

## WINTER 2011

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## PRESIDENT'S MESSAGE

I hope you are all managing to get through these cold, snowy, ice filled days with a smile, although they have been very trying to say the least! This must be a record year for the number of incident reports filed on slips and falls! I certainly hope the worst weather is over and I for one can't wait till spring. On March 10th, we will be hosting an educational conference at the Harmonie Club which will be a great opportunity to network, enjoy a delicious dinner and listen to Dr. Steven Safyer, the President and CEO of Montefiore Medical Center. He will be speaking on current and future issues facing hospitals and healthcare systems as well as individual providers. The brochure and registration are available online on the AHRMNY website.

The annual full day conference is at the Helmsley this year on June 10, 2011. We will keep you posted on that day's topics as soon as they are finalized, but, in the planning stage are Medicaid redesign, creative discharge planning and a panel discussion of the future of risk management. We are reserving a block of rooms at the Helmsley; if anyone is traveling and wishes to reserve a room for June 10th please contact me. We can never thank our generous sponsors and contributors enough for, without their support, these events would not happen.

The Public Relations Committee Members are working to make the audio tape of the December 10, 2010 conference available on our website and we will announce the availability when completed. You can also find our group on Linked In.

We completed our tax exempt application and our accountant has advised us we can submit it to the IRS. If our application is approved, it will save us fees at the venues where we hold our seminars, and will enable us to put our dues and donations to better use. Our Fundraising Committee continues to reach out for sponsors to support our programs.

It is that time of year again, and so our Nominating Committee will be meeting to nominate the members for vacancies for officers and directors and getting the ballots out to our members to vote. We also want to remind you about the Distinguished Service Award we implemented last year. All AHRMNY members are eligible. Candidates for the Award may be nominated by submitting a paragraph of no more than 200 words. The prize is a free annual membership and free registration for the full day conference. All candidates will be voted on by AHRMNY membership with electronic ballot.

I will close by reminding you that it is not too late to renew your membership or join our AHRMNY group for the first time. We are pleased to report that we currently have 263 members which is almost as high as our record membership year of 2008. Remember we want you to reach out to us if you need our support in any way.

I hope you enjoy this edition of the Risk Management Quarterly. I think it is packed with interesting, topical and useful information. Our Publications Committee has produced another outstanding publication.

Looking forward to seeing you on March 10, 2011.

*Peggy*

*The Risk Management Quarterly (RMQ)*, the official journal of the Association for Healthcare Risk Management of New York, Inc. is published four times a year.

**RMQ's Mission Statement:** To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as other relevant information of interest to risk managers. The articles are usually written by *AHRMNY* members, so the journal serves as an opportunity for members to showcase their writing talents.

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

Please forward any ideas or submissions for publication in the *RMQ* to "Editors", via email with attachments to: [ahrm@optimum.net](mailto:ahrm@optimum.net)

The deadline for submission and consideration for the next journal is March 23, 2011.

**Reminder:**

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

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# RISK MANAGER'S PRACTICAL GUIDE TO BRINGING A FORWARD-LOOKING APPROACH TO A HOSPITAL RISK MANAGEMENT PROGRAM

BY TINA H. SERNICK-WEINSTEIN, ESQ.

## Abstract

A previous article in this journal described what an integrated forward looking approach entails and the rationale and benefits of such an approach. (See, "An Integrated and Forward-looking Approach to Risk Management in Healthcare", *Risk Management Quarterly (RMQ)*, Sernick, T and Knight, A., Spring 2010.) The purpose of this article is to provide a practical guide for healthcare Risk Managers interested in bringing a forward-looking or predictive approach to some aspect of their risk management program. This author proposes that engaging in a patient safety project is an effective way to introduce a forward-looking approach. This article describes why using a patient safety project is a good mechanism to introduce a forward-looking approach to an organization's existing risk management program. It describes guiding principles to assist the risk manager in introducing and getting support to develop a forward-looking patient safety project and provides references to tools to assist the risk manager in this effort.

## Article

### OVERVIEW

Historically, healthcare risk managers have relied heavily on medical malpractice claims and patient occurrence reporting data to react to their malpractice environment, in part, because of limitations on gathering, compiling, and integrating data from multiple, diverse sources. (Sernick, T and Knight, A) This has had implications on the way hospital resources have been allocated to risk management. In the NYC region where this author works, the culture of risk management has typically been one that focuses on claims management, avoiding predictive practices. But the tide seems to be changing across the country based upon developments in technology and research. This author proposes that it now makes sense for hospitals and their risk managers to take a second look at predictive risk management practices. Opportunities exist for risk managers in this region to bring meaningful change to the way their organization manages risk by shifting some of the risk management resources to developing a patient safety forward-looking infrastructure. While there has been much skepticism from hospital leadership about whether a forward-looking approach is feasible, it is now more than ever possible for risk managers to provide leadership with empirical evidence demonstrating the value of developing a forward-looking infrastructure within a hospital's existing risk management program. There has been a flurry of activity in the research arena and technology development that will enable a risk manager to introduce the concept of obtaining and using predictive data to develop action steps targeted to prevent medical errors from occurring in the first place. Demonstrating value through empirical evidence is critical to building awareness that will eventually translate into support from leadership. Research published by the Rand Corporation this year provides evidence linking improvements in safety to decreasing malpractice claims. According to this study, when hospitals in California improved their safety climate as measured by decreasing the rate of preventable medical errors, the hospitals were sued less often. (See, Is Better Patient Safety Associated with Less Malpractice Activity?)

Given this research, how do hospitals effectively improve safety and what role can the risk management play in this? This article addresses these concerns by describing how a risk manager can positively impact an organizations safety climate and medical malpractice claims with a forward-looking approach.

### BUILDING A FORWARD LOOKING APPROACH

Prevailing standards in the industry require a healthcare organization to identify its safety climate and understand its culture of safety as part of its efforts to delivering safe care. Since Joint Commission Standard LD.03.01.01, **Culture of Safety and Quality**, mandates "Leaders create and maintain a culture of safety and quality throughout the [organization] and the " Elements of Performance for LD.03.01.01, require that "leaders regularly evaluate the culture of safety and quality using valid and reliable tools."), it makes sense for risk management to work within the safety arena when addressing the organization's safety climate. These requirements imply that building a program that ensures safer care requires both the building of a safety infrastructure to prevent errors from taking place and monitoring progress against established goals. One mechanism for achieving this is to first measure the safety climate to identify safety concerns. Next, identify a champion team to establish a project to identify the primary and secondary drivers of the safety issues and then target efforts at eliminating these safety concerns through small tests and process change implementation. By attacking safety concerns, the organization is safer and less medical errors as the Rand Corporation has shown, results in less medical malpractice claims.<sup>1</sup> Ultimately the return on investment will be that the risk manager will be able to work within their organization to reduce medical malpractice claims while improving their organization's safety climate.

It is Central to the forward-looking process to use an evidenced based attitudinal or cultural safety assessment tool for the hospital to identify their safety problems and then work to prevent negative outcomes caused by safety issues. The measurement of your organization's safety culture is usually accomplished by administering a culture of safety survey.<sup>2</sup> Safety culture surveys are designed to enable hospitals to proactively address safety issues by providing data that a hospital can use to target efforts to correct the safety issues, thereby preventing problems before they occur.<sup>3</sup> While there are many published tools, each with benefits and weaknesses, the two surveys this author has used are the Sexton Safety Attitudes Questionnaire<sup>4</sup> and the Agency for Healthcare Research and Quality Hospital Survey on Patient Safety<sup>5</sup>. The results of the safety culture surveys provides a metric that can be made visible to leadership and clinical staff and then later serve as the springboard for developing a roadmap for changing the organization's safety climate.<sup>6</sup> In addition, there are some third party consulting organizations that have the capability to apply sophisticated analytics by incorporating safety climate survey data with medical malpractice and adverse event data to further hone in on safety and medical error issues.<sup>7</sup>

## KEY CONSIDERATIONS

How does one move forward with building this forward-looking approach if it has never been done before by your organization? Before interfacing with leadership to convince them of why this is a good idea, take the time to plan and develop your ideas. The very first step is to determine where on the radar this type of program is in the C-Suite or with the leadership at your hospital and whether this is consistent with the systems goals and strategic plans. It is important to introduce a new concept like this by incorporating your organizations values, goals and strategic vision. If the risk manager is introducing this as a new concept, it is crucial that the (s)he create a plan that will show how this program will work within your organization's existing risk management infrastructure as well develop the program infrastructure. After you have done this, it is recommended that you create a value proposition document that will be used to convince leadership to move forward. The following are some initial but key considerations when thinking about "how this will work" and what the risk manager will need to consider when developing the infrastructure for a forward-looking patient safety project. Additionally, there is a discussion about how to develop a value proposition.

1. Engaging the interest of a senior level executive early on will help avoid the "yet another project" mentality and will be key to help keep this transformative project moving forward with the necessary level of support. Think about the culture of your organization and use that information to help target the senior level executive you are seeking support from. Consider what your vision is and how you can demonstrate that your vision meshes with your organization's strategic objectives, values, vision and/or mission.
2. The key to a successful effort is to select a relevant area of high need balanced with something that is manageable in scope. Project wisdom is to start small and expand as you succeed. Some useful areas to consider are Labor & Delivery, Emergency Department, or Operating Room. For example this author used her organization's need to restructure its risk management program to decrease its malpractice costs as a vehicle to initiate a forward-looking approach that identified areas of safety concern and develop targeted action steps to decrease medical errors in its Emergency Department.
3. Once you have decided on the scope of the area under review, investigate which survey tool you will be using and whether you will be using outside resources to analyze the results. You should also consider whether you will be able to use your claims and adverse event data in combination with your culture of safety data to help pinpoint safety areas of concern. There are some third party consultants that have developed analytics to support this type of analysis.
4. In order to address the results of the safety survey, a systematic approach to prioritizing the findings and what to target is necessary. It is recommended that a project incorporate the concepts of multidisciplinary champion teams made up of physicians, nurses, receptionists, housekeeping and other administrative support services such as transport, admitting, case

management and pharmacy, depending upon the area being addressed and the goals of the project. These champion teams will be the driving forces that help identify the primary and secondary drivers of the safety findings and then test and implement the targeted efforts at bringing about the desired change.

5. The project will require the champion teams to collect data and develop run charts to monitor progress over time. Your project team must have at least one individual that is capable of understanding data analytics to the extent of identifying trends and special causes. The run charts should be displayed on the project units to encourage participation, build accountability and celebrate success. An excellent data resource is [Data Sanity: A Quantum Leap To Unprecedented Results](#) by Davis Ballistracci, Jr., 2010
6. Make certain that you have executive sponsorship that is engaged and vested in the success of the project. In addition, there must be clinical and administrative leadership engagement that will be held accountable for project success. These leaders should include the Chief Medical Officer, the Chief Nursing Officer and a senior level administrator responsible for oversight of the ancillary services. Additionally, these leaders must be capable of enforcing the meaningful participation by the champion teams.

## GUIDING PRINCIPLES FOR DEVELOPING A VALUE PROPOSITION

This author recommends developing a value proposition for executive leadership as part of your efforts to bring a forward-looking patient safety project to your existing risk management program. The value proposition should include a value proposition document (in either power point or Word) that will be shared with executive leadership in a face to face meeting where the risk manager will make the case for getting approval for developing a forward-looking patient safety program. It is important to be mindful of your audience and the level of detail expected for a preliminary proposal such as a value proposition. A value proposition document is not a work plan to get you started nor is it an educational treatise. It is a high level document proposing that the organization undertake some action or work, but displayed in a broad enough fashion so leadership can quickly see its overall impact, how this incorporates your organizations values, goals and priorities and what value it provides to the organization's bottom line. Your immediate goals are to align the thinking of the recipients of the value proposition with your proposal, so much so that at least one key executive comes away agreeing that what is being proposed is needed, pertinent, useful, practical and timely; and most importantly, that you are the most logical resource to bring this your organization. Your longer term goals are to get past the value proposition, to garnish sufficient support that a key executive recognizes that it is imperative for your organization to address patient safety in a forward-looking manner, that the program being proposed presents a realistic solution for the imperative and; sees the risk managers value by empowering the risk manager to move forward. For the purposes of this article, the value proposition being used as an example relates to a hospital Director of Risk Management seeking the support of the C-suite to develop a new patient safety program within its existing risk management infrastructure and proposes using a forward-looking approach to drive the improvement in safety and risk.

**COMPONENTS OF A VALUE PROPOSITION**

There is no one prototype for a value proposition. This author has had success with developing a value proposition that encompasses the following elements: establish an imperative and state “why now”; set forth the benefits, elaborating why what is being proposed is needed, pertinent, useful, practical and timely; provide an enticing glimpse at the actual solution in the form of a proposal summary and; finally, provide a timeline with some reference to work steps in sufficient detail that the recipients can picture how this would “work.” The following provides some sample details for each of the components of a value proposition this author used in developing a forward-looking patient safety program.

1. **Show why now**: Consider establishing the imperative of your proposed program at the outset by showing how it will carry out your organization’s priorities, such as depicted in the sample chart below:

<p><b>We have an opportunity to act –</b></p> <p><b>To make patients safer at every one of the system hospitals &amp; establish measurable goals for improvement:</b></p> <p>Systematically and reliably measure and map safety culture</p> <p>Identify and map, through medical malpractice claims, areas of risk</p> <p>Working with Corporate finance, Legal and Quality Departments</p> <p>Predict where safety issues are likely to develop</p> <p>Proactively manage the risk related to safety issues</p> <p>Working in partnership with hospitals’ operational and clinical leadership</p> <p>Improve quality performance to achieve actuarial evaluations that within 4 years supports reduction in financial contributions necessary to fund medical malpractice claims.</p>
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2. **Stating the benefits**: Some of the benefits one might consider communicating in a value proposition document when proposing a patient safety program include the information depicted in the sample chart below:

<p><b>The benefits of this program would be:</b></p> <p>Safer more reliable care</p> <ul style="list-style-type: none"> <li>• Less adverse outcomes</li> <li>• Identify problem areas and act to prevent unsafe care</li> <li>• Reduce risk and insurance exposure;</li> <li>• Reduced medical malpractice claims and the cost of those claims to the system and hospitals over time</li> </ul>
<p>Standardized mechanism to measure/quantify safety</p> <ul style="list-style-type: none"> <li>• Ability to quantify impact of patient safety on medical malpractice and to act upon the results</li> <li>• Prioritize &amp; target improvement efforts</li> <li>• Establish accountability at all levels: Corporate, Hospital and Unit</li> <li>• Establish accountability in all spheres: Operational &amp; Clinical</li> </ul>
<p>Responding to increasing patient safety regulatory related standards</p> <ul style="list-style-type: none"> <li>• Expanding patient safety accreditation standards: Joint Commission, American Board of Medical Specialties, Accreditation Council for Graduate Medical Education</li> <li>• Expanding role of DOH adverse outcome reporting</li> </ul>
<p>Federal Government Pay for Performance, or no pay for occurrence</p>

3. **Provide the solution**: It is critical that the value proposition demonstrate that there is a solution and that the solution is realistic. Consider the proposed achievements listed in the chart below to convey the proposed solution and that the solution is realistic.

<p><b>Proposed solution</b></p> <p>The program will partner with Operations, Medical Informatics &amp; Finance to establish regular reporting of trend in claim volume, cost of managing claims and establish finance goals associated with patient safety improvement targets</p> <p>The program will establish a safety profile, with short and long term goals for improvement</p> <p>Cultural Assessment will be conducted at each hospital to establish a baseline</p> <p>Results will be shared with operational and key clinical leadership at the hospital level</p> <p>Buy-in will be obtained from the operational and clinical leadership to ensure improvement in the safety profile</p> <p>The Program will create a culture shift in how the hospitals manage and deliver care:</p> <p>Operational &amp; clinical leadership sets the goals and standards for achieving improvement in safety profile and celebrating success</p> <p>Engagement by clinical and administrative staff in the development, implementation and monitoring of patient safety efforts</p> <p>Learning to use data to identify drivers of safety issues and develop measures</p> <p>Testing data driven interventions before implementation</p> <p>Data driven observation cycles and measurement of progress</p> <p>Continuous education to improve teamwork &amp; communication</p>
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4. **Timeline and overview**: This is where the theoretical comes together with the how to get it done, to paint a picture for leadership so they can easily imagine “how” this program will work with in your organization. This aspect of the value proposition is a delicate balance of detail and overview. This where you show leadership how the rubber hits the road. It is your first opportunity to show how your proposal will transform theory into function. This document should showcase that you have the ability to translate your idea into measurable action steps, while focusing on resources and the organizations goals and values at a high level.

<p><b>TIMELINE &amp; WORK STEPS OVERVIEW</b></p>
<p><b>Phase I: LAYING THE GROUNDWORK</b></p>
<ul style="list-style-type: none"> <li>• <b>3-4 months</b></li> </ul>
<ul style="list-style-type: none"> <li>• Develop Program Infrastructure</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate With Finance to Developing Data Reporting Mechanisms</li> </ul>
<ul style="list-style-type: none"> <li>• Defining Scope, Setting Priorities</li> </ul>
<ul style="list-style-type: none"> <li>• Collaborate with Med Mal Captives</li> </ul>

<b>Phase II: ESTABLISH TEAMS, CREATE BASELINE,</b>
• <b>2 months</b>
• Create Project Leadership, Project Teams & Work Plan
• Cultural Assessment: Result Reporting
• Team & Observational Training
<b>Phase III: CREATING PLAN FOR IMPROVEMENT</b>
• <b>1-2 months</b>
• Define Aims, Drivers, Measures
• Develop Tests and measurement mechanism
• Develop Project Reporting Framework
<b>Phase IV: IMPROVEMENT INTEGRATION GOES INTO IN FULL SWING</b>
• <b>9 months</b>
• Develop Result Reporting
• Initiate Data Driven Implementation
• Develop Progress Advertising
<b>*12 Month Cycle, from Phase II will reinitiate after completion of 2nd Cultural Assessment</b>

## CONCLUSION

A healthcare organization that develops effective targeted action plans aimed at key safety concerns is an organization that will be able to prevent medical errors from occurring in the first place. The key to success for the risk manager is to know how to get to the starting line as well as obtain buy-in, commitment and approval from the organization's leadership. Once the risk manager is able to get the approval necessary develop a forward-looking program, (s) he is uniquely qualified to develop a program that effectively measures and interprets its organization's safety climate data; accurately identify its organization's safety concerns; collaborate to prevent medical errors using the safety data by splicing targeted safety practices in to the everyday processes of the front line staff and the organization as a whole. All of these are the cornerstone of an effective forward-looking approach to managing risk and improving safety.

<sup>1</sup> Is Better Patient Safety Associated with Less Malpractice Activity? Greenberg, M.D.; Haviland, A.; Ashwood, J.S.; Main, R., RAND CORPORATION TECHNICAL SERIES, 2010

<sup>2</sup> Id

<sup>3</sup> Safety Culture Assessment: A tool for improving patient safety in healthcare organizations

V F Nieva, J Sorra Qual Saf Health Care 2003;12(Suppl II):ii17-ii23; Assessing Patient Safety Culture: A Review and Synthesis of Measurement Tools Aneesh K. Singla, MD, MPH, Barrett T. Kitch, MD, MPH, Joel S. Weissman, PhD, and Eric G. Campbell, PhD Journal of Patient Safety volume 2, Number 3, September, 2006

<sup>4</sup> Sexton JB, Thomas EJ. The Safety Climate Survey: Psychometric and bench making properties, Technical Report 03-03. Available at: [http://www.uth.tmc.edu/schools/med/patient\\_safety/Safety%20Climate%20Tech%20Report%200303.ppt](http://www.uth.tmc.edu/schools/med/patient_safety/Safety%20Climate%20Tech%20Report%200303.ppt). Accessed September 13, 2006. The University of Texas Center of Excellence for Patient Safety Research and Practice (AHRQ grant nos. 1P01HS1154401 and U18HS1116401).

<sup>5</sup> Hospital Survey on Patient Safety Culture. Agency for Healthcare Research and Quality, Rockville, MD. Available at: <http://www.ahrq.gov/QUAL/hospculture/>. Accessed September 13, 2006.

<sup>6</sup> Safety Culture Assessment: A tool for improving patient safety in healthcare organizations

<sup>7</sup> See, <http://www.pascalmetrics.com>

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## LEGISLATIVE UPDATE

### Public Health Law- Patient's Right to Palliative Care Information (2997-c)

Effective February, 2011, if a patient is diagnosed with a terminal illness or condition, the patient's health care practitioner (i.e., physician and nurse practitioner) shall offer to provide the patient with information and counseling regarding palliative care and end-of-life options that are appropriate to the patient, including, but not limited to: the range of options appropriate to the patient; the prognosis, risks and benefits of the various options and the patient's legal rights to comprehensive pain and symptom management at the end of life. Terminal illness or condition is defined as an illness or condition which can reasonably be expected to cause death within six months, whether or not treatment is provided.

This information may be provided orally or in writing. When there is more than one physician or nurse practitioner who share the responsibility for the patient, each of them has the responsibility under this section, unless they agree to assign the responsibility to one of them.

When a patient lacks capacity to reasonably understand and make informed choices, the attending health practitioner shall provide the information and counseling to a person with authority to make decisions for the patient.

If the attending health care practitioner is not willing to provide the patient with the information and counseling under this section, he or she shall arrange for another physician or nurse practitioner to do so, or refer or transfer the care of the patient to another physician or nurse practitioner who is willing to do so.

### WE WANT TO HEAR FROM YOU FOR THE SPRING AND SUMMER EDITION

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

*RMQ* is published four times a year with a distribution of 200-300 copies per quarter.

Please forward any ideas or submissions for publication in the *RMQ* to "Editors", via email with attachments to: [AHRM@Optimum.net](mailto:AHRM@Optimum.net)

# The Apology Program

By Cheryl M. Wendt, JD, LLM and Cassiah Ward, JD

A strong ethical and practical consensus has emerged in the healthcare industry that favors prompt disclosure of medical errors. This consensus has become known in many circles as “the apology program”. An apology program is designed to aid medical professionals and their institutions in addressing an adverse outcome or medical error when one occurs. The primary focus of such a program is disclosure.

An apology program starts with the belief that health care professionals have an ethical obligation to disclose unexpected treatment outcomes to patients. Theoretically, the purpose of an apology program is to promote better quality of care, assist health care professionals to address their errors, and foster better communication with patients and their families. The potential benefits are that the institution will improve patient safety and quality of care, while at the same time reducing medical malpractice claims. This, of course, leads to high marks for the institution by both health care professionals and patients in terms of reputation and standing. It perhaps goes without saying that, while in theory an apology program sounds like a panacea for dealing with medical errors, there have been mixed acceptance concerning its benefits.

Historically, there has been a deep-seated fear among doctors and risk managers that admitting fault is an invitation to a lawsuit. While conclusive data is still lacking, researchers from Brigham and Women’s Hospital in Boston and the University of Michigan Health System have found that an apology program consisting of disclosure and offer reduced by half the average rate of monthly malpractice lawsuits, decreased the median time to resolve claims by several months, and decreased the average cost for lawsuits by 60 percent. A study of the Michigan program funded by Blue Cross Blue Shield of Michigan Foundation found that although they could not prove that the disclosure and offer program reduced liability, the study did show it did not increase litigation costs as many feared.

In recent months, the Michigan program has received much acclaim. Michigan implemented their disclosure and offer program in 2001 with the hope of improving patient safety and reducing medical malpractice errors. Michigan summarizes their program as “apologize and learn when you’re wrong, explain and vigorously defend when you’re right and view court as a last resort”. According to the program statistics, in 2010 the number of claims and lawsuits at their facility dropped dramatically from more than 260 in 2001 to just under 100. Legal costs, on average, are down by more than 50 percent per case. The severity of the claim being made against their physicians and the monetary amount of each claim is rising far less rapidly than the national average, and opening to closing times for claims are down from more than 20 months to 10 months. Also, malpractice premiums have remained level, despite increases in clinical business.

Michigan has a disclosure and offer program that has been implemented within a very specific legal framework. The legal framework is different from many states including New York. The State of Michigan has passed several malpractice reforms that are key to their program. For example, Michigan has mandated a six month cooling off period which means that before a patient can sue, the patient must first alert the defendants by notice of intent to sue. The parties then have six months to consider their cases before going to court. The University of Michigan uses this period to investigate complaints and open dialog with patients

and their attorneys when they are represented. By their own admission, it is this critical first step of investigation that has led to a successful program. As a result of this investigative process, they have been able to often eliminate the need for a lawsuit. They have also been successful in implementing clinical improvements, and have empowered staff to speak out by utilizing a secure online patient safety reporting form. The University of Michigan also has a unified system, which allows the institution to approach patients on behalf of everyone involved rather than everyone working independently with their own insurance carriers and their own lawyers. Notably, under the malpractice reforms implemented by Michigan, the University of Michigan may only be sued as an agency in the Court of Claims, which means no jury is involved. University employees can be sued individually in Circuit Court with the case being tried to a jury, but such lawsuits are joined administratively, not consolidated, and there are separate judgments obtained in each suit that goes to verdict.

Whether an apology program similar to Michigan’s would be appropriate or practical in New York is debatable, but there are valuable lessons that can be taken from their approach. Key to an apology program is transparency as well as sincerity and honesty by all involved. With these goals in mind, protocol can be developed to enhance quality of care through the handling of adverse medical outcomes in New York.

## Montefiore’s Program

Some prominent institutions in this State, Montefiore Medical Center among them, have already embraced an apology program. The Montefiore program emphasizes *transparency and disclosure* to the patient and communication with the patient’s family. Their philosophy is that increased communication is required to meet the needs of patients and improve patient care

The investigative process is as essential to the Montefiore program as it has been with the program at the University of Michigan. At Montefiore, once an adverse event occurs, a specific protocol is followed, enabling the Hospital to (1) gather the facts; (2) ascertain what happened; and (3) determine how to prevent it from reoccurring in the future.

Under the Montefiore program, disclosure is the responsibility of the attending physician. When an error is alleged to have taken place, the role of an apology is to inform the patient and/or the family that the hospital and the physician recognize the adverse event. Keeping in mind that the apology cannot be premature, and can only occur once all the facts are known. Further, it is important that no one else is implicated in communicating the apology, for example, Dr. Jones cannot say “I’m sorry that Dr. Smith committed this egregious error”. In short, no blame is placed and no fingers are pointed during the apology. In the end, under the Montefiore program an apology should convey compassion without statements of cause. Benefits of the program include better quality of care and patient communication, the process also teaches physicians to address their errors. In addition, Montefiore has quality assurance review. An ad hoc cross-departmental committee may be convened within days of an adverse event that involves multiple services to quickly understand contributing factors and implement corrective actions. **The quality assurance process is privileged.** However, be advised that statements at quality assurance are not privileged

or shielded from disclosure if made by parties, so it is best not to have the involved attending physicians at quality assurance, so as to shield their opinions from the disclosure process (Education Law 6527 (3) and Logue v Velez, 92 N.Y.2d 13, 677 N.Y.S.2d 6 (1988).

### **An Ideal Apology Program**

An apology following medical error should be comprised of three main components. First, there is the legal component, which requires analyzing the situation to avoid admissions. Second, there is the idea that doctors and institutions want to "do the right thing" by addressing the situation in a prompt manner not just to protect the health care provider and/or the hospital, but also to do what is best for the patient. The third component involves diffusing the situation in order to mitigate or avoid a law suit.

The nature of apology and what comes first depends on the particular situation and the type of medical error that must be addressed. By addressing that a problem exists, even if it cannot be solved immediately and a lengthy investigation becomes necessary, the difficult situation is one that reminds the patient and/or the family that their treating physician cares. The physician should explain to the patient that, as their doctor, their primary concern is for the patient's well being. A plan should be determined for future handling of the patient's care, either with the treating physician or by the treating physician facilitating the patient's transition to treatment with another doctor.

Rather than a vague apology, an apology should be genuine, framed and shaped by consulting with counsel in order to ensure the adequacy of the apology. It is also advisable for the apology to be "institutionalized", meaning that no individual doctor is blamed. In order to be effective, an apology must outline what will take place going forward regarding treatment and education. For example, at a teaching hospital, doctors can inform patients that the hospital will be talking to other medical professionals to ensure that the mistake will not be repeated. Knowing there is a system in place to handle medical errors, will hopefully ferment goodwill with patients and/or their families.

Heretofore the blending of the legal system and medical ethics, and decisions about care and what doctors can say and do has, in part, been left in the hands of the courts. To keep the decision within the medical community and focus on care, hospitals may want to also consider creating ethical committees to address issues of medical error and adverse outcome. The ethical committee in conjunction with a committee consisting of lawyers, risk managers, doctors, nurses, and other health care professionals employed by the institution would be responsible to develop a program policy. The fact remains that lawyers must be involved at some point to determine appropriate disclosure and the extent of the apology, otherwise there is a risk of saying too much or too little without awareness of the legal ramifications. Once this committee has established an apology protocol, risk management should be charged with ensuring that hospital staff is informed and the protocol implemented. Medical professionals should be encouraged and taught to seek advice from risk management when an event occurs that they do not know how to handle.

Role playing may serve as another avenue to assist health care professionals and future health care professionals to become comfortable with the apology process. A lawyer or risk manager can "teach apology", using role play to demonstrate the appropriate components of an effective apology. Once the components of an effective apology are understood, compassion typically something that cannot be taught, can be learned by example when working with attending physicians. Increased communication with patients and increased willingness to discuss medical errors with patients must start from the top down.

Additionally, an apology must be made in the context of a patient's culture. A hospital or medical school's ethics committee can help foster sensitivity to a patient's particular culture. This is especially true in communities such as New York, where a diverse patient population exists.

At the heart of any apology program is the idea that quality of care is the primary concern of the hospital and the health professionals it employs. By opening a dialogue that addresses how to handle all aspects of a patient's care, including unexpected outcomes, quality of care as well as the doctor-patient relationship can be enhanced. A successful apology program will begin in the earliest stage, with medical students being taught the philosophy behind an apology program to eliminate the fear associated with addressing medical errors. A piecemeal program won't work. The program requires commitment of the entire organization, along with a well-defined policy on what disclosure is and who is responsible for it. Foremost, a disclosure program that includes apology as a component imparts an element of humanity that demonstrates to the patient, the providers, and the community that the organization cares.

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**Acknowledgment:** The authors thank Gary Kalkut, MD, MPH, Senior Vice President and Chief Medical Officer Montefiore Medical Center; Robert Ward, M.D., Division Chief of Pediatric Otolaryngology, Weill Cornell Medical College; and Madeline Schachter, JD, Partner, Global Director of Pro Bono and Corporate Social Responsibility, Baker & McKenzie, LLP for their invaluable efforts and contributions to this article.

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# Workplace Violence: Strategies for Avoidance and Prevention

By: Paul J. Siegel, Esq., Ana C. Shields, Esq. and Alessandro G. Villanella, Esq.

Violence in the workplace accounts for approximately 800 fatalities annually in the United States. In addition, almost two million non-fatal acts of violence occur annually in workplaces in the United States. Of those, approximately 320,000 are aggravated assaults. Registered Nurses (“RNs”), Licensed Practical Nurses (“LPNs”) and other healthcare workers have been identified as being particularly at risk.

## I. Impact On The Nursing Industry

On a daily basis, nurses and other healthcare workers interact with angry, distraught, mentally disturbed, or potentially violent individuals, often late at night, placing them at a substantially higher risk of assault or other forms of violence. The risk is amplified during isolated interactions with difficult patients. Further, patients, family members and the general public often enter facilities without proper identification or screening.

The risk is real. In August 2010, a registered nurse severely was injured after suffering a brutal attack at the hands of a psychiatric patient. She repeatedly was punched in the face and head and struck with a telephone receiver. In September 2010, a nurse suffered an attack at the hands of a psychiatric patient, who reportedly patient utilized a broken piece of chair to beat the nurse’s face.

Effective November 1, 2010, legislation amends Section 120.05 of the New York Penal Law – Assault in the Second Degree - to include assault on an RN or LPN with the intent to prevent the RN/LPN from performing their duties; or with the intent to cause physical injury. The law places nurses in a protected category with police officers, firefighters and other emergency responders. A physical attack against an on-duty RN or LPN is a Class D felony, subject to a maximum of seven years in prison. Proponents of the law hope it will encourage employers to take action to address violence that occurs in the workplace.

Given the private and intimate nature of many of the jobs available in the healthcare industry, employers must be particularly prudent when making decisions to hire, fire, or retain employees and when establishing security protocol. Under statutory law and common law principles, an employer is obligated to take reasonable steps to provide a safe workplace. Assaults upon employees can expose an employer to lawsuits under an assortment of theories including, but not limited to, negligent hiring and retention, *respondeat superior* theories of negligence (meaning “let the master answer” or be responsible for the negligence), the Occupational Safety and Health Act (“OSHA”), and other local laws.

## II. Mitigating The Risk

In reviewing workplace violence avoidance policies and reporting mechanisms, consider the following:

- Does your policy provide definitive guidelines regarding the employer’s objectives and expectations from its workforce? The policy comprehensively and clearly should notify employees about what the employer prohibits, including threats, intimidations, stalking, harassing communications/calls and verbal/physical assaults. Examples provide guidance.
- Is your policy communicated both in writing and verbally during routine in-service training? Properly trained supervisors or staff can help to insulate an organization against violence in the workplace by taking prompt corrective action and notifying appropriate security personnel when violence is suspected to erupt. Also, because harassment in the workplace can precipitate incidents of workplace violence, employers should consider combining anti-harassment and workplace violence training.
- Are employees asked to sign acknowledgment forms acknowledging receipt of the written policy and their attendance at training? When workplace violence occurs, these forms can be used as evidence of policy distribution and training.
- Does the policy contain clear instructions for reporting potentially violent co-workers, vendors or visitors, including anti-retaliation provisions? Such instructions help staff to feel comfortable reporting potentially dangerous situations without fear of reprisal.
- Is the policy implemented consistently? Violators should be subject to discipline up to and including discharge (if by an employee) or forfeiture of visitation rights (if by a third party). A policy is most effective if threats and misconduct are taken seriously and investigated promptly. If employees perceive the policy as non-negotiable standards of safe and proper conduct and see that those who complain are not subject to retaliation, they will be more likely to comply with their obligations to act responsibly and to report possibly dangerous circumstances.

In addition to the implementation of a workplace violence prevention policy, employers should utilize reference checks and background screening to identify unsuitable candidates.

Adequate security measures are also critical to workplace violence avoidance. Newly discharged employees should be prevented from returning to the facility and security should immediately be alerted regarding their discharge. Vendors, family members and other third parties must be required to clear security before entering the facility.

\* \* \*

While this legislation does not in and of itself subject employers to any additional liability, best practices dictate that employers ensure employees are trained and aware of reporting protocol in cases of workplace violence and that employers take such reports seriously. The best businesses proactively seek to eradicate the problem of workplace violence by apprising themselves of their available options, including knowing how to protect their employees when violent conduct is threatened or actually occurs.

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## INSURANCE UPDATE

### **Medical Malpractice Claims across the United States shows frequency declining, severity stabilizing**

Data collected from 1,600 hospitals in from years 1997 through 2007 reveals that health care organizations medical malpractice claim frequency is slightly declining and severity is leveling off, according to a report released by Zurich, one of the leading insurers of hospitals and health care organizations in North America. Not so much in New York, however...

The fifth annual Zurich benchmarking report on claims trends in the healthcare industry is now available online and can be viewed here:

<http://www.zurichna.com/internet/zna/SiteCollectionDocuments/en/Products/healthcare/PerspectivesHCnwsltrFall.pdf>

The report indicates that claims severity, or the average amount per claim, has stabilized over the past several years. The average annual rise over the past 11 years is four percent.

Additionally, Zurich reports that teaching and children's hospitals have higher claim severity than acute care community hospitals and outpatient facilities. Non-profit hospitals have the lowest severity; and among non-profits, faith-based institutions have the lowest severity of all.

The report notes that the most severity prone states continue to be New York, Illinois, and Pennsylvania. From the 1997-2007 period, New York generated the fourth highest average loss cost per occupied bed equivalent at \$4,522.

Our system in New York remains broke...



# Risky Business

## “When Common Sense is Uncommon”

By: Pamela Monastero, MBA

### Dear Risk Manager:

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

### **COMMON SENSE TIPS FOR STAFF:**

This quarter's column focuses on cultural and social issues that may impact patient care and present risk management challenges.

Clinical staff, social work professionals, patient representatives, medical interpreters and other healthcare staff must be well versed on cultural issues and must be open minded when eliciting prior medical and social histories from patients. This is especially pertinent in healthcare settings with diverse staff and a diverse patient population, further complicating the communication process. Listed below are a few examples of cases where staff members need to “go the extra mile” to obtain appropriate information from patients.

#### Social issues:

- a. In some cultures, patients do not consider beer to be an alcoholic beverage so, when asked questions related to drinking habits, patients may tend to discount the fact that beer is an alcoholic beverage and thus fail to relay this information to clinical staff. It is essential for staff to elicit whether a patient is an occasional or social drinker, a heavy drinker or an alcoholic.
- b. Young adults and teenagers may not consider the use of high caffeine beverages (e.g. RedBull™) or high caffeine/alcohol beverages (Four Loko™) to be significant enough to relay to healthcare providers in medical treatment (or emergency) settings. Not having this information can delay the formulation of diagnoses and treatment.
- c. Patients may not understand that the use of vitamins, supplements or homeopathic remedies should be communicated to healthcare providers (e.g. excessive use of Vitamin E, which can cause bleeding, or use of St. John's Wort which interferes with some prescribed medications, etc.).

- d. Female patients may not consider prescription oral contraceptives or estrogen to be medications. In certain instances (e.g. those patients are overweight and who also smoke), the failure to communicate the use of oral contraceptives can be dangerous and lead to delayed diagnoses, e.g. pulmonary embolus, stroke, etc.
- e. Allergies are another area that must be specifically explored with patients in detail. Most patients may not be savvy enough to communicate drug, environmental, food and skin allergies (e.g. latex allergies), among others, to their healthcare provider.

#### Use of Interpreters/Limited English Proficiency:

- a. Words describing anatomical parts can differ within the various dialects of each language. Caution and attention to linguistic detail are essential when communicating medical information. For example, there are many different variations of the Spanish language so addressing a Hispanic patient using generic Spanish terminology may not result in appropriate communication.
- b. A patient's level of sophistication and education must be taken into consideration in addition to any language issues, hearing impairment issues, etc.

#### **Tips & Tools:**

1. Whenever possible, it is desirable to build no pass fields with drop down menus in the electronic medical record that prompt the user to query the patient on social issues that are essential to obtaining a thorough medical history.
2. When using interpreters, the interpreter must be a trained speaker so that the nature of the questions and responses are truly understood by all parties—patient and clinical staff. Barriers such as cultural issues and patient education level must also be taken into consideration to ensure effective communication and understanding, especially when obtaining a clinical history and when dealing with informed consent issues. Remember, the ultimate goal is to have the patient understand what is happening with respect to his/her disease process and available treatment options.
3. Obtaining thorough patient histories and appropriate use of interpreters should be built into continuous medical education programs in healthcare facilities.

#### **Tools, Resources and Literature:**

[www.JCAHO.org](http://www.JCAHO.org)

[www.diversityrx.org](http://www.diversityrx.org)

# Long-Term and Continuing Care

By: Jose L. Guzman, Jr., RN, BS, MS

## Introduction

“Long-term and continuing care” (LTC) is no longer an easily definable term. Increasingly, LTC is provided in a wide variety of settings, even at home. The LTC paradigm now encompasses care and services for residents ranging from pediatric to those with temporary disabilities who require rehabilitative services – as well as the stereotypical over-65 geriatric resident.<sup>1</sup>

The following article deals with challenges facing younger consumers of LTC services, as well as, the challenges professionals face when addressing the plan of care for younger residents in LTC settings.

### More young people are winding up in nursing homes<sup>2</sup>

By MATT SEDENSKY  
The Associated Press  
Friday, January 7, 2011; 1:17 PM

SARASOTA, Fla. -- Adam Martin doesn't fit in here. No one else in this nursing home wears Air Jordans. No one else has stacks of music videos by 2Pac and Jay-Z. No one else is just 26.

It's no longer unusual to find a nursing home resident who is decades younger than his neighbor: About one in seven people now living in such facilities in the U.S. is under 65. But the growing phenomenon presents a host of challenges for nursing homes, while patients like Martin face staggering isolation.

"It's just a depressing place to live," Martin says. "I'm stuck here. You don't have no privacy at all. People die around you all the time. It starts to really get depressing because all you're seeing is negative, negative, negative."

The number of under-65 nursing home residents has risen about 22 percent in the past eight years to about 203,000, according to an analysis of statistics from the Centers for Medicare and Medicaid Services.

That number has climbed as mental health facilities close and medical advances keep people alive after they've suffered traumatic injuries. Still, the overall percentage of nursing home residents 30 and younger is less than 1 percent.

Martin was left a quadriplegic when he was accidentally shot in the neck last year by his stepbrother. He spent weeks hospitalized before being released to a different nursing home and eventually ended up in his current residence, the Sarasota Health and Rehabilitation Center. There are other residents who are well short of retirement age, but he is the youngest.

The yellow calendar on the wall of Martin's small end-of-the-hall room advertises activities such as arts and crafts. In the small common room down the hall, a worker draws a bingo ball and intones, "I-16. I-one-six." As Martin maneuvers his motorized wheelchair through the hallway, most of those he passes have white hair and wrinkled skin.

"It's lonely here," Martin says, as a single tear drips from his right eye.

Martin exchanges muted hellos with older residents as he travels down the hall to smoke outside. His entire daily routine, from showering to eating to enjoying a cigarette, is dictated by the schedules of those on whom he relies for help.

He usually wakes up late, then waits for an aide to shower him, dress him and return him to his wheelchair. He watches TV, goes to therapy five days a week and waits most days for his friend to bring him meals.

He mostly keeps to himself, engaging in infrequent and superficial conversations with his elders.

Martin's parents are unable to care for him at home. His father is a truck driver who is constantly on the road, and his stepmother is sick with lupus. Medicaid pays his bills; it could take a lawsuit for him to get care outside a nursing home.

Advocates who help young patients find alternatives to nursing homes say people are often surprised to learn there are so many in the facilities. About 15 percent of nursing home residents are under 65.

In October 2010, in Tampa, Florida during the American Society for Healthcare Risk Management (ASHRM) annual conference, AHRMNY Board Members Jose Guzman, Jr. and Francine Thomas addressed the various paradigms impacting LTC and included the needs of younger aged residents now living in LTC facilities. Risk exposures in LTC facilities have resulted in increased regulatory oversight by The Centers for Medicare & Medicaid Services (CMS.)<sup>3</sup> Over the past few years, CMS has updated their rules of participation to include addressing the dignity and rights of residents and the quality of life provided to residents. For example, a CMS “F-Tag” violation under dignity and rights incorporates the following definition:

***F-Tag 241 §483.15(a) - Dignity***  
***The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.***

Additionally, CMS released several revisions to its Quality of Life F-Tags requiring review to ensure that your organization is meeting the needs of everyone living at the facility. Supplemental F-Tags should be reviewed to determine the facility’s compliance with age-specific plan of care needs. These F-Tags include but are not limited to:

- F172 Access and Visitation Rights
- F175 Married Couples
- F241 Dignity
- F242 Self-Determination and Participation
- F246 Accommodation of Needs
- F247 Notice Before Room or Roommate Change
- F252 Safe, Clean, Comfortable and Homelike Environment
- F256 Adequate and Comfortable Lighting
- F371 Sanitary Conditions
- F461 Resident Rooms

Accommodating younger residents may include the need to find an appropriate roommate. However, in this effort, the facility must plan for the possibility of

a room or roommate change. Staff must be made aware of regulatory expectations regarding the transfer of residents from one room to another. There are potential risk exposures beyond failing to recognize the residents’ right to have control over their personal decision-making and failure to acknowledge their dignity and rights. As well, staff should be documenting changes which affect the resident’s environment-of-care, including the discussions of these changes onto a comprehensive care plan map, validating interdisciplinary processes. Failure to follow and validate this plan of care approach, likely will result in a CMS regulatory violation of F-Tag 246 under “Accommodation of Needs.”

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- 3 Center for Medicare and Medicaid (CMS) <http://www.cms.gov>

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In 2009, Mr. Guzman was Chairperson for the American Society for Healthcare Risk Management (ASHRM) PEARLS-LTC Task Force to update the LTC guide regarding LTC risk management services and was a guest lecturer at the 2010 ASHRM Annual Conference. Currently, Jose serves on the Board of Directors for AHRMNY and is an Officer for the ASHRM Board of Directors as a member of the ASHRM nominating committee.

**Should you have any suggestions or questions regarding this column; or topics of interest for future Long-Term Care columns please e-mail any suggestions to the AHRMNY Publication Committee “Editors” at [ahrm@optimum.net](mailto:ahrm@optimum.net)**

# REDEFINING MIDWIFERY: A NEW WORLD WITHOUT PROTOCOLS

Barry G. Saretsky, Esq.

On July 30 of 2010, then-governor Paterson signed into law Assembly Bill A.8117-B, which, in significant respects, redefined the practice of midwifery without actually changing a midwife's authorized scope of practice. The new law eliminates the requirement that a midwife can practice only "in accordance with a written practice agreement" with an obstetric physician or a hospital that provides obstetrical care through licensed physicians. Under the new law, which is consistent with the practices in fifteen other states, midwives are required only to have a documented "collaborative relationship" with such professionals and/or institutions. Now that the law is in effect, midwives, physicians, hospitals and the public at large will be closely monitoring how the elimination of the requirement for written practice agreements impact public health issues.

## **The Role of Midwives**

The legislative history of the new law states that midwives are an "integral part" of New York's health care system.<sup>1</sup> Since New York's Midwifery Practice Act was passed in 1992, over 1300 midwives have been licensed to practice in New York State. Midwives attend approximately 10% of all births, and 15% of all vaginal births.<sup>2</sup>

Midwives are licensed to do more than assist in childbirth. They may also assist women throughout the management of normal pregnancies, in post-partum care, and in birth control.<sup>3</sup>

## **Abolishing the Written Practice Agreement**

Not surprisingly, supporters and opponents of the new law have differing views concerning the efficacy of written practice agreements and how the elimination of the requirement for those agreements would impact public health and the professional status of midwives in New York State. Arguing in favor of the bill's passage, the New York State Nurses Association and The Nurse Practitioner Association New York State opined that written practice agreements stood as obstacles to the care provided by midwives, particularly in certain rural communities, where, these associations said, there are no physicians available to sign them. They also argued that, even when a midwife was able to secure a written practice agreement, such an agreement has "served as the basis for limiting the practice of midwifery by wrongly implying that midwives require direct supervision and interfering with effective coordination of care."<sup>4</sup>

While recognizing that "[m]idwives are an important part of the health care team," the Medical Society of the State of New York ("MSSNY") opposed the bill, arguing that the requirement for a written practice agreement does not restrict access to care and to the

choice of a licensed midwife as a health care provider. Instead, according to MSSNY, a written practice agreement "simply ensures that women who choose a midwife to provide their health care and obstetrical care are provided with every possible protection for themselves and their babies."<sup>5</sup> Similar arguments were made in opposition to the bill by The American Congress of Obstetricians and Gynecologists ("ACOG"), which opined that midwives "play an integral role in the delivery of women's health care," and that written practice agreements "prevent ambiguity, especially in regard to high-risk births," by "carefully detail[ing] the responsibilities of each provider when caring for obstetrical patients."<sup>6</sup>

In passing the new law, the legislature concluded that the requirement of a written practice agreement unnecessarily limited women's health care choices, particularly in the many areas in the state where a shortage of physicians leaves midwives as the primary reproductive health care providers.<sup>7</sup> Thus, as the legislative history explains, the bill was intended to "promote and enhance access to health care services, especially in rural and lower-income urban areas, and increase the quality of care for those women who choose midwifery services."<sup>8</sup>

The former law required a midwife's practice agreement to provide for physician consultation, referral and emergency obstetrical coverage and mandated that the agreement "include written guidelines and protocols." The new law eliminates the practice agreement requirement and the mandated protocols for physician consultation. It substitutes instead the requirement that a midwife have a "collaborative relationship" with a physician or institution that allows the midwife to access physician or hospital medical care for women with emergency obstetrical and/or gynecological issues.

The new law also eliminates the former law's requirement that the midwife's relationship with a physician or hospital include a provision for dispute resolution by which "the judgment of the appropriate physician shall prevail as to whether the pregnancy, childbirth or postpartum care is normal and whether the woman is essentially healthy in the event the practice protocols do not provide otherwise."

The formerly-required written practice agreement was also required to specify the midwife's authority to prescribe and administer drugs and diagnostic tests, and order laboratory tests. The new law retains the midwife's authority to make these medical decisions, but removes the requirement that a physician or hospital oversee the midwife's options through written protocols.

## **A World Without Protocols**

A goal of the new law's sponsors was to ensure that midwives are full-fledged health-care providers, while enabling them to avail themselves of physicians' assistance in emergencies.<sup>9</sup> How that goal will be accomplished, and at what cost, remain to be seen. An issue that will have to be played out in many contexts relates to the feasibility of "collaborative relationships."

Supporters of the new law pointed out that midwives provide management of "normal" pregnancies,<sup>10</sup> and many would opine that most pregnancies are "normal." But in a memorandum opposing the bill, MSSNY explained that midwives provide health care only for routine, uncomplicated deliveries and are not licensed to provide independent care for emergencies. And because emergencies cannot always be anticipated, a physician always needs to be "standing by." MSSNY expressed concern that, without a written practice agreement binding a midwife to a physician or hospital, an emergency could arise in which no physician would be "standing by" in close proximity to the site where the midwife is providing the care.<sup>11</sup>

ACOG opined that a written practice agreement is needed in order to identify conditions that lead to high-risk births. In ACOG's view, by the time the midwife recognizes the risk, the delivery may be in progress, and a physician or a surgeon, if needed, may not be available in time to prevent injury or death to the mother or infant.<sup>12</sup> Thus, from ACOG's perspective, women who dispense with physician care may be putting themselves and their unborn children at unnecessary risk.<sup>13</sup>

ACOG makes a similar point about home births. These, it argues, pose greater risks than births in a hospital, risks that are magnified by potential difficulties in obtaining prompt medical help if a home birth turns into an emergency.<sup>14</sup>

## **Whither Collaborative Relationships?**

At this point it is unclear how the new law's requirement that midwives establish a "collaborative relationship" with a physician or a hospital will be interpreted. In the legislature's view, the requirement "reflects current professional standards for midwifery."<sup>15</sup> The language of the new law endorses those standards. It states that the collaborative relationships the law contemplates will provide for "consultation, collaborative management and referral to address the health status and risks of [the midwife's] patients" and "include plans for emergency medical gynecological and/or obstetrical coverage."<sup>16</sup>

The new law is clearer about the purpose of the collaborative relationships than about their nuts and bolts. Perhaps in an effort to avoid what were perceived by some to be onerous requirements of written practice agreements, the new law's legislative history states that the "documentation referred to can be in the nature of a statement or file memorandum by the midwife describing the elements of the collaborative relationship."<sup>17</sup> Thus, it requires the midwife to retain "documentation" of all such "collaborative relationships," but does not specify the detail with which the relationships must be documented.

Another concern is the insurance implications to midwives and physicians. One of ACOG's memoranda in opposition to the bill quoted a statement attributed to Medical Liability Mutual Insurance Company ("MLMIC"), a medical malpractice insurer in New York<sup>18</sup>:

should the current law change and [written] collaborative [practice] agreements not be required, any physician who would be covering for a midwife for complicated deliveries would be exposed to the risk of significantly increased liability as a result of this type of arrangement. In our experience a 'complicated delivery' is often diagnosed very late in the birth process and both midwife and covering physician would have significantly increased risk. Although we would obviously not insure an independent midwife under such an arrangement, we would also need to evaluate the increased liability of the "covering" physician in terms of the underwriting risk inherent in this type of patient care.

This statement certainly suggests that liability insurers may decide to examine a midwife's "collaborative relationship" documentation in determining whether to provide, or renew, a midwife's malpractice insurance. It may also suggest that the quality of that documentation may be a factor in the underwriting of physician risks.

At this point, there does not yet appear to be authoritative guidance in this state concerning the content and necessary documentation of a collaborative relationship. This is not to suggest that standards for professional responsibility are lacking, just that established standards for "collaborative relationships" with other medical providers do not yet seem to exist in New York State. The Standards of Practice for Midwifery promulgated by the American College of Nurse-Midwives, for example, include the requirement that the midwife operate under a program for quality management that provides the midwife with the opportunity to seek consultation to review problems, including peer review of care.<sup>19</sup>

With the new law still in its infancy, health care and malpractice insurance providers, and the health care system itself, undoubtedly will see changes and adjustments connected with it.

<sup>1</sup> See S 5007-A 08117-B, 2009-2010 Regular Sessions (N.Y. 2010) (Memo).

<sup>2</sup> *Id.*

<sup>3</sup> N.Y. Education Law §6951 (McKinney's 2010).

<sup>4</sup> New York State Nurses Association, Memorandum of Support (A8117-A), June 21, 2010; The Nurse Practitioner Association New York State, Memorandum of Support (S.5007, A.8117), undated.

<sup>5</sup> Medical Society of the State of New York, Memorandum in Opposition (S.5007, A.8117), June 7, 2010.

<sup>6</sup> ACOG, Memorandum in Opposition (S.5007, A.8117A), June 18, 2010.

<sup>7</sup> See S 5007-A 08117-B, 2009-2010 Regular Sessions (N.Y. 2010) (Memo).

<sup>8</sup> *Id.*

<sup>9</sup> See S 5007-A 08117-B, 2009-2010 Regular Sessions (N.Y. 2010) (Memo).

<sup>10</sup> New York State Nurses Association, Memorandum of Support (A8117-A), June 21, 2010.

<sup>11</sup> Medical Society of the State of New York, Memorandum in Opposition (S.5007, A.8117), June 7, 2010.

<sup>12</sup> ACOG, Memorandum in Opposition (S.5007, A.8117), June 7, 2010. See ACOG District II, Memorandum in Opposition (S.5007, A.8117), June 18, 2010.

<sup>13</sup> See generally, *id.*

<sup>14</sup> ACOG, Memorandum in Opposition (S.5007, A.8117), June 7, 2010 (stating that ACOG has taken the position that home births compromise safety).

<sup>15</sup> See S 5007-A, A 08117-B, 2009-2010 Regular Sessions (N.Y. 2010) (Memo).

<sup>16</sup> N.Y. Education Law §6951 (McKinney's 2010).

<sup>17</sup> See S 5007-A 08117-B, 2009-2010 Regular Sessions (N.Y. 2010) (Memo).

<sup>18</sup> ACOG District II, Memorandum in Opposition (S.5007, A.8117), June 15, 2010.

<sup>19</sup> American College of Nurse Midwives, Standards for the Practice of Midwifery (Revised and Approved December 4, 2009), Standard VII.

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# SOCIAL MEDIA – WHAT IS IT AND IS YOUR ORGANIZATION READY?

By Lauran L. Cutler and Kristi Eldredge



## How did we get here?

It is difficult to imagine a world without YouTube, Twitter, Blogs, Facebook, LinkedIn and MySpace. Indeed, it is impossible for those born in the new millennium to remember a world without social media. Social media is a group of internet-based applications that build on the ideology and technological foundations of Web 2.0 to create a platform to connect and interact with others on topics of common interest and create a virtual community. In its infancy, the internet was a static or "read-only" modality which provided information in one direction in a company-controlled format. Millions of these passive, read-only websites appeared during the ".com" boom. Since 1999, Web 2.0 has ushered in an era of internet interactivity, permitting the creation and exchange of user generated content known as "social media".<sup>1</sup> Social media applications differs from websites by enabling users to engage in real-time conversations, as well as share information and ideas, thereby expanding "word of mouth" to everyone in their network, including users in other connected networks.

Social networks enable individual users to create profiles containing information in public or semi-public profiles. Networks enable users to share pictures, videos, and blogs for others to read. Additional features on some social networking sites allow users to create "groups" that share common interests or affiliations and hold discussion forums.<sup>2</sup> Individuals may use social media as a form of entertainment and education, as well as a vehicle to communicate and network on both a personal and professional level. Businesses, including healthcare, use social media for marketing, public relations, customer service, employee recruitment and establishment of a dialogue with their customers.<sup>3</sup>

The use of social media has exploded since its inception. As of October, 2010, Facebook reports more than 500 million active users with fifty percent of active users logging on daily, spending over 700 billion minutes per month on the site.<sup>4</sup> Twitter reports it currently has over 106 million users who send approximately 55 million tweets (messages) per day.<sup>5</sup> More than 2 billion videos are viewed daily on YouTube. Twenty-four hours of video are uploaded to YouTube every minute of every day.<sup>6</sup>

According to a Nielsen Company survey, the use of social networking has tripled in the past year.<sup>7</sup> This burgeoning trend has not excluded physicians and nurses. In one survey, 60% of surveyed physicians and 65% of surveyed nurses were interested in using social media in their professional practices.<sup>8</sup>

According to a survey by Medimix International, 34% of physicians use social media.<sup>9</sup> Social networking web sites dedicated exclusively to physicians such as Ozmosis, SocialMD and DoctorNetworking report memberships between 3,000 and 10,000 physicians each. Sermo, the largest and most popular social networking site targeted solely to physicians, currently has over 100,000 members. Uses of social media by physicians include research, continuing education, collecting health and prescription information, and consulting with other physicians. With more than 700 followers, RNChat represents a site exclusively directed to nurses for networking and discussion of a range of issues related to nursing. Popular topics include the nursing shortage, improving health care technology and nursing education.<sup>10</sup>

## Types of Social Media

There are many types of social media sites available. Understanding how these applications are used is the first step in analyzing what may work best for your organization.

Blogs are applications where individuals provide entries (referred to as postings) of any type of content, including video or text, to inform or create discussions. Blog postings are date-stamped and listed in reverse chronological order. Examples of blogs include Tumblr, Blogspot, and Bloglines. Microblogs are blogs limited to 140 characters. Examples of microblogs include Twitter, Tweetdeck, and Twitterific.

Social networks are applications that host multiple communities of individuals or organizations with similar interests. These sites enable users to connect, invite others who can then access their profiles in the network, and send messages between users. Examples of social networks include Facebook, LinkedIn and MySpace.

Podcasts are applications that enable users to post and distribute photography, video, text or audio. YouTube, Vimeo, and Flickr are among the applications with imaging capabilities.

## Most Common Social Media Sites Used By Hospitals

As of November 2010, Ed Bennet reported 890 of the approximately 5000 U.S. hospitals to be using social networking sites. Facebook, Twitter, YouTube, LinkedIn and blogs, in this order, are the most common sites used by U.S. hospitals. New York, with 93 hospitals using some form of social media, leads the nation in the number of hospitals using social networks sites.<sup>11</sup> Most hospitals using social networks are larger institutions, many with teaching and

and research affiliations. Below is a list of the top ten states with the largest number of hospitals engaged in some form of social media.

o New York	95	o Texas	45
o Michigan	56	o Ohio	36
o California	53	o Maryland	31
o Illinois	46	o North Carolina	29
o Florida	46	o Massachusetts	29

### **Social Media and Hospitals**

Due to their legitimate concerns related to patient privacy, hospitals and medical providers have been slow to engage in the use of social media. Realizing the growing number of Americans who reach out to the internet for healthcare information, hospitals and medical providers now are recognizing the need to incorporate social media into their business strategy in order to communicate with, among others, their current and prospective patient population.

Hospitals effectively use social media to promote health and wellness programs for patients and employees through posting educational videos, blogging and creating virtual communities to share and exchange information and concerns on common health-related issues. Patient satisfaction is monitored through tweets, blogs, patient testimonials and surveys, providing a unique opportunity for patients to chat directly with hospitals regarding their experiences -- both positive and negative. When crisis strikes a community, hospitals often occupy the epicenter of the disaster response activity. Social media can provide real-time updates for the affected community and hospital employees. Public relations and marketing efforts are expanded by using social media to connect to the localities served by the hospital.

### **Risk Exposures Related to the Use of Social Media in Hospitals**

Although the use of social media has many productive uses in healthcare, risk managers and administrators must understand the associated exposures and implement a strategy to minimize those risks.<sup>12</sup>

#### Violation of Federal and State Laws

Privacy violations constitute the most critical issue for hospitals. Two Wisconsin nurses were fired for allegedly taking photographs of a patient's x-ray and posting them on Facebook. The case was subsequently referred to the FBI for further investigation.<sup>13</sup> In another situation, a nurse took a picture inside the operating room and posted it to Facebook.

Unknowingly, the picture captured a patient in the background.<sup>14</sup> While conversations disclosing identifiable patient information occurring in an elevator, hallway or at a party violate the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and various state privacy laws, social media accelerates and magnifies this type of violation with a click of the mouse.

#### Medical Liability Litigation

Blog postings are public conversations and can be used as evidence in a malpractice action. On his personal blog, an emergency department (ED) physician complained that uninsured patients used EDs as primary providers, creating logjams and preventing doctors from attending to urgent cases. At a later date, the blogging physician was sued by an uninsured patient, alleging a missed diagnosis. The plaintiff's attorney produced copies of the blog posting, making the medical malpractice case more difficult to defend. In another situation, a pediatrician was sued by the parents of a child who died from complications of diabetes. Under a pseudonym, he blogged about his courtroom experiences, discussing such sensitive topics as jury preparation tactics and defense strategy. Late in the trial, the plaintiff's attorney accessed the blog and identified the defendant as its writer. The next day, the physician settled the case for a substantial amount.

*Everything* an organization publishes online is indexed, and saved as part of the internet timeline.<sup>15</sup> *Everything* that is published about an organization is also indexed and saved as part of the internet timeline.<sup>16</sup> The permanence of postings on social network sites, combined with the casual conversational tone, may thus have a deleterious effect upon medical malpractice litigation.

#### Provider/Patient Relationships

Posting medical information on social media sites and engaging in conversations with patients can blur the lines between providing educational information and providing medical advice. However, the educational message embedded in videos posted to YouTube or Facebook can be controlled. Conversations on Twitter and other blogs enable patients to move the conversation from the generalities of a disease process to specific facts and circumstances regarding their medical condition. Such situations potentially may be interpreted by patients as medical advice, ultimately creating a question as to whether a patient/provider relationship has been established, which may raise numerous issues, including allegations of patient abandonment.

Providers who offer only broad, generic information on social media sites, regardless of circumstances are least likely to be found to have established a provider-patient relationship.<sup>17</sup> However, ethical issues can arise when providers include patients in their "friend" network, which then may blur the distinction between professional and personal roles. Therefore, healthcare institutions and providers should consult with their legal

counsel to establish parameters surrounding social media conduct to avoid the creation of a provider-patient relationship through these contacts.

#### Intellectual Property

Copyright infringement and distribution of proprietary information has increasingly become an issue in the use of social media networks. Sites allow users to post videos, photos and other digital files for public viewing, without regard to the identity of the owner or creator of the content. The ability to effectively monitor and search postings across social media sites can facilitate the discovery of copyright or trademark violations. In addition, broad and immediate distribution of information also increases the exposure to violations of intellectual property rights.

#### Workplace and Employment Issues

Information obtained relating to potential or existing employees through the surveillance of social media sites by an employer can give rise to discrimination claims. In addition, social networking can create vicarious liability for a healthcare employer for threatening, harassing and other inappropriate messages posted by employees from workplace computers.<sup>18</sup>

#### Organizational Reputation

Bloggng by disgruntled patients and employees can damage an organization's reputation. With only the author's comments to consider, the public may draw its own conclusions regarding the quality of the entity. Absent the formulation of guidelines and policies regarding appropriate response to these postings, the use of social media in an effort to build loyalty or recruit new patients can be counterproductive.

Every communication on a hospital's social media site should be considered an official corporate message. Therefore, hospital representatives posting to social media sites must have a thorough understanding of the organization's corporate philosophy.<sup>19</sup> Other areas of risk exposure include, but are not limited to, deceptive or false advertising, jurisdictional issues and allegations of defamation or fraud.

#### **Risk Control Strategies**

An effective risk management strategy begins with the recognition that hospitals and healthcare organizations probably cannot avoid the use of social media in the current environment. Whether or not hospitals decide to adopt the use of social media as a business and communication strategy, at a minimum, hospitals must establish a framework to minimize risk associated with the use of social media by employees, medical staff, residents and others. Although social media cannot be absolutely controlled, it can be effectively managed through the establishment of policies and protocols, as well as staff training and monitoring.

Before embarking upon the development of policies and procedures in this area, an organization must examine its culture

culture, including brand identity, message, and tolerance for risk and dissent. Decision makers and stakeholders also should review various social media sites to enhance their understanding and explore avenues for potential alignment with the culture and goals of their enterprise.

Social media is built on the concept of exchange, discussion, and information sharing through "authentic" conversations. Engaging in this arena enables hospitals to speak directly to their audience. Similarly, the recipients of these communications are poised to respond in this public forum. Hospitals will seek to respond to deceptive or defamatory postings and must determine the optimal approach by designing appropriate techniques to address such criticism.

If a decision is made to actively engage in social media, begin slowly by starting with those areas that can be effectively managed. Many organizations have started by constructing a basic Facebook page with one-way communication to the public, regarding hospital events and educational information. Even the most modest steps into the world of social media may require the designation of an individual to manage a social media presence. This representative must have experience, skills and knowledge of both the social media and healthcare environments. Responsibilities of this individual should include overseeing the organization's social media presence. The oversight should encompass implementation of the following activities:

- formulating strategies to monitor social media sites for postings related to the organization
- conveying the message and brand of your enterprise
- facilitating the development and ongoing revisions to associated policies and procedures
- communicating with patients and staff through social media developing and implement education and training programs for all levels of staff addressing social media policies and procedures

Hospital policies and procedures should address the issues raised by the use of social media in order to reduce liability and clarify organizational expectations. The following elements should be considered in devising a social media policy:

- Define social media, its scope and use.
- Review existing policies, procedures, and guidelines and establish cyclical review timelines for modification of such protocols.
- Clearly state the application of the policy both inside and outside of the workplace when their affiliation with the organization is known identified or presumed.
- Incorporate privacy and confidentiality statements which prohibit posting any patient identifiable information such as pictures, audio, video, stories or experiences that could reveal a patients identity, or any postings that may constitute a violation of federal or state privacy laws.

- Outline rules of behavior prohibiting harassing, defamatory, libelous, threatening, or embarrassing statements related to the organization or its employees, physicians, board of directors, affiliated vendors and consultants, etc.
- Ensure compliance with all applicable state and federal laws and regulations.
- Identify parties authorized to speak on behalf of the organization.
- Prohibit the posting of proprietary or copyrighted information.
- Use appropriate disclaimers.
- Prohibit the disclosure of the identity and/or statements made by patients, employees, clients, business partners, vendors and others without their express written consent.
- Restrict posting of hospital information on non-hospital hosted and approved sites.
- Provide staff with written notification of the right of the employer to monitor electronic communications made on facility-owned computers and the consequences of inappropriate conduct.
- Obtain legal and informational technology review of all social media-related policies to ensure regulatory compliance and technical relevance.<sup>20</sup>

## Conclusion

Social media is transforming how hospitals and healthcare providers communicate and share information among themselves and with their patients. While this technology can provide improved access to healthcare information, it also creates many challenges and potential areas of liability. Hospitals must determine the role of social media in their organization and develop strategies to limit the associated liability. Finally, ongoing training and education at all levels of the organization on the productive ways to use social media in the healthcare arena will help limit the potential liabilities.

### Disclaimer:

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<sup>11</sup> Social Media Resources for Healthcare Professionals by Ed Bennett, <http://ebennett.org/hsnl/>. Last accessed January 6, 2011.

<sup>12</sup> CNA AlertBulletin; *Electronic Media: Sound Policies Maximize Benefits, Minimize Improper Use*, Issue 3, 2010.

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<sup>15</sup> Active Rain, What Happens on Vegas...Stays on Facebook, <http://activerain.com/blogsview/1198677/what-happens-in-vegas-stays-on-facebook->. Last accessed January 6, 2011.

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<sup>17</sup> Acupuncture Today, Ending a Doctor-Patient Relationship, <http://acupuncturetoday.com/mpacms/at/article.php?id=27644>. Last accessed January 6, 2011

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## EMERGING HEALTHCARE TECHNOLOGY

By Dylan C. Braverman, Esq.

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Starting with the Risk Management Quarterly's (*RMQ*) first edition of 2011, and following as a regular column, the *RMQ* will provide an update on emerging healthcare technology. The word "technology" has inserted itself into our every day consciousness. Most people think of the smart phone glued to their child's hand - and which result in \$1,000.00 phone bills, or the fancy gadgets used by pretty people listening to cool music in Apple™ advertisements.

This type of technology is certainly pervasive, but it is in healthcare that emerging technology is saving, extending and improving lives; resulting in new and "exotic" or unusual potential lawsuits. A growing focus for legal counsel is defending clients from potential liabilities stemming from technology related claims. These vary from the amazing life saving advances in medical devices and pharmaceuticals, to the equally mind bending ways engineering technology is assisting in clinical treatment and surgery.

The healthcare technology column will attempt to provide an answer to questions, provide updates on new laws, regulations and case law, and identify areas where technology may provide potential liability. Rest assured that the goal of the column is not to intimidate the reader, but to point out potential pitfalls that exist, assist with the understanding of the onslaught of related government regulations and oncoming mudslide of red tape and to, hopefully, offer real time ways to avoid being named in a lawsuit.

Following this introduction, there will be a regular article regarding emerging healthcare technology written by subject-matter experts in their field. In this issue, we invite you to read Jennine Gerrard's article about the potential liability that can arise from the content of your facility's website. Ms. Gerrard explains how your website may create a loophole allowing private patients of attending physicians to bring a direct action against the hospital where they otherwise would have been barred from making a claim under the well known *Mduba* doctrine.

Beyond such vicarious liability, however, is the more troubling instance where the claim is directly against the hospital. This liability is growing, and plaintiffs will continue to look hard for new ways to directly implicate the hospital and its perceived "deep pockets."

### How you can help

Should you have any suggestions or questions regarding this column; or topics of interest for future emerging technology columns please e-mail any suggestions to [dbraverman@blawpc.com](mailto:dbraverman@blawpc.com) and/or contact AHRMNY Publication Committee "Editors" at [ahrm@optimum.net](mailto:ahrm@optimum.net)

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## YOUR HOSPITAL'S WEBSITE –PROVIDING PLAINTIFFS WITH A PORTAL TO YOUR POLICY?

Like all businesses, healthcare facilities advertise on the Internet. In this competitive market for healthcare, hospitals create flashy websites advertising their superior staff, new technology, perhaps marketing themselves as a special type of treatment center, emphasizing one procedure or area of medicine. And patients are paying attention. They remember which hospital advertises “bloodless surgery,” or holds their facility out as the best place for cardiac care. Advertising is crucial, but the way you word your hospital’s webpage may allow plaintiffs to bring a viable claim against the hospital when the prevailing case law says that you should be insulated.

For that reason, one of the first analysis performed by legal counsel is whether or not the case is a “Mduba situation,” referring to the prevailing case law which allows service patients who come in through the Emergency Room to sue the hospital under a theory of vicarious liability. Mduba v. Benedictine Hosp., 52 A.D.2d 450, 384 NYS2d 527 (1976).

Normally, a hospital is not held liable for the acts of private attending physicians. Hill v. St Claire’s Hosp., 67 NY2d 72, 499 NYS2d 904 (1986). There are exceptions to this, but they come up fairly infrequently. Generally, if the patient does not come in through the Emergency Room, and is admitted for treatment with their private doctor, the hospital is insulated from liability for the acts of the physician. An exception would involve a situation where the hospital maintains some type of control or supervision over the doctor. Klippel v. Rubinstein, 300 A.D.2d 448 (2d Dept, 2002). The amount of control that the hospital exerts over the doctor’s treatment can tilt the scales, and overcome the rule that private physicians are legally separate from the hospital.

Another situation in which the hospital may become liable for the acts of a private attending physician is when the patient **perceives** the care that they are receiving to be from hospital staff. Obviously, this situation is very fact- specific, and it is important for counsel to take a thorough deposition to establish how the patient came to be treated in the hospital, or whether the physician was provided by the hospital (such as a radiologist or anesthesiologist), and whether the patient reasonably believed that the physician was acting at the hospital’s behest. Sarivola v. Brookdale Hosp. and Med Ctr., 204 AD2d245, 612 NYS2d 151 (1<sup>st</sup> Dept, 1994), citing Soltis v. State of New York, 172 A.D.2d 919 (3<sup>rd</sup> Dept, 1991). This is called “ostensible agency theory,” and is the portal through which plaintiffs may attack the hospital as a result of poorly worded websites or advertising.

There are two elements required to establish a medical malpractice claim against a hospital based on an ostensible agency theory. First, there has to be an element of “holding out,” the private physician, with conduct or words attributable to the hospital. Second, the patient must accept the doctor’s services in reliance on their belief that the physician was an employee or agent of the hospital. Sampson v. Mt. Vernon Hospital, 2008 NY Slip Op 7648; 55 AD3d 588; 865 NYS2d 634 (2<sup>nd</sup> Dept, 2008).

In the following case, the way in which a hospital worded its website opened it up for liability under the ostensible agency theory.

Imagine that a wrongful death case is started against a prestigious New York hospital. The plaintiff sues several private attending physicians as well as the hospital. The named physicians are in a private group, not employed by the hospital. No claims are made with respect to any hospital staff. The Risk Manager can breathe a sigh of relief, right? Not so fast. As discovery began, the patient’s wife testified that she and her husband chose this particular hospital because of its reputation for excellent cardiac care. She testified that she went onto the hospital’s website, as she didn’t know the names of any specific doctors, and saw a highlighted section entitled, “**Our Doctors.**” This part of the website contained a drop-down menu which listed the names of all the private physicians, without any language explaining that they were affiliated with the hospital but not employed by the hospital. The plaintiffs picked a name at random, called the physicians’ group for an appointment, and thus the relationship began. In this case, there was an argument made at trial that the hospital had exposure under the theory of **ostensible agency**, as the hospital’s website explicitly held the physicians out as “their doctors.”

Under this theory, it is the plaintiff’s perception that governs. It is the same theory under which hospitals are held liable as the *de facto* excess insurer of private groups providing services in anesthesia and radiology. The average patient doesn’t think about the fact that the person taking their x-ray during a hospital admission is a private attending physician, not employed by the hospital. The case law often supports claims against hospitals for such services, as the patients believe that they can rely upon the fact that people treating them in the hospital are in fact, hospital employees. This issue has been covered in cases such as Dragotta v. Southampton Hospital, 39AD3d 698, where the Court denied the hospital’s motion for summary judgment, holding that there was an issue of fact as to whether a hospital may be liable for a private radiology group providing services within.

In the case discussed above, in which the hospital held private physicians out as “Our Doctors” on their website, the private attending physicians won their case, mooted the issue of vicarious liability for the hospital. However, the plaintiff’s attorney did make this argument in the middle of trial, and the Court felt that it was a fair question to submit to the jury. **The hospital has since redesigned its website, to include a disclaimer, explaining that certain doctors are not employees of the hospital.**

Although there is no case law yet with respect to vicarious liability for hospitals based on their website’s design or advertising, there is an analogous case which deals with printed materials given to patients. In Contu v. Albert, 18 A.D.3d 692, 795 N.Y.S.2d 740 (2<sup>nd</sup> Dept, 2005), a plaintiff sued a hospital, seeking to impose vicarious liability for treatment by private physicians. In this case, the hospital was handing out printed brochures, stating that patients would receive a personal consultation with the defendant doctors, who were a “team of specialists” that comprised the hospital’s prostate unit. The Court held that the hospital was vicariously liable for the defendant doctors’ negligence because it held the doctors out as its employees through an advertising campaign. They said that, “Apparent agency may be found when a hospital represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent.” The patients relied on the brochure, which referred to the defendant doctors as part of their “team of specialists.” The Court said that this was enough to hold the hospital responsible for the private physicians.

By now, you have hopefully pulled up your hospital’s website and carefully examined the wording to make sure that private physicians are not being “held out” as employees or agents of your facility. To be sure, referring to them as “Our Doctors” is enough to let this issue go to a jury to decide. Any type of advertising of your facility should contain language distinguishing private physicians from hospital staff in a way that will not discourage patients from selecting your hospital. The distinction between advertising that a group is “our team” and “a team of specialized physicians affiliated with the facility” seems subtle, but the more information that patients are given about the relationships of medical staff to the hospital, the smaller your chances are of battling a case for liability based on the theory of ostensible agency.

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## **AHRMNY Conference Summary Fall Half-Day Conference – December 10, 2010 New York Helmsley Hotel**

**On December 10, 2010, AHRMNY hosted a very successful half day educational seminar at the Helmsley Hotel with over 100 attendees. We gratefully acknowledge our generous sponsors, Kaufman Borgeest & Ryan, LLP and Pilkington & Leggett, PC. Many thanks to the Education Committee for their time and efforts.**

**The program opened with a timely and informative panel discussion on the Family Health Care Decisions Act (FHCDA), moderated by Carolyn Reinach Wolf, Esq., Senior Partner Abrams, Fensterman, et al. Panelists were Jeffrey Berger, MD, Director, Clinical Ethics, Winthrop University Hospital, Karen Blick, LCSW, LNHA, Administrator Schnurmacher Center for Nursing & Rehabilitation and Robert Herel, LCSW, Director Social Work/Chairperson Ethics Committee of the Silvercrest Center for Nursing & Rehabilitation. Discussion included practical aspects of operationalizing the FHCDA in diverse healthcare settings, the role of the Ethics Review Committee and addressed the unique challenges that providers face today in healthcare decision making.**

**The second speaker, Aviva Halpert, Privacy and Security Officer/Chief HIPAA Officer Mt. Sinai Hospital presented a lively, engaging overview of HIPAA Compliance and Privacy issues from the perspective of a major teaching institution. Ms. Halpert reviewed both the highlights of the regulations and related scenarios.**

**The session concluded with a dynamic lecturer, Kenneth N. Rashbaum, Esq., Rashbaum Associates, LLC who provided a very thought provoking presentation on A Perfect Electrical Storm; The Electronic Health Record (EHR) in Litigation and Oversight Proceedings. Mr. Rashbaum explored a comprehensive overview of current and future EHR issues, including demand, preservation and legal hold process, liability/risks, loss mitigation admissibility, HIPAA security and emphasized risk management by design.**

**We look forward to our next educational program to be held March 10, 2011.**

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