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MARCH 2009
VOL. 31, NO. 3 • (pages 25-36)

Downturn in economy may bring more challenges for risk managers

Expect more ED usage, lower patient compliance, reimbursement problems

The current recession is hitting every sector of the economy, and health care is no exception. In addition to the financial woes that are affecting many companies, health care providers are facing a second threat — the increased risks and liabilities that stem from the way people respond to their own money problems. Health care risk managers should be on the lookout for those recession-related risks and do what they can to minimize the damage.

One of the most direct effects of the recession will be seen in the emergency department (ED), says **Michael Mathis**, a health care analyst and consultant with the Dallas office of Korn/Ferry International, a consulting company that focuses on executive recruitment. State-level budget cuts for Medicaid recipients will result in increased ED visits, he predicts, and that means an inevitable increase in ED-related liability exposure.

"It is absolutely true that we are seeing state-level budget cuts for Medicare recipients," he says. There is a pendulum of reasoning for this — nonprofit health care systems rely on a growth engine that revolves

EXECUTIVE SUMMARY

The faltering economy will increase risks and liabilities in the health care sector, so risk managers should act proactively to minimize the impact. Some analysts predict that effect will come later than in the rest of the economy, because the health care sector lags behind the rest of the economy.

- Financial difficulties will cause more people to use emergency departments for primary care.
- Employers and third-party payers will tighten reimbursement standards.
- Focus on sound risk management principles to lower economy-related risks.

around access to capital for growth. With the capital markets being frozen right now, we are experiencing impacts on operating performances," Mathis says. "As Medicare reimbursements remain flat or decline, we see debt levels increase. Along with this, we see ED levels rise, because patients lose access to primary care services. They begin to hold off on receiving care until it is a dire situation. Hence, the increase in ED visits."

Mathis says ED patient volumes have grown 2.5% to 3% over the past decade, and that figure is only going to accelerate during a recession. In addition, he expects inpatient and outpatient volumes to decline in the near-term as patients put off nonlife-threatening operations and procedures.

Risk managers also should watch for decreased staffing ratios that could threaten patient safety, says **Christy Dempsey**, RN, MBA, CNOR, senior vice president for clinical operations at Patient Flow Technology Inc., a company based in Boston that provides advice on improving ED management.

"I worry that the economy will force hospitals to increase the number of patients per nurse, which is a huge risk for hospitals in terms of medication errors and adverse events," she says. "Elective surgery cases are already showing a decline. People will wait longer to go to the doctor and will be sicker when they arrive in the ED or the clinic. This will require more and more expensive treatments, further driving up the cost without the bread-and-butter revenue from elective volume."

Risk managers may become involved in the controversy over executive compensation, says **C.J. Bolster**, vice president with the Atlanta office of the Hay Group consulting firm, which assists companies with executive recruiting and other management issues. The recession and the government bailouts have put a spotlight on executive pay packages and perks that some consider excessive, so Bolster says health care risk managers should be prepared to respond.

"Scrutiny of executive compensation practices has increased in the past year and will only continue to increase this year. Greater transparency is required from hospitals," he says. "There is a high likelihood that the criticism of for-profit executive compensation practices will cascade into the not-for-profit arena, thus impacting many hospitals."

That criticism, and the organization's response to it, may have a significant impact on recruitment and retention of top leaders, Bolster says.

"Risk managers must work to assist boards to meet their regulatory obligations while at the same time being mindful that outstanding leadership will need to be in place to navigate the turmoil that lies ahead," he says. "It's a delicate and often uncomfortable line."

Take proactive approach to recession

Mathis says risk managers must approach the issue with a proactive attitude. ED costs in hospitals already are scrutinized closely, and now the risk manager must emphasize that there is even less margin for error in a challenging economy. One strategy is to divert people from the ED in the first place. Discourage them from coming to your high-liability department by giving them other options.

Healthcare Risk Management® (ISSN 1081-6534), including **HRM Legal Review & Commentary**™, is published monthly by AHC Media, LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

POSTMASTER: Send address changes to ***Healthcare Risk Management***®, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $495. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $545. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are $87 each. (GST registration number R128870672.)

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This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

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"In order to take some of the strain off the ED, many organizations are establishing community centers as health care access alternatives, especially for those without insurance. These centers are set up to diffuse ED traffic with the hope that related ED visit costs will go down," Mathis says. "The intention is that with the availability of community centers, patients will think twice before visiting EDs."

An additional goal of the centers is to inform patients of health care system benefits, which in turn may result in them obtaining coverage. Educating patients is increasingly important, Mathis says, which means web sites must be up to date, on-site seminars should be offered, and corresponding literature should be available. While there is a front-end cost to establishing those centers, he says it is a worthwhile investment and is beneficial even if one out of 10 garners coverage.

There are numerous ways that the economy affects health care risk management, Mathis says. For instance, institutions that depend on charitable giving may see less revenue, which almost always means tighter budgets for risk management and everyone else.

"A lot of health care systems depend on philanthropic donations, and we have already seen significant declines in giving in this market," he says. "For many corporations and organizations, philanthropy is the first area to receive drastic cuts. This impacts health care organization growth, as this funding source generally provides for enhanced services and new buildings. With the current decline in giving, organizations are also holding off on adding staff in this area."

Elective procedures declining

Many facilities already are seeing a decline in elective surgeries, which can mean a big decline in revenue, say **Kevin Schulman**, MD, a professor of medicine at Duke University's School of Medicine in Durham, NC. He also serves as the director of the school's Health Sector Management program.

"We'll probably also see difficulty in collecting patient copays and deductibles, if you're not seeing that already," Schulman says. "There's also an immediate hit on capital planning, which seems to be driven by the banking crisis as much as the overall economy. That being said, health care still seems to be holding up OK right now. We may not see the real effects for a while."

Some analysts say the health care industry may be among the last to feel the full brunt of the economic slowdown, because health care tends to lag behind the rest of the economy. But the effects are coming, they say. **(See p. 28 for more on the timing of the recession's effects.)**

"If the economy is still down this summer, then the contracts we sign for next year will look very different from the contracts we have today," he says. "We'll see increasing difficulties from the uninsured this year, but next year from the insured, in terms of what their benefit packages look like."

The dropoff in elective procedures may have a substantial effect on some providers, cautions **George Pillari**, a managing director with the Healthcare Industry Group at Alvarez & Marsal in San Francisco.

"These procedures tend to be the bread and butter for some facilities, the profitable procedures that usually have good payers, and you can count on that money as a solid part of your revenue stream," he says. "When that revenue falls off sharply, you lose a small but important part of your payer mix. Even if they represent only a couple percent of your overall revenue, they might represent 20% of your profits."

That revenue decrease can ripple through an

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organization and prompt budget cutbacks and staff cuts, but Pillari says it remains to be seen whether the decrease is just a temporary response borne of fear and uncertainty or whether it will be a lasting effect for the next couple of years.

Employer-based health insurance programs are going to feel the pinch of the economy and tighten their payment standards, says **Joan T. Schmit**, PhD, professor of risk management and insurance at the University of Wisconsin-Madison, Wisconsin School of Business.

"I would anticipate a major effect of the economy will be a retrenchment of employer-based health insurance programs. Employers are likely to watch their costs much more than in the past, forcing health care providers to justify their activities even more than before, and likely restricting what is covered," she says. "I would anticipate the possibility of greater liability threats in this environment, for example, exclusion of procedures that when denied lead to further health deterioration."

Ron Wince, CEO of Guidon Performance Solutions, a consulting group based in Mesa, AZ, says he has been advising his health care clients not to let patient safety and risk management take a hit because of the economy. Though it is common to hear employers say every department has to share the pain of budget cuts, it can be shortsighted to cut risk management efforts, he says. The result could be a significant liability payout in the future that more than negates the budget savings.

"We're also encouraging our clients to keep their attention on the small improvements they can make without any added expense," he says. "This includes ideas like making sure items are clearly labeled and easily identified even in a dark room, where you store oxygen bottles, how you store gurneys so they don't create a hazard for staff and patients. We have to remember the impact things like this can have even when we're worried about more big-picture concerns with the economy."

Even in the face of recession-related challenges for health care, Schmit says risk managers should remember that they already have the skills and the tools to address them. Health care risk managers must focus on the basics, she says.

"The fundamentals of risk management do not change. Health care providers should be encouraged to continue to maintain their quality of service, risk communication, transparency, and long-term focus," Schmit says. "Their profitability is likely to suffer in the short run as some retrenchment occurs, but the long-term success of their practice will be more likely to succeed." ■

Recession effects may be delayed, but still inevitable

Don't believe anyone who tells you the health care industry is "recession-proof," says **Thomas E. Getzen**, PhD, professor of risk, insurance, and health management at the Fox School of Business at Temple University in Philadelphia. Getzen also is executive director of the International Health Economics Association.

The health care sector may be the last to feel the effects of the recession, but it is not immune, he says.

"It would be more accurate to say that health care is inertial, responding only slowly over time to macroeconomic changes. That means that the impact of a recession may be delayed, even to the point that health care will feel the effects just as the rest of the economy begins to turn upward again."

The recession is likely to produce only superficial effects for health care risk management changes in 2009 and 2010, Getzen predicts. He says major layoffs, abandoned construction projects, physician bankruptcies, and sudden drops in price of care are unlikely. But further down the road, he says, there could be substantial changes in organization and financing, which then create structural shifts in employment and prices.

The near future provides a false sense of security for health care risk managers, he says. Getzen says he expects continued growth in health care employment throughout 2009 and then moderating in 2010 or after. Health care employment is not as vulnerable to the sudden ups and downs of the economy as some other sectors, he notes.

Spending for programs such as Medicare and Medicaid is set in advance, Getzen notes, which makes them less reactive to economic changes. Private insurance, however, is more responsive to current events. Even there, the effect usually is

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not dramatic, because premiums are set in advance. Changes usually are related to changes in medical expenses, he says. ■

Patient compliance, test results are problematic

The struggling economy makes **William J. Spratt**, JD, a health care attorney with K&L Gates in Miami, worry about the effect on health care providers. Spratt is a former health care administrator, so he has seen the health care industry from all angles and says risk managers will face more trouble in the near future. Some of the problems will not have an obvious connection to the recession, but the causal link is there if you look, he notes.

"Patient compliance will be a major issue, especially among some demographics, such as the low income, the elderly, those on Medicare and Medicaid. Physicians are reporting that patients are canceling appointments, not filling prescriptions, not having diagnostic work done, and not returning for follow-up appointments, because they can no longer incur the expense of copayments," Spratt explains. "This will require physicians to be especially attentive to follow up with patients, especially on critical diagnostics and referrals to specialists, and will require thorough documentation of patient compliance/noncompliance with treatment orders and referrals."

Physicians should consider staffing a critical case management function to identify, track, and follow up with those patients who are most at risk, Spratt suggests. In anticipation of an increasing number of patients canceling appointments or not showing up, encourage physicians to develop a mechanism for referring the charts of those patients to a clinician to ensure that appropriate follow-up occurs.

Risk managers should be especially wary about test results not being communicated and important follow-up care falling through the cracks, he says. Tighter budgets and smaller staffs may mean that there are fewer resources for following up on a breast cancer diagnosis, for instance, and failure to do so can create major liability.

"When we start cutting staff and budgets and telling everyone to tighten up, there is the real possibility that those follow-up calls won't be made, that no one does anything when the patient doesn't respond to an important test result, or maybe that test result isn't even communicated to the patient," he says. "You can't let the standards slip for that kind of work, no matter how bad the economy gets." ■

SOURCE

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Training, high standards can reduce copter risks

(Editor's note: This is the second of a two-part series about the hidden risks and liabilities of medical helicopters. In last month's Healthcare Risk Management, *we explored the risks and reviewed recent crashes. This month, we compile advice on lowering those risks and take a closer look at one hospital that has revamped its medical helicopter system after experiencing two crashes.)*

For all their undeniable benefits, medical helicopters bring with them a high risk of tragedy and liability for the hospital. When a helicopter goes down, most often people die and huge lawsuits result. But there are ways to minimize those risks.

Risk managers have a strong impetus to act. Thirty-five people were killed in nine medical helicopter tragedies in 2008, the deadliest year

EXECUTIVE SUMMARY

The risks and potential liability associated with medical helicopter services can be reduced through strict adherence to the highest professional standards. Merely complying with the minimum government standards is not enough.

- Crew and administrators must be willing to turn down missions that are too risky.
- Provide safety equipment that addresses some of the most common causes of crashes.
- Insulate the hospital from liability when contracting with a helicopter service.

ever for such crashes, prompting the National Transportation Safety Board (NTSB) to investigate the causes and consider tighter restrictions on medical helicopters. The NTSB has investigated 65 fatal medical helicopter crashes since 1989.

Risk managers should focus on five key steps for reducing the risks and potential liability from a medical helicopter crash, says **Don Maciejewski**, JD, an aviation attorney with the Jacksonville, FL, law firm of Zisser Robison. He also is a certified aircraft accident investigator, and before practicing law, he was a U.S. Army helicopter pilot. He now specializes in litigation related to helicopter and airplane crashes.

Maciejewski outlines these five ways to reduce the risks and liability exposure:

1. Train the crew appropriately and to the highest standards.

Provide, or require as a condition of your contract with a vendor, that they provide all flight crew with training in "cockpit resource management," which ensures that the crew members communicate with each other effectively. In many cases, for instance, a co-pilot or other crew member knows that something is wrong but is reluctant to say anything to the pilot.

2. Use good risk management when deciding whether to accept missions.

Employ a risk assessment matrix that factors in safety elements and the urgency of the mission. If the patient is critical and likely to die without an air evacuation, then that must be considered differently from a case in which the patient could be transported by ground even though that trip would be longer. If weather conditions are iffy, you must be willing to refuse the noncritical mission. And when weather conditions are beyond acceptable, you must be willing to refuse even the critical patient. If your crew and administrators are not willing to make that hard decision, you have the wrong people in those positions.

3. Insure your facility for the worst possible scenario.

That means a helicopter crash that kills five people, leaves one child permanently disabled, and the crash was caused by crew and/or administrative error.

4. Insulate the hospital from the helicopter operator as much as possible.

When developing a helicopter service, which often means contracting with an outside company to provide the aircraft and sometimes the crew, place the risk on that other company at every opportunity. Strive for a contractual arrangement that places the liability on the helicopter company to the greatest extent possible.

Maciejewski points out that it is difficult for a hospital to escape liability following a helicopter crash, even when the aircraft was leased from another company. If the helicopter was flying under the auspices of the hospital and at the direction of the hospital, there will be ample legal arguments for suing the provider, he says.

"That doesn't mean you don't try to put some distance between your organization and the other," he says. "You have a memorandum of understanding that says your hospital's responsibility is to say, 'Here's the patient; here's their status; here's where they need to go.' Then it's up to the other company to decide whether to go or not. The smaller hospitals especially have to do it that way, because they can't afford to insure against risk."

5. Formalize the helicopter service and follow strict protocols.

The helicopter service must be set up to adhere to the strictest standards from the NTSB and best practices for aviation. Never forget that flying helicopters is vastly different from operating ground ambulances and that you must have a highly organized system in place that requires everyone involved to follow set protocols.

FAA standards not enough

The Federal Aviation Administration (FAA) requirements for medical helicopters are not as stringent as the nonbinding guidelines from the NTSB, notes **Kathy Poppitt**, JD, a partner in the Austin, TX, office of the law firm Thompson & Knight. So don't be misled by claims that a helicopter meets all FAA requirements. That's a fine start, she says, but risk managers should strive for compliance with the NTSB guidelines for a higher measure of safety. **(For more on a program that goes beyond the minimum requirements, see the article on p. 32.)**

In January 2006, the NTSB issued a special investigation report which noted that many of the 55 EMS-related aviation accidents (fatal and nonfatal) that occurred between January 2002 and January 2005 could have been prevented with simple corrective actions, including oversight, flight risk evaluations, improved dispatch procedures, and the incorporation of available technologies. The NTSB issued four safety recommendations to the FAA, which have not yet been fully implemented. *(Editor's note: The complete report and recommendations can be found online at www.ntsb.gov/*

SOURCES

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publictn/2006/SIR0601.pdf.)

The Safety Board also has added medical helicopter safety to its Most Wanted List of Transportation Safety Improvements. *(Editor's note: A summary of the Oct. 28, 2008, board meeting regarding the Most Wanted List of Transportation Safety Improvements is online at www.ntsb.gov/recs/mostwanted/fedmwlppt webfinal.pdf.)*

Flights may not be reimbursed

In addition to the crash risk, risk managers should remember that poor flight decisions can cause reimbursement difficulties, Poppitt says. An air transfer can be twice as expensive, sometimes much more, than ground transport, so third-party payers are not shy about denying reimbursement on the grounds that the helicopter trip was not really necessary.

"So, when your dispatcher is making that call whether to go or not, they have to remember that even when the weather is good and there's not really much of a safety question, you still can't send the helicopter out for every possible run," she says. "There is evidence that these services are overused, and payers are aware of that. They're going to kick it back and leave you with the bill."

And using the helicopter when it wasn't really necessary provides strong ammunition for a plaintiff's attorney, Poppitt notes. When tragedy strikes, the other side is going to say, "They didn't really need to send the helicopter out at all, and now three crew members are dead."

Advanced technology can help reduce the risks, particularly night vision goggles and devices that alert the pilot to dangerous terrain and low altitude. Providing that equipment, or requiring that your vendor provide it, can greatly enhance safety for your helicopter program, Poppitt says. But she also cautions not to put too much faith in those systems.

Terrain warning systems, for instance, can produce too many false-positive warnings and cause the crew to grow complacent, Poppitt says. The problem is that the systems are designed largely for aircraft that don't spend a great deal of time flying low and landing in unusual places, as medical helicopters do, so they warn of terrain so often that the helicopter crew doesn't take much notice when they really are about to fly into a mountain. Such technology can improve safety, but it is not a panacea.

Check company's safety record

When selecting a helicopter company to provide air service for your hospital, you should focus on safety as a top priority, says **David Norton**, JD, an attorney with the law firm of Shackelford Melton in Dallas. Norton also is a pilot who helps his clients own, operate, buy, sell, and/or lease all sizes and types of business aircraft. A large part of his practice deals with providing aviation regulatory counsel and legal risk management for his clients. There will be many cost and business factors to consider, as when selecting any vendor, but for this service the safety record and overall safety program must be a top priority, Norton notes.

"Look for the company that goes beyond the minimum standards," he says. "This is not an area where you want to settle for the company that's just doing what they have to do to be in compliance."

Due diligence is important, Norton says. Take advantage of the Internet to research the charter company as much as you can to find public records and news reports about the company's history and current standing with regulators. Always ask if the charter company has had any regulatory violations or other issues with the FAA, and how they were addressed, he suggests. Remember, however, that the FAA regulations are so complex that nearly every charter company has had some sort of violation.

"The thing you want to know is what kind of run-in they had with the FAA," Norton says. "Was it because they didn't complete some piece of paperwork in the right way, or was it because a tail rotor fell off in flight?" ■

Wake Forest revamps after two copter crashes

The air ambulance program at Wake Forest University Baptist Medical Center in Winston-Salem, NC, goes beyond the minimum requirements in an effort to make its medical helicopters as safe as they can be.

The institution flies its medical choppers under the guidelines recommended in 1988 by the National Safety Transportation Board (NTSB), which the Federal Aviation Administration (FAA) still has not adopted as requirements for all programs. Wake Forest has good reason to take helicopter safety seriously: The program began in 1986 and soon experienced two fatal crashes. Those accidents prompted the hospital to put safety first.

Those crashes occurred when the aircraft were not as advanced, and terrain avoidance systems would have helped in both cases, says **James Bryant**, RN, MSN, director of emergency and transport services at Wake Forest. The hospital now flies an EC-135 Eurocopter, which is smaller and more fuel-efficient than its predecessor, and it comes equipped with terrain avoidance, autopilot, satellite tracking, and a digital cockpit as opposed to older dial-type gauges.

The crew consists of one pilot, a nurse, and a paramedic. It typically carries one patient but can take two if needed. The hospital just recently acquired night vision goggles, and the crew was to begin training with them in January.

Wake Forest contracts with Air Methods, a company based in Englewood, CO, that provides the aircraft, pilots, mechanics, and logistical support. Wake Forest provides the medical crew, billing, dispatching, and flight monitoring for the missions. Flight operations are monitored from Air Methods' Colorado base, aiding the Wake Forest crew with weather reports and decision making about each mission. Wake Forest has a strict policy that says any crew member can veto a mission for safety reasons.

"If any flight member believes the flight is not a go, and that includes everything down to just a gut feeling, then we do not go on the flight," Bryant says. "Anyone can decline a flight. It could be a bad feeling about the weather or it can be that they're not feeling well, they haven't had a good day, and they don't think they can fulfill their obligation to safety."

Wake Forest never second-guesses or challenges pilots or mechanics about safety. If a mechanic says the aircraft can't fly today, that's the end of the discussion. But at the same time, Bryant says, the crew is held to extremely high standards for compliance with safety regulations. A paramedic recently was grounded for a period of time because he left a trash bag near the helicopter — a safety risk because the bag could be sucked into the engine. The pilot found the bag and had the paramedic temporarily grounded, a strong message that safety infractions will not be tolerated.

The Wake Forest program works proactively to minimize many risks by designating safe landing areas in many communities, studying the approach and hazards in advance. Even with a single aircraft, Wake Forest flies about 600 missions per year, averaging two per day.

Bryant is in the process of working out an arrangement with his counterparts at other hospitals in the community, so they can share satellite tracking data for their helicopter programs, in effect creating an air traffic control system for area medical helicopters. He already has worked out an agreement with one nearby hospital and hopes to include many more. Such an arrangement could help avoid crashes, such as the June 29, 2008, incident in which seven people died when two helicopters crashed into each other near Flagstaff (AZ) Medical Center. The two helicopters, from different air ambulance services, were both trying to deliver patients to the hospital.

Wake Forest requires that its medical choppers fly under the FAA's "Part 135" rules, referring to a part of the FAA regulations governing the minimum weather allowances for safe flight, rather than the "Part 91" rules. The FAA allows medical choppers to fly under "Part 91," which means flying in worse weather, but Wake Forest insists on meeting the higher safety standards. The pilots also are instrument-rated for flying in bad weather.

"On the same day that they had a crash in

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Wisconsin recently, we had really bad weather with a lot of clouds rolling in as our pilot was already out on a mission, and so he made the decision to cancel the mission and land at a local airport. We picked our crew up at the airport and brought them back by ground," Bryant recalls. "Instead of trying to navigate that bad weather, he made the right decision to use instruments for a safe landing and wait for a pickup. That's the decision making we want from our crew."

Despite the best efforts to ensure safety, Wake Forest knows from experience that a medevac flight can end in tragedy. So, the hospital provides an extra $1 million in life insurance coverage for each member of the crew, beyond any insurance and other benefits they may receive from their employers.

"It gives the crew a little bit of security to know that if something were to happen, their families won't be left in need," Bryant says. "We don't want to think about crashes all the time, but we have to remember that it can happen." ■

Kickback case holds lessons for risk managers

The recent high-profile conviction of a hospital CEO involved in kickbacks and providing unnecessary care to homeless patients shows that risk managers always must be on alert for illegal activities that may be hidden behind the doors of an executive suite.

Rudra Sabaratnam, MD, was CEO of City of Angels Medical Center before being charged with two counts of paying for illegal patient referrals. He recently pleaded guilty, admitting that he had billed government programs for unnecessary care given to homeless people. Sabaratnam could face up to five years in prison on each charge, and he also has agreed to pay more than $4.1 million in restitution to Medicare and Medi-Cal. In his guilty plea, Sabaratnam admitted that he had paid almost $500,000 to recruit homeless people to receive unnecessary treatments that the hospital billed to public health programs.

Sabaratnam was arrested on Aug. 6, 2008, with Estill Mitts, who operates a health center on Skid Row in Los Angeles. Authorities accused the two men of using homeless people to falsely bill Medicare for millions of dollars. When he pleaded guilty to the charges, Sabaratnam admitted to paying Mitts and others to refer homeless Medicare and Medi-Cal beneficiaries to City of Angels for inpatient treatment. Sabaratnam created a false contract to conceal the illegal kickbacks. The arrest came after an investigation that has been ongoing since 2006.

The total amount of illegal kickbacks that Sabaratnam paid and caused to be paid to Mitts and others was about $493,382. City of Angels billed Medicare and Medi-Cal for inpatient services to the recruited homeless beneficiaries, including those for whom inpatient hospitalization was not medically necessary.

U.S. Attorney **Thomas P. O'Brien**, JD, called the arrangement "a sophisticated scheme to defraud health care programs that are financed by taxpayers." A judge ordered Sabaratnam to appear for sentencing on June 8, 2009.

The case should be a reminder to risk managers that even the executive offices must be watched closely for signs of fraud, says **Charles H. Cole**, JD, chairman of the Public Policy Committee of DRI — The Voice of the Defense Bar, a group representing defense attorneys, based in Chicago. When it comes to ferreting out fraud and financial shenanigans, you can't stop when the possible perpetrator is your boss, he says.

"It probably has become necessary to engage in careful monitoring of even the chief executive officers of medical centers who receive public funding," he says. "Very clear rules exist to prevent Medicare and Medicaid fraud. Implementation of those rules — and a determination of compliance with those rules — may determine the survival of the health care institution."

Cole notes that the ramifications for the institution are significant. The medical center could face separate prosecution if it was part of a criminal enterprise. In addition, the federal government

EXECUTIVE SUMMARY

A hospital CEO pleaded guilty to charges of paying kickbacks for patient referrals and providing unnecessary care to patients. Risk managers must monitor activities that could hide such illegal activities.

- The CEO agreed to pay restitution and faces years in prison.
- Staff must feel safe in reporting suspicions of fraud.
- Investigate executives for past suspicions of financial wrongdoing.

SOURCES

For more information on preventing and detecting fraud, contact:

- **Kimberly Baker**, JD, Past Co-Chair, Medical Liability and Health Care Law Seminar, DRI — The Voice of the Defense Bar, Chicago. Telephone: (312) 795-1101.
- **Charles H. Cole**, JD, Chairman, Public Policy Committee, DRI — The Voice of the Defense Bar, Chicago. Telephone: (312) 795-1101.

could place the center on probation or suspension in obtaining Medicare or Medicaid reimbursement.

Cole does not see a trend in such fraud, even though the difficult economy has heightened the sensitivity of publicly funded medical institutions to the need for funds. Fraud such as that uncovered in Los Angeles usually is driven more by the individual's desire for money than any effort to save the institution, he says.

"Delays in funding can create problems but does not usually result in criminal activity," Cole says. "We all understand that greed can, unfortunately, be an important motivator."

Preventing and uncovering high-level fraud can be difficult, he says. Clear policies must be established in the rules and regulations of the health care institution prohibiting such conduct.

"Whistle-blowing policies may be necessary to halt unlawful behavior or even behavior that presents the appearance of impropriety," Cole says. "The chain of command must be established, so the competent risk manager has protection and encouragement to resolve this matter as soon as practicable."

Kimberly Baker, JD, past co-chair of the Medical Liability and Health Care Law Seminar of DRI — the Voice of the Defense Bar, says the culture of the hospital can determine whether such fraud takes place, or how quickly it is rooted out. Risk managers should promote a culture of openness and zero tolerance for fraud, she says. Baker also says risk managers should encourage a more thorough vetting of executives than often takes place.

"We need to know more than where they went to medical school and where they got their business degree," she says. "We need to make further inquiries to see if there have been complaints about their billing, whether there have been questions about finance in their departments. I think people too often focus on the clinical picture or the resume highlights vs. the whole picture of this person who is going to be leading an organization."

Baker notes that people hired to work in billing typically do get this kind of scrutiny, but it does not often extend to CEOs and other executives who are minding the whole store. That thorough investigation should extend to physicians as well, she says.

"We ask about past malpractice cases, but we also should be asking if there have been complaints by the attorney general or state consumer fraud departments about their billing and their physician recruitment," Baker says. "Sometimes, it's not fun to peek under the bed and see what's there; but if you don't, the whole organization is at risk."

By the same token, she adds, it is important to educate staff about how to watch for suspicious activity and to create a culture that supports reporting. If a nurse notices anything suspicious, such as a sudden spike in a certain type of treatment, there must be a mechanism for reporting that suspicion without fear of retribution. External auditors — of both financial records and medical charts — can be key for detecting fraud, Baker says.

Never underestimate what someone will do for money, she cautions.

"We saw it in the investment banking, where the banks were pretty untouchable for years and greed was running amok. And now here we are with that problem," Baker says. "I think if hospitals are not vigilant about looking at their whole operation as a business and not just as a health care provider, they could see the same thing happen." ■

Settlements affect care for homeless, uninsured

Two recent settlements could have an impact on how health providers do business. In the first case, two Illinois hospital systems have agreed to settle lawsuits alleging that they overcharged thousands of uninsured patients and provided inadequate financial assistance.

As part of the agreement, Resurrection Health Care and Advocate Health Care will recalculate patients' bills and give refunds to needy patients who were eligible for free or discounted medical care. Resurrection, which owns eight hospitals in and around Chicago and is the state's largest chain of Catholic medical centers, also has agreed to give a 25% discount to anyone who is uninsured regardless of his or her income level. Advocate agreed to

a similar plan for patients with bills of at least $5,000 or more in a single year.

Jeannie Frey, JD, senior vice president of legal affairs for Resurrection, issued a statement saying the health system did not admit wrongdoing but settled the suit because of "the cost of litigation and the toll it takes internally on an organization."

Resurrection notified 220,000 patients of the settlement and the opportunity to apply for financial relief on outstanding or past bills. Advocate Health Care, which operates nine hospitals, sent similar notices to 170,000 patients.

Resurrection is placing annual limits on what people without insurance will be asked to pay for hospital services in any given year — no more than 10% of annual income for those with incomes under 400% of the federal poverty level, and no more than 15% others. Those limits are more lenient than required in a new Illinois law that caps hospital payments for people without health insurance at 25% of income. That law goes into effect April 1, 2009.

In the second case, UnitedHealth Group agreed to change the way it determines the portion of reimbursements for which health insurers are responsible when members receive services from out-of-network providers. New York state Attorney General Andrew Cuomo recently announced the settlement terms.

The settlement ends an investigation into concerns that health insurers understated the portion of reimbursements for which they are responsible for such services by as much as 28% in some cases. The underpayments amounted to hundreds of millions of dollars over the last 10 years, according to Cuomo's office.

Under the settlement, UnitedHealth will pay $50 million to finance the development of a new database that an undetermined university will operate. UnitedHealth will not admit any wrongdoing and will not have to pay restitution to consumers. ■

CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

Joint Commission report shows gains in safety

Like most risk managers, you've probably been pushing extra hard to improve safety over the last few years, and The Joint Commission says all the hard work is paying off.

Hospitals have steadily improved the quality of patient care over a six-year period, saving lives and improving the health of thousands of patients, according a recent Joint Commission report. The data come from *Improving America's Hospitals: The Joint Commission's Report on Quality and Safety 2008*, an analysis of National Patient Safety Goal compliance and hospital quality measures related to heart attacks, heart failure, pneumonia, or surgical conditions, provides scientific evidence of improved patient care.

There were some dramatic improvements over the six-year period of data collection, especially in providing smoking cessation advice. For example, hospitals provided this advice to 98.2% of heart attack patients in 2007 compared with 66.6% in 2002. Hospitals greatly improved their results from 2002 to 2007 in providing this advice to heart failure patients (from 42.2% in 2002 to 95.7% in 2007) and patients with pneumonia (from 37.2% to 93.7%). Other strong improvements included providing discharge instructions to heart failure patients (from 30.9% to 77.5%) and providing pneumococcal screening and vaccination to pneumonia patients (from 30.2% to 83.9%). ■

COMING IN FUTURE MONTHS

- Some adverse events not documented
- Ruling creates vicarious liability risk
- Case study: Winning a 'no-win' case
- More temps bring more risks

CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

9. What hospital department is likely to be first to see a direct effect from the recession, according to Michael Mathis?
A. Emergency department
B. Discharge planning
C. Radiology
D. Maintenance and housekeeping

10. James Bryant, RN, MSN, is in the process of working out an arrangement with his counterparts at other hospitals in the community so they can share satellite tracking data for their helicopter programs, in effect creating an air traffic control system for area medical helicopters. Which of the following is true?
A. Bryant already has worked out an agreement with one nearby hospital and hopes to include many more.
B. No hospitals are cooperating with the effort.
C. All hospitals in North Carolina have agreed to participate.
D. Federal regulators have warned Bryant that the plan cannot be allowed.

11. Which of the following is part of the effort to improve medical helicopter safety at Wake Forest University Medical Center?
A. Purchasing three additional helicopters.
B. Sharing satellite tracking data with other hospitals, in effect creating an air traffic control system for area medical helicopters.
C. Requiring two physicians on every mission.
D. Moving the helipad off the hospital property.

12. According to Kimberly Baker, JD, which of the following is true regarding preventing and detecting financial fraud?
A. Executives already undergo too much investigation of their backgrounds.
B. The vetting of executives should not extend to financial improprieties.
C. Anti-discrimination laws prohibit inquiring about past allegations of financial fraud.
D. Risk managers should encourage a more thorough vetting of executives than often takes place.

Answers: 9. A; 10. A; 11. B; 12. D.

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Failure to administer calcium after thyroidectomy: $4.7 million settlement

By **Radha V. Bachman**, Esq.
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News: Following an elective thyroidectomy, a woman was diagnosed with hypocalcemia. Although calcium was ordered, it was never administered to the woman, despite persistent symptoms of the calcium deficiency. The woman eventually went into cardiac arrest and sustained anoxic encephalopathy, becoming comatose. She is in a vegetative state and requires nursing coverage 24 hours a day, seven days a week. The hospital claimed that the woman's calcium level was within a normal range and, therefore, the failure to administer calcium was not the cause of the woman's injury. The parties settled prior to the lawsuit being filed for $4,700,000.

Background: Following an elective thyroidectomy for removal of an enlarged thyroid, a 50-year-old woman's calcium level fell from 9.4 to 7.3. The woman eventually was diagnosed with hypocalcemia. Hypocalcemia is known to be the most common complication after total removal of the thyroid. As many as 6% of patients having a total thyroidectomy suffer this complication. Hypocalcemia is the presence of low serum calcium levels in the blood, typically less than 2.1 mmol/L or 9 mg/dl or an ionized calcium level of less than 1.1 mmol/L (4.5 mg/dL) and is an electrolyte disturbance. The common symptoms for hypocalcemia are neuromuscular irritability, muscle cramps, numbness, irritability, and confusion. Calcium was ordered for the woman but never administered, despite the fact that the calcium was taped to her hospital bed. As the evening progressed, the woman became increasingly nervous and agitated and also had difficulty swallowing. A second-year resident, who had only been at the hospital for a total of three weeks, visited the patient, but did not administer the calcium — despite the fact that the calcium was provided in the patient's room.

The next morning the woman awoke groggy and complained of shortness of breath and increased swelling where to operation had taken place. The resident was called again for a consult. At the time of the consult, the woman went into respiratory failure and cardiac arrest. A code was called, and the woman was intubated. While her breathing was restored, the woman sustained anoxic encephalopathy and became comatose. The woman never recovered from the coma and now requires around-the-clock nursing care for her vegetative state.

The woman's guardian filed suit against the ENT physician who performed the thyroidectomy and the operator of the hospital, introducing head and neck surgery and neurology experts. The plaintiff alleged that the resident had failed to respond in a timely manner to the woman's

shortness of breath and difficulty breathing, claiming that those symptoms were caused by the hypocalcemia, which, if low enough, could have caused the woman's breathing to be substantially reduced. Or, the plaintiff suggested, it could have been caused by a surgical-site hematoma, which could have compromised the woman's breathing passage. Despite records to the contrary, the resident claimed he responded quickly and was at the woman's bedside 11 minutes prior to the time the code was called.

The plaintiff also claimed that the administration of the calcium to the woman would have avoided the subsequent injury. The resident responded, claiming that he had properly opened the surgical site and removed clotted blood that was potentially compromising the woman's airway or lymphatic system. The defendant claimed that the woman's calcium level, at 7.3, has never been shown to cause cardiac arrest or difficulty breathing and, therefore, was not the cause of the woman's subsequent injury.

The physician who performed the thyroidectomy was removed as a defendant from the lawsuit. Ultimately, the plaintiff reached a settlement with the hospital in this case for $4,700,000.

What this means to you: Based on the facts presented here, clearly this case was one to settle. While the hospital attempted to articulate certain defenses, they were almost embarrassingly weak.

The medical literature recognizes that hypocalcemia is a well-known complication after total removal of the thyroid. However, regardless of the cause (which the hospital attempted to raise as a defense), in this case the hypocalcemia was diagnosed and appropriate treatment (calcium) was ordered. Unfortunately, it was never administered. Cardiac arrest also is clearly recognized in the medical literature as a life-threatening complication of untreated hypocalcemia. The patient went into cardiac arrest in this case, which resulted in catastrophic injuries.

The care (or more appropriately, the lack of care) provided to this patient is very troubling. After recognizing the complication, appropriate treatment was ordered but never carried out. The facts contain no explanation as to why the calcium was not given. Even more disturbing is the fact that the calcium had actually been "taped to the woman's hospital bed." There is no acceptable reason (or defense) for not administering the medication, and "taping" it to the bed only adds insult to injury.

The actions and inactions of the resident physician aggravate an untenable position. Unfortunately, the facts do not fully detail why the resident visited the patient the evening before she suffered a cardiac arrest. Was the resident called by nursing staff because the patient was exhibiting certain symptoms? Did the resident notice that the calcium was taped to the bed? What did he do, if anything? The resident's acts of omissions — in not administering the calcium and/or further treating the patient — are disturbing. Also, the resident's claims of being present prior to the patient's cardiac arrest the next day do very little to support a defense. If, in fact, the resident was present at the patient's bedside at the time of the patient's cardiac arrest, why were life-saving measures not taken sooner?

It is a nurse's responsibility to administer medications ordered by a physician. Why was the calcium not administered? The facts do not reveal the time lapse between the recognition of the hypocalcemia and the ordering of the calcium; however, it would appear that this was timely. What did the documentation indicate? Or, was the hospital dealing with a lack of documentation?

Based on the facts, this case provides several risk management lessons:

- **Periodic medication audits can prove very helpful in identifying weak spots in compliance from transcribing orders to administering them to documenting them.** Such information then can serve as a basis for nursing education.
- **Supervision of residents is critical.** A second-year resident should have been capable of recognizing the significance of the patient's symptoms and taking appropriate action. The hospital should have assessed the mechanisms that were in place to assure that the resident's actions/inactions were being reviewed and further determine what communications took place between the nursing staff, resident, and attending physician.
- **The attending physician bears ultimate responsibility for the care provided to his or her patient and should be involved in the event there is a complication or suspected complication.** The hospital should have monitored what communication was taking place between the attending physician, nursing staff, and resident.

This case proves again what has been demonstrated by research: A significant number of claims involve "system" errors — such as medication-related errors, communications errors, and documentation errors. It appears clear from the facts that the implementation and monitoring of good

"systems" through consistent audits could have prevented the plaintiff's devastating injuries in this case.

Reference

• Westchester County (NY) Supreme Court, Case No. 11285/05. ■

Torn tendon results in $1.2 million settlement

News: A man sustained lacerations to his right index finger and middle finger and was immediately taken to the emergency department (ED) of a local hospital, where a physician's assistant sutured the wound. The man returned to the hospital on three occasions, where hospital officials noted decreased extension in the man's long finger of his right hand. The hospital referred him to a hand specialist, who determined that the man's injury included a complete tear of the extensor tendon of the man's long finger and soon thereafter repaired the tendon. Within months, the man began experiencing a dropping of his uninjured ring finger and eventually began suffering the effects of carpal tunnel syndrome and related ailments. The man sued the hospital, claiming that the actions of the ED staff in not recognizing the torn tendon were outside the normal standard of care. Despite the fact that the man could use his hand for normal activities, a jury awarded the plaintiff damages in the amount of $1,278,000.

Background: A 56-year-old man, who was employed as a supermarket executive chef, sustained lacerations to the back of his right, dominant hand. Lacerations were suffered on his right index finger and the back of the large knuckle of his long finger. Immediately following the injury, one of the man's co-workers took him to the ED of a local hospital. The injuries were sutured by a physician's assistant, who was being supervised by an ED physician. At the time of discharge, the diagnosis read, "laceration to finger without tendon injury, laceration to hand without tendon injury."

Unfortunately, the man's injury did not heal properly. He visited the hospital on three additional occasions during the two weeks following the date of the injury. During those visits, the hospital noted decreased extension in the middle finger of his right, and more dominant, hand. During his last visit, the hospital advised him to consult a hand specialist and provided him with a referral slip stating "rule out ligament injury."

About 20 days following the date of the injury, the man visited a plastic surgeon with no special training in hand reconstruction. The physician splinted the man's hand and scheduled him for an MRI one month later. The MRI scan showed that the man's injury actually was a complete tear of the extensor tendon of the middle finger of the right hand. The physician performed surgery to reconnect the tendon via primary repair at another local hospital.

A few months following the surgery, the man began experiencing a dropping of the uninjured ring finger of the right hand, also known as "mallet finger," probably caused as a result of the slackening in the ring finger's tendon when the long finger's tendon was tightened by the plastic surgeon during the reconnection surgery. The majority of mallet finger injuries can be treated without surgery. Physicians recommend that ice should be applied *immediately,* and the hand should be elevated above the level of the heart. A doctor may apply a splint to hold the fingertip straight (in extension) until it heals. Most of the time, a splint will be worn full time for eight weeks. Over the next three to four weeks, most patients gradually begin to wear the splint less frequently. Although the finger usually regains an acceptable function and appearance with this treatment plan, many patients may not regain full fingertip extension.

Nevertheless, as a result of an extensive period of swelling, immobilization, pain, nonuse, and altered use of the hand/wrist, the man developed severe carpal tunnel syndrome and thereafter, reflex sympathetic dystrophy, also known as complex regional pain syndrome, in the right hand and lower arm. The man underwent surgery for carpal tunnel release about two years after the initial injury. Carpal tunnel release can improve strength and decrease pain in most patients, if they are good candidates for the surgery. The procedure improves pain, nerve tingling, and numbness better than it improves muscle weakness. The longer the patient has had symptoms, the longer the recovery time and the less fully he or she may recover.

The man filed suit against the treating hospital, alleging that the hospital's ED staff failed to diagnose the torn extensor tendon in his right middle finger and that the failure constituted a gross deviation from the accepted standard of care. Likewise, the man's plastic surgeon testified on his behalf

stating that the ED physicians' failure to recognize the possibility of a torn tendon was a deviation in the standard of care. As a result of the alleged negligence, the man suffered the permanent effects of carpal tunnel syndrome and reflex sympathetic dystrophy, including tremors, burning pain, a hyperextended long finger, a dropped ring finger, decreased strength, and diminution of his fine motor skills. In light of these effects, the man claimed that he was unable to return to work as a chef, earning $50,000 per year.

The man also argued that the hospital's records failed to provide any evidence that ED staff had performed "standard" tests necessary to rule out a torn tendon. Those tests include the "strength against resistance" test that is protocol for potential injuries to the tendon; because if the tendon tear is close to the juncturae tendinum, then the patient still would be able to display motion on other, nonresistance-bearing, physical exams. Finally, the man argued that while the ED staff may have ruled out a tendon tear as to the injury to his middle finger, they did not do so as to the index finger.

The hospital's expert witness countered by stating that the failure to diagnose a torn tendon can occur in the absence of negligence, and the fact that torn tendons do not always lie directly beneath the location of the wound make them more difficult to diagnose. Under cross-examination, the hospital expert did concede that a patient may be able to pass a physical examination of the injured finger despite the existence of a torn tendon, thereby highlighting the importance of testing similar to the strength against resistance test.

In response to the man's claim that he could not return to work because of the long-term injury, defense counsel introduced evidence that the man was able to rake leaves, drive his car, open his trunk, and carry large bags of grocery from his car to his home.

Ultimately, a New York jury felt that the hospital's ED staff had not met the requisite standard of care and awarded the man $1,278,000 in damages.

What this means to you: This case illustrates an issue that does not receive sufficient attention: Return visits to the ED.

The patient was a chef. Since the law mandates that you "take the patient as you find him" this fact becomes significant in assessing damages. Given the patient's occupation, the injury he suffered was not only foreseeable, but could also negatively affect his ability to engage in his profession. It appears from the limited facts that this injury occurred during the course of the patient's employment, and thus would be perceived as an injury covered by workers' compensation. Since the facts do not touch on this issue, it is unknown how this issue was managed and whether any award was secondary to insurance coverage.

The patient was taken promptly to the ED by a co-worker; however, it appears that even on this first visit, it could be argued that sufficient care was not provided in that there is no evidence that the physician's assistant conducted appropriate tests to determine if there was additional injury to the patient's fingers and hand. This points out an issue with supervision of physicians' assistants and the importance of protocols that require appropriate training and oversight.

Also important is the fact that the patient returned to the ED three additional times during the two weeks following his initial visit to the ED. Even if the failure to diagnose a torn tendon can happen in the absence of negligence, there can be no excuse for the failures to appropriately treat this patient on three additional visits.

It appears likely that the jury took this fact into consideration, as well as the fact that the negligence directly affected the patient's ability to perform his profession in awarding the patient more than $1 million in damages.

The issue of return visits to the ED has traditionally received attention only retrospectively during routine quality assurance reviews. However, a more proactive approach would not only improve patient care, but also it would decrease the likelihood of claims. To that end, it is recommended that ED staff develop policies and procedures to address return visits that include the following criteria: 1) level of review; 2) need for consult; 3) additional lab or X-ray studies; 4) a call-back system; and 5) detailed documentation. When a patient returns within a relatively short period of time with the same symptoms, it is incumbent upon the health care providers to heighten the level of inquiry and a specific course of action related to the patient's injury. Clearly, when a patient returns three additional times within two weeks, bells should have gone off, alerting staff to the need for greater diligence in treating this patient.

Reference

• New York County (NY), First Judicial Circuit, Case No. 108872/03. ■