuver to open the patient's airway by repositioning her jaw. However, the nurse was having difficulty with the maneuver, and the physician ceased the administration of the epidural and assisted with the jaw thrust.

The surgical technician asked the physician if she should call the nursing director, but he told her not to because the patient was breathing and her airway was good. The surgical technician summoned the nursing director anyway using a surreptitious text message. When the nursing director arrived, the patient was lying face down on the table with five-inch needles in her back and the physician was at the head of the table holding the patient's jaw to maintain an airway. During this time, the pulse oximeter continued sounding an alarm and registering zero, and the blood pressure monitor was recycling, inflating repeatedly without registering a reading.

The nursing director grabbed a stretcher so that the patient could be turned on her back and resuscitated, but the physician prohibited resuscitation. He instead claimed that the pulse oximeter was malfunctioning and did not show the patient's true oxygen saturation. He further stated that the patient had a pulse, was breathing, and was fine. The physician directed the nursing director to retrieve a second oximeter which she placed on the patient's toe, but it also registered a reading of zero oxygen saturation. The physician continued to insist that everything was fine and resumed the procedure as various staff attempted to physically maintain the patient's airway. The procedure was finally completed 18 minutes after it began.

After completion of the procedure and removal of the needles, the patient was turned onto her back and placed on the stretcher. A pulse oximeter began registering a blood oxygen level in the low 50% range. The patient was then given medication to reverse the effects of some of the medication in her system, and the physician began manually ventilating her with a bag valve mask. Her oxygen levels quickly rose to the 90s, and she was able to maintain that level with oxygen being administered.

The patient was taken to the ED in a state of acute respiratory distress that same evening, but it was too late. She was cognitively impaired and a quadriplegic for six years until her death. The patient's estate sued the physician, the nursing director, the surgery center, and a related professional corporation. The plaintiffs presented evidence that she suffered a catastrophic brain injury caused by oxygen deprivation during the ESI and that she died from complications of that injury.

A jury found the nursing director not liable but otherwise found for the plaintiffs with an award of almost

$22 million, with 50% liability to the physician, 30% to the surgery center, and 20% to the professional corporation. However, after a lengthy appeal process, the state's supreme court determined that the jury was improperly instructed on liability, reversing the award and ordering a retrial.

What this means to you: Legal procedures aside, this case shows the need for hospitals to implement procedures for the proper management of hypoxia, especially when a patient is anesthetized. If a patient is left for a significant amount of time without adequate blood oxygen saturation — and certainly if he or she has a zero-oxygen saturation — severe harm can result. Hypoxia should be treated as an emergency situation, and oxygen therapy should be approved in a hypoxia situation without the need for physician direction or prescription. While hypoxia itself is a symptom, not a diagnosis, the underlying cause must be determined for adequate treatment. Hypoxia often can be caused by pneumonia, shock, asthma, heart failure, pulmonary embolisms, myocardial infarction, postoperative states, pneumothorax, and abnormalities in the quality and quantity of hemoglobin. In conjunction with the administration of oxygen, medical professionals can use several different techniques to ensure the patient returns to a healthy blood oxygen saturation level.

Another lesson from this case is demonstrated by the way the surgical center functioned. When staff recognize an emergency situation, they must take immediate action. Notifying the anesthesiologist in this case was appropriate. However, when the anesthesiologist did not take immediate action, the staff should have felt empowered to speak up and insist. The nurse should have informed the doctor that she was calling the nursing director despite his protests, rather than taking a clandestine approach. The nursing director should have insisted that the anesthesiologist remove the epidural needles, turn the patient on her back, place an oral airway, and ventilate the patient. While there were many individuals involved, the physician incorrectly disregarded these concerns and the individuals were unable to ensure proper action.

All healthcare organizations must put policies and procedures in place that empower staff to quickly activate the chain of command when faced with an emergency situation that is not being handled appropriately by the person in charge. It is far better to have an angry physician whose orders were not followed than a harmed patient and a lawsuit. Additionally, healthcare organizations should consider policies that mitigate and deter physician bullying, a common cause of staff reluctance to intervene.

Hospitals also should ensure procedures are in place in emergency situations for the transfer of patients to an ED. Moreover, hospitals should develop interfacility transfer procedures where a patient's needs cannot be fully met due to lack of specialty or equipment. Accurate documentation of the reasons for and the specifics of transfers are critical to ensure a thorough medical record. One particularly attractive option is an electronic sign-in/out system to track patient records and locations. An electronic system easily can be more efficient than an oral and paper transfer system.

More important, though, is developing a set of procedures that prescribe under what circumstances a patient should be transferred. Patients have the right to transfer between medical care facilities based on preference, but the more appropriate focus is on situations where the actual care of the patient depends on a transfer. To ensure intrafacility transfers are conducted efficiently, medical professionals should be familiar with hospital departments and specialty areas. Personnel should be trained on common disorders and illnesses that a facility is not capable of treating. Finally, hospitals must keep a record of nearby medical facilities that can treat disorders and illnesses that they cannot. This allows for the most efficient transfer and can foster collegiality among facilities.

In this matter, the patient's injury was indisputable, but legal procedure plays a critical role in any malpractice case, regardless of the nature and extent of the patient's injury. Such procedure can be complicated and necessarily varies from state to state. Healthcare professionals are wise to consult closely with attorneys to weigh the prospective procedural challenges to medical malpractice cases. As demonstrated with this matter, the jury's incorrect instruction on the issue of liability resulted in the reversal of a multimillion-dollar award. That is not necessarily the end of this litigation, but it is a temporary reprieve and provides the healthcare professionals with another attempt to convince a jury that they provided care within the appropriate standards. ■

REFERENCE

Decided on March 5, 2018, in the Supreme Court of Georgia; case numbers S17G0732, S17G0733, and S17G0737.