PRMS Residents' Education Program (PREP)

University of California, San Diego
November 19, 2020

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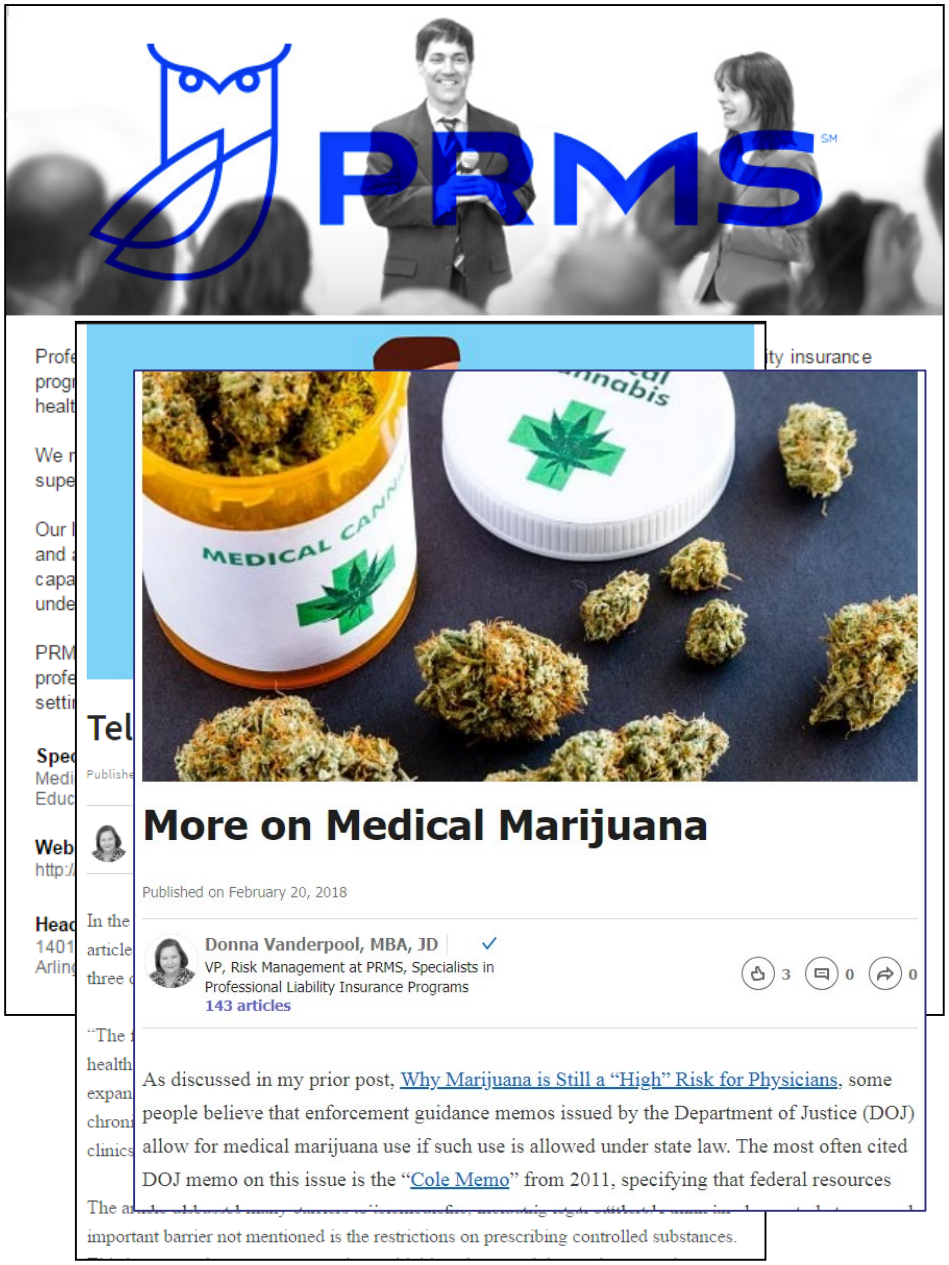
www.PRMS.com
www.PsychProgram.com



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www.LinkedIn.com

www.prms.com

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Resources

www.prmsu.com

Disclaimers

Nothing I say is legal advice.

Sage Advice

- Build a support network:
  - Mentor
  - Attorney
  - Accountant/practice manager
  - Join relevant professional organizations
  - Insurance professional

Risk Management

- Psychiatry is a low-risk specialty
- Communication:
  - Consultation with a colleague
  - Patient safety = exception to confidentiality
- Gather information:
  - Consider practice guidelines
  - Assessments are key
  - Medication monitoring:
    - RFTs, Li levels
    - LFTs, Depakote levels
    - AIMS testing
    - Screen for metabolic disorders
    - Check the PMP database
- Documentation:
  - Document your thought processes – why actions were taken/rejected

Insurance

- Occurrence versus Claims Made
- Consent to settle
- Practice – Policy mismatch

Trending & Emerging Risks

- Telepsychiatry
- Social media
- Electronic health records
- Driving
- Marijuana

Sage Advice


Professional organizations
Insurance professional
Attorney
Psychiatrist mentor
You
Accountant/Practice manager

High Exposure Areas in Psychiatry and Risk Management

Psychiatry Claims

Psychiatry is a low-risk specialty

- Low risk activities
  - Forensic
  - Child and adolescent practice
  - Psychoanalysis

Psychiatry Claims

PRMS Experience

- 77% of claims close without indemnity payment or by dismissal or summary judgment
- 20% of claims settle
- 3% go to trial
  - Greater than 99% defense verdicts

Professional Risk Management Services (PRMS)

Cause of Loss – Claims and Lawsuits

2010 – 2019

Primary Allegation	All Aged Patients
Incorrect Treatment	31%
Medication Issues	21%
Suicide/Attempted Suicide	13%
Other	10%
Incorrect Diagnosis	4%
Hospital Commitment / Discharge	7%
Breach of Confidentiality	5%
Improper Supervision	4%
Boundary Violation	2%
Forensic (expert testimony, IMEs, etc.)	1%
Duty to Warn / Protect	1%
Abandonment	1%

Notes:

- "Primary allegation" is the main allegation by plaintiffs' attorneys of what the psychiatrist did wrong
- "Incorrect treatment" will represent a high percentage of cases because plaintiffs' attorneys often use a broad, general allegation initially; this category includes all types of cases, including suicide and psychopharmacology
- The category labeled "Improper Supervision" refers to supervision of patients as well as of other providers

Elements of a Lawsuit

- Duty of Care
  - The physician owed a duty to the patient
  - To meet the standard of care
- Breach of Duty
  - The physician was negligent (the care provided fell below the standard of care)
- Damages
  - The patient suffered an adverse outcome (injury)
- Proximate Cause
  - The patient's damages were a direct result of the physician's negligence

The Standard of Care

In Medical Malpractice:

The degree of skill, care, and diligence exercised by members of the same profession/specialty practicing in light of the present state of medical science.

The Expert Witness

- Testifies by providing opinion testimony about:
  - What the applicable standard of care is
  - Whether the defendant met the standard of care
  - Whether the breach of the standard of care was the proximate cause of plaintiff's injuries

- Bases opinion on:
  - Items evidencing the applicable standard of care
  - The clinical record
  - Clinical experience
  - Education
  - Other items

Determining the Applicable Standard of Care

Many items may be admissible, along with expert testimony, to determine the issue of standard of care. The following items could be relied upon as ***evidence of*** the appropriate standard of care:

- Statutes – federal and state
- Regulations – federal and state
- Case law – federal and state
- Other materials from federal and state regulatory agencies – state medical boards, DEA, FDA, etc.
  - Rules
  - Guidelines
  - Policy statements

Determining the Applicable Standard of Care

- Authoritative clinical guidelines
- Policies and guidelines from professional organizations
- Learned treatises
- Journal articles
- Research reports
- Accreditation standards
- Facility's own policies and procedures
- PDR recommendations
- Drug manufacturer recommendations
- Other items

www.mbc.ca.gov

Resident Liability

Myths

- Residents are rarely sued as plaintiff attorneys look for deeper pockets
- If sued, residents are always dismissed from suits as liability for the acts of residents rests with the attending
- Residents are always held to a lower standard of care

Resident Liability

Facts

- When there is an adverse outcome, anyone with a role in treatment may be named in a lawsuit
- If you have malpractice insurance, your pocket will likely be deep enough to keep you in the game if negligence is suspected
- An attending may be found liable for the acts of the resident
  - BUT – this does not negate the resident's own liability

Psychiatry Claims

Most prevalent

- Suicide/attempted suicide

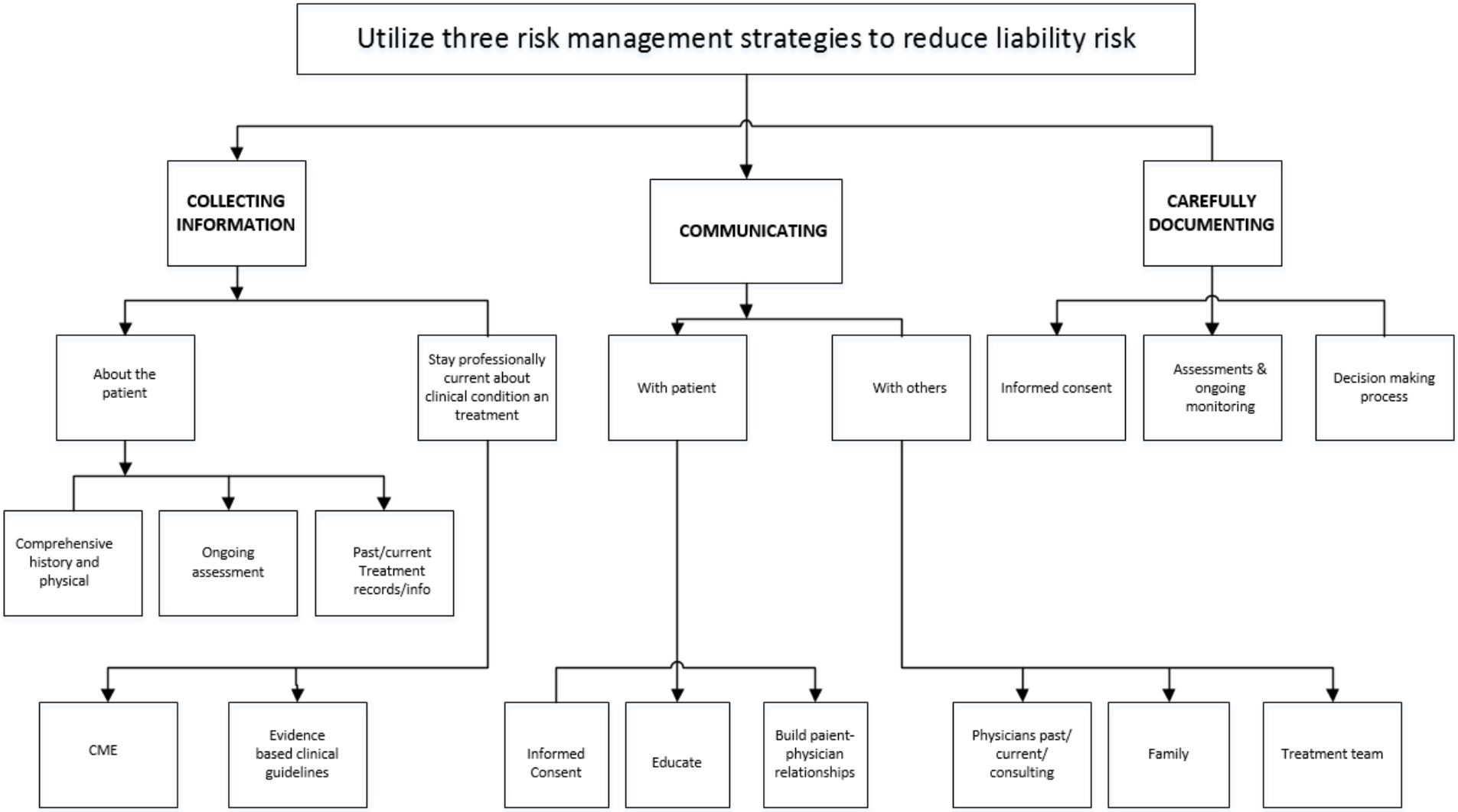
(Low frequency, but high severity, suicide is the single most identifiable cause of loss for psychiatrists.)

- Medication misadventure

Most expensive

- Severe injuries that require life-long care

3 Cs of RISK MANAGEMENT



Standard of Care – Suicide Cases

Whether the psychiatrist:

- Adequately identified and evaluated suicide risk indicators and protective factors for the patient
- Developed a reasonable treatment plan based on the assessment of the patient's clinical needs
- Appropriately implemented the treatment plan and modified it based on an ongoing assessment of the patient's clinical status
- Was professionally current regarding the assessment and treatment of patients with suicidal behaviors
- Created documentation that was adequate to support that appropriate care was provided in terms of the assessment, treatment, and ongoing monitoring of the patient

Standard of Care – Medication Cases

Whether the psychiatrist:

- Performed adequate history and physical
- Properly prescribed
- Obtained consultation or make referral
- Adequately informed of side effects
- Monitored drug levels and physiologic tests
- Recognized and appropriately responded to adverse drug reactions
- Communicated with other providers
- Adequately screened for contraindications
- Accessed and review PMP data

Collecting Information *About the Patient*

- Assess patients at significant points in treatment
- Assessment is ongoing
  - Consider the possibility of comorbid conditions
    - Substance use
    - Medical conditions
- Try to get prior records; if can't, document attempts
- Obtain collateral information from family and significant others
- Inquire about access to weapons
- Consistently utilize specific, reputable suicide assessment and treatment methodology/resource

Collecting Information
About the Patient

- Lithium levels
- RFT
- Depakote levels
- LFT
- Screening for metabolic disorders
- AIMS testing
- Checking the PMP database

Communicating
With Others

- Communicate with other healthcare professionals
  - Do not hesitate to seek consultation or second opinion
  - Other treating providers, covering providers

- Communicate with family and significant others
  - Involve and educate
  - Stress responsibility
  - Access to weapons

Communicating
With Others

- Remember: patient safety is *exception* to confidentiality

- Consider alerting family members / significant others to risk of suicide without patient authorization when:
  - The risk is significant
  - They do not seem to be aware of the risk
  - They might contribute to patient's safety

Communicating
With the Patient

Educate the patient on issues such as:

- Restrictions (driving, diet, activity, etc.) associated with the medication
- Monitoring, such as blood work, that is needed
- Purpose, dose, and frequency of the medication
- How to identify side effects, and what to do if patient experiences
- Ensuring patient's other physicians are aware of new prescriptions

Communicating
With the Patient

Informed Consent Standard Elements:

- Nature of proposed medication
- Risks and benefits of proposed medication
  - Including potential for tolerance, dependence, addiction, overdose
- Alternatives to proposed medication
- Risks and benefits of alternative treatments
- Risks and benefits of doing nothing

Plus:

- Prescribing policies
- Reasons for which medication may be changed or stopped

Communicating
With the Patient

“MATERIAL RISK”

- Disclose risk if SEVERE, even if infrequent
- Disclose risk if FREQUENT, even if not severe
- FDA medication guides
- Disclose possible driving impairment
- Golden Rule

Communicating
With the Patient

Medication Guides

- FDA
  - www.fda.gov/drugs/drugsafety/ucm085729.htm
- AACAP / ParentsMedGuide - ADHD
  - www.aacap.org/App_Themes/AACAP/Docs/resource_centers/adhd/adhd_parents_medication_guide_201305.pdf

FDA's Patient Counseling Document for Opioids

- www.fda.gov/downloads/forindustry/userfees/prescriptiondrug userfee/ucm361110.pdf

Carefully Documenting

Critical junctures for documentation:

- At first psychiatric assessment or admission
- With occurrence of any suicidal behavior or ideation
- Whenever there is any noteworthy clinical change
- For inpatients, before increasing privileges or giving passes and before discharge

Carefully Documenting

Critical junctures for documentation:

- Switch medications
- Large dosage changes
- Start or discontinue medications

Basic Methods for Reducing Risk

- Communicate
  - With others
    - Consultation
    - Hand-offs
  - With the patient
    - Informed consent
- Gather information
  - About the patient
    - Patient history and physical
    - Ongoing assessment
    - Past treatment records
    - Follow-up on diagnostic tests
    - Ongoing monitoring
  - About the illness
    - Practice guidelines
- Document
  - Document for continuity of care
  - Document thought process

Quick Risk Reduction Recipe

Medications

- Lithium levels
- RFT
- Depakote levels
- LFT
- Screening for metabolic disorders
- AIMS testing
- Checking the PMP database

Suicide

- Assess
- Assess
- Assess
- Consider a formal assessment tool

Insurance

Read Everything!

Two Types of Medical Professional Liability Policies

Occurrence

Covers claims arising from events that occur during policy period

Claims-Made

Covers claims reported during policy period arising from events that occur during policy period

Tail Coverage

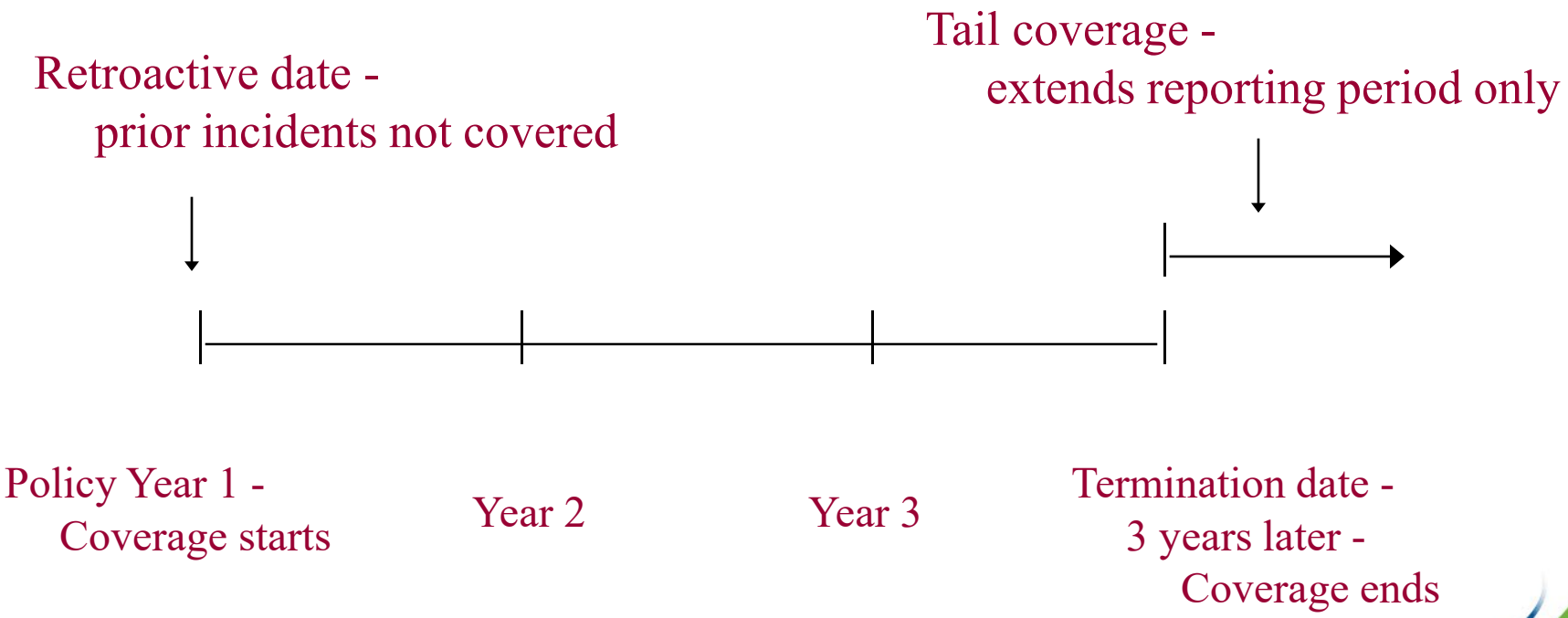


Illustration of Occurrence vs. Claims-Made Coverage

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	TOTAL
Occurrence	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$60,000
Claims-Made	$3,500	$6,000	$7,500	$8,500	$9,500	$9,500	$44,500
Difference	$6,500	$4,000	$2,500	$1,500	$500	$500	$15,500

NOTE: Amounts listed are for illustrative purposes only – actual premium amounts will be different.

Tail Coverage

- Can be $$$$
- Entire amount due immediately

TIP: If another entity pays for your claims- made policy, get it in writing that that entity will also pickup the tail coverage

Tail Coverage

- MD took job as employee of group
- Employment contract: employer was to "provide and pay the premium for malpractice insurance coverage covering employee"
- Policy was claims-made
- MD left group

Patel v. Assoc. in Obstetrics & Gyn., 2010 WL 2347015

Tail Coverage

- Tail = $146K
  - Group refused to pay
  - MD had to pay, then sued group
- MD lost case

- Lessons learned:
  - Get it in writing
  - Can not have a gap in coverage

Patel v. Assoc. in Obstetrics & Gyn., 2010 WL 2347015

Consent To Settlement

Your input in the claims settlement process

- Unlimited consent
- Limited with arbitration
- Limited with hammer clause
- No consent

Specific Coverages

- Vicarious liability
- Medical director
- Supervision of other providers
- Peer review
- Utilization review / QA activities
- Practicing outside of specialty
- Geographic areas
- Forensic activities

Assorted Terminology & Concepts

- Policy limits
  - Per incident
  - Aggregate
- Policy period
  - CM = 1 total
  - OCC = typically 1 year
- Definitions
- Conditions
- Exclusions
- Endorsements
- Defense costs “inside” or “outside” of policy limits
- Administrative defense
- Loss of earnings
- Coverage area
- Geographic limitations
- Declarations page

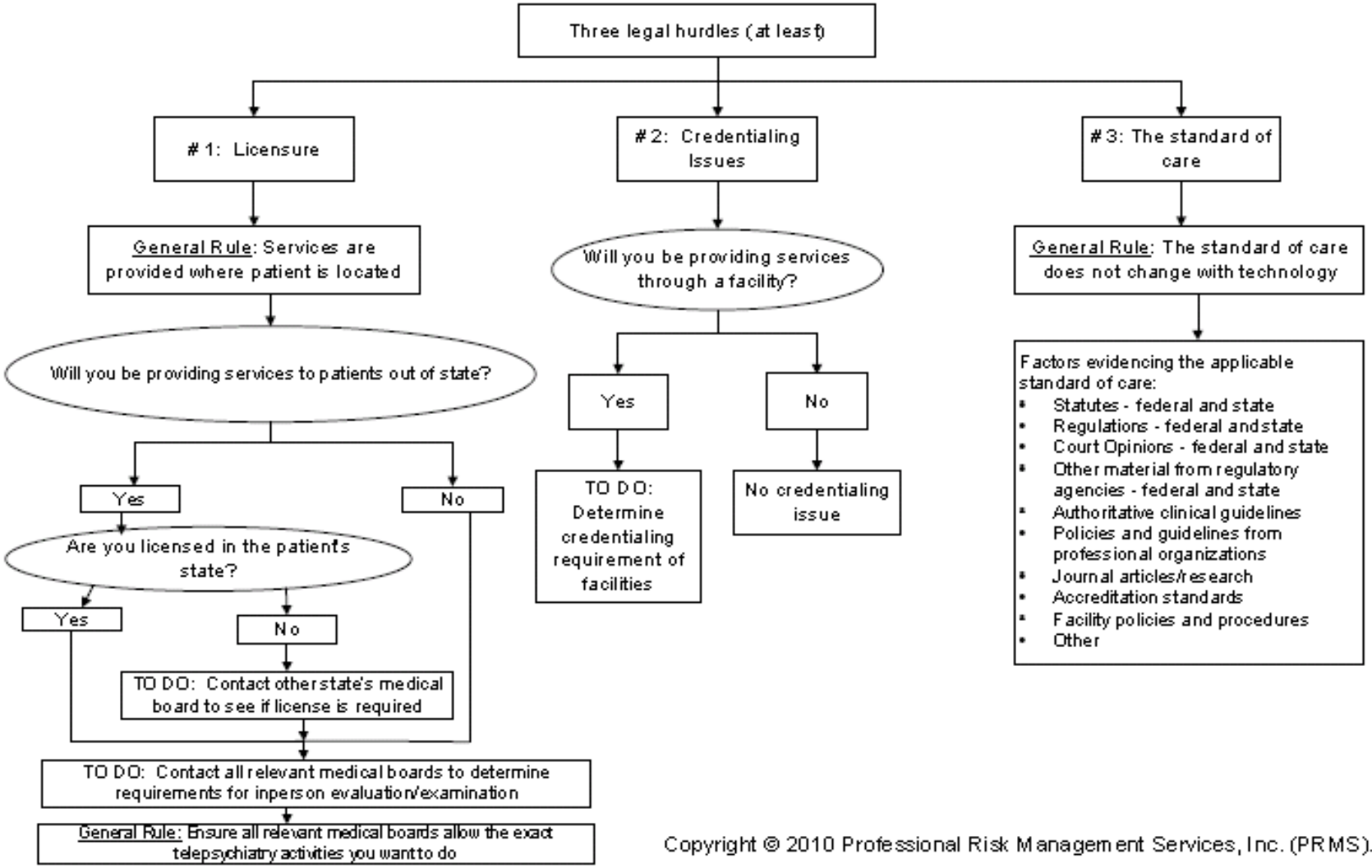
Cost

- Type of coverage
- Policy limits
- Discounts
- Specialty coverage
- Additional coverage

Trending & Emerging Risks

TELEPSYCHIATRY

LEGAL HURDLES



Hurdle #1

You must be able to meet the standard of care – it is the same standard of care that would apply if the patient was in your office or facility.

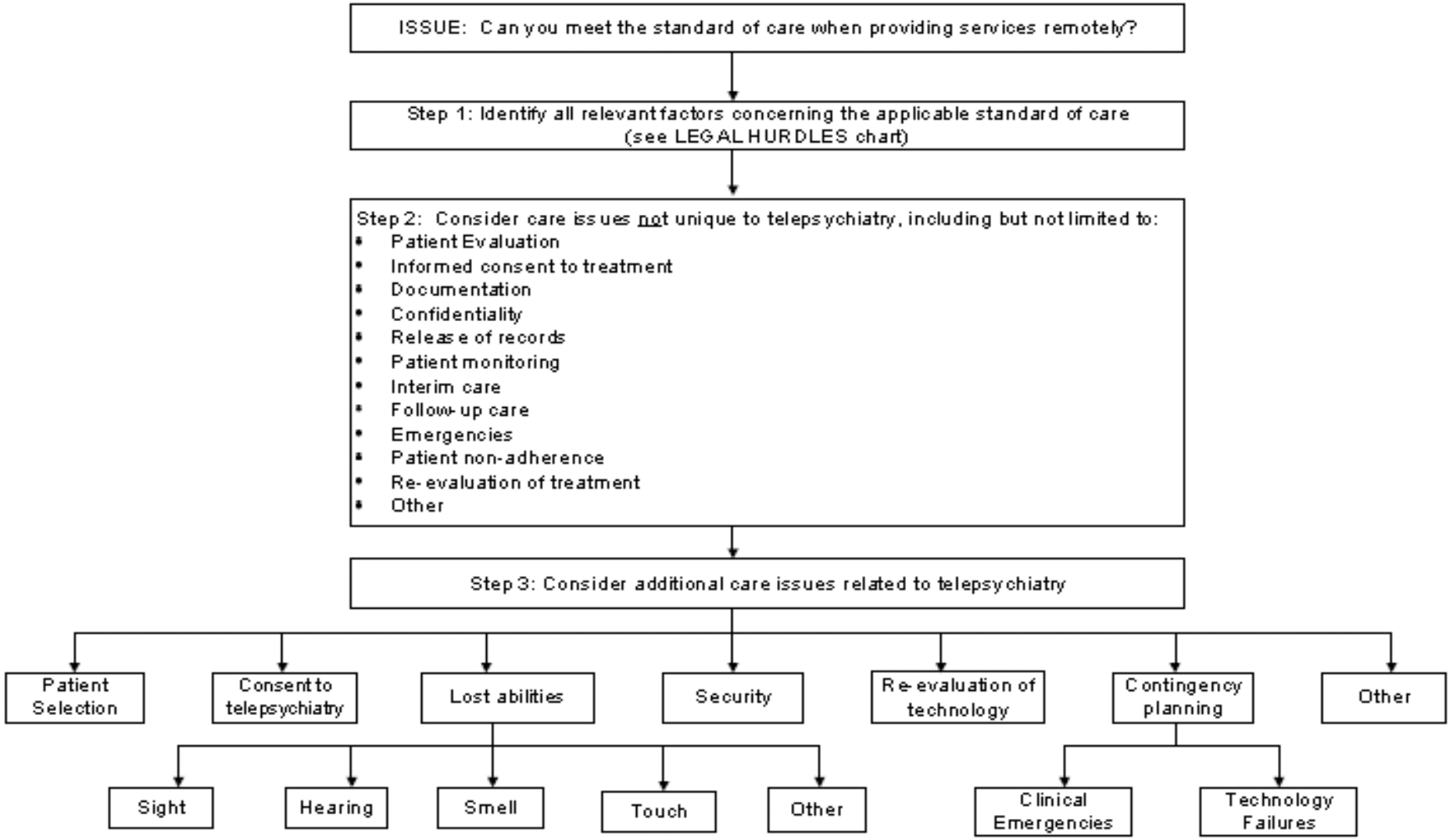
Hurdle #2

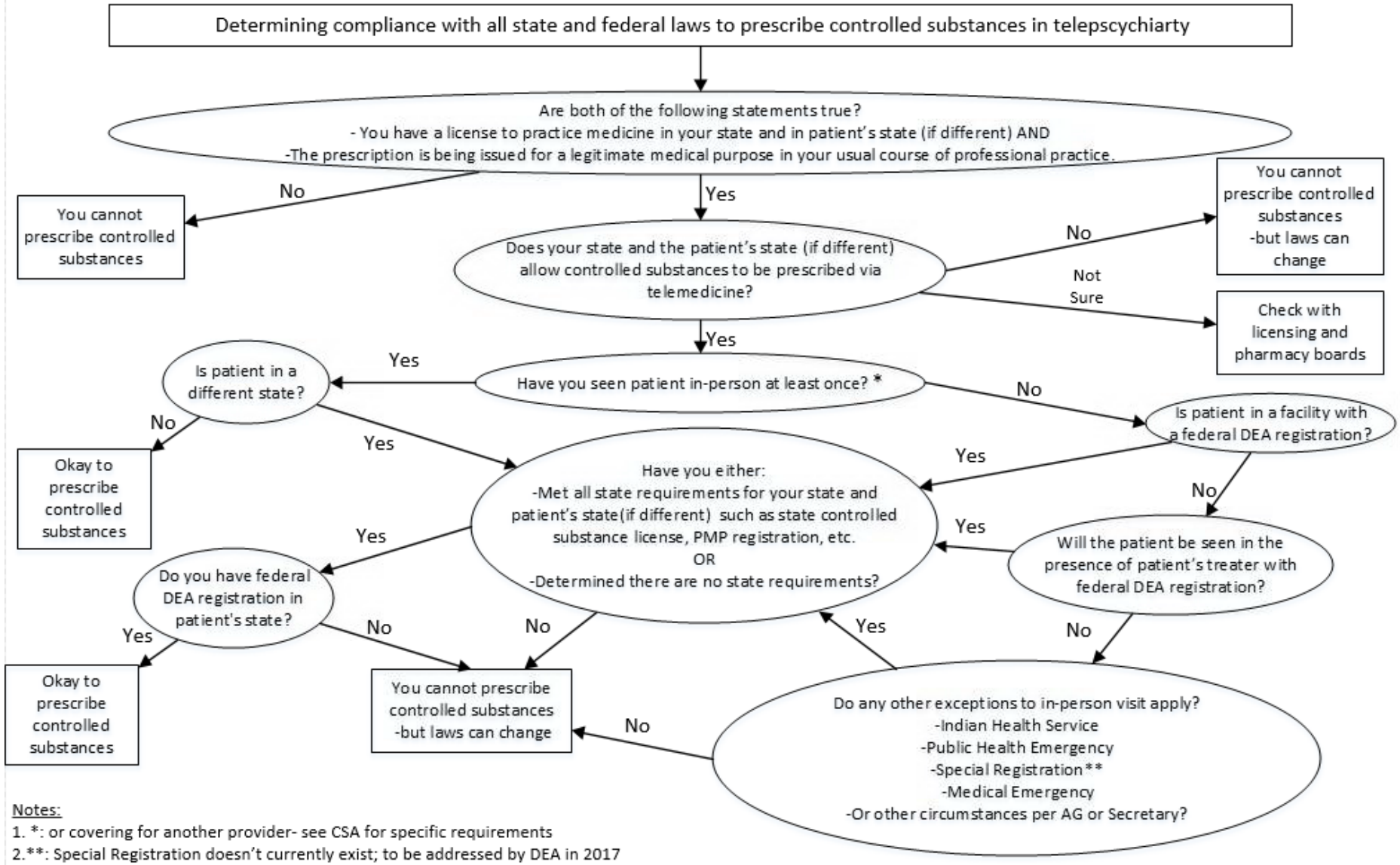
Contact all applicable medical boards to determine if you can treat the patient without violating applicable laws!

- Licensure requirements
- Other requirements

TELEPSYCHIATRY

CLINICAL HURDLES





Notes:

1. *: or covering for another provider- see CSA for specific requirements
2. **: Special Registration doesn't currently exist; to be addressed by DEA in 2017
3. This is a risk management resource- it is not legal advice.
4. There can always be exceptions to these rules, especially if practicing within VA or IHS.
5. You should check with licensing boards in your state, and patient state's (if different) for specific requirements and prohibitions.

Technology Is Only A Tool

Technology is a tool that can partially restore the lost abilities to evaluate and treat patients at a distance, but by itself, *technology cannot completely restore all abilities.*

STATE MEDICAL BOARD INVESTIGATION OF PHYSICIANS' ONLINE ACTIVITIES

Hypothetical Physician Online Activity	Percentage of Boards responding "likely" or "very likely" to investigate		
	>75%	50% - 75%	<50%
Citing misleading information about clinical outcomes	81% (39/48)		
Using patient images without consent	79% (38/48)		
Misrepresenting credentials	77% (37/48)		
Inappropriately contacting patients	77% (37/48)		
Depicting alcohol intoxication		73% (35/48)	
Violating patient confidentiality		65% (31/48)	
Using discriminatory speech		60% (29/48)	
Using derogatory speech toward patients			46% (29/48)
Showing alcohol use without intoxication			40% (19/48)
Providing clinical narratives without violation of confidentiality			16% (7/48)

Source: Greysen SR et al., Online Professionalism Investigations by State Medical Boards: First, Do No Harm. Ann Intern Med. 15 Jan 2013;158(2):124-130

Social Media

- Blogs & Twitter
- Facebook, *et al.*
- Google patients?
- Online reviews (*Do not astroturf!*)
- E-Mail
- Texting
- Sermo, *et al.*

September 24, 2012

American Hospital Association
Richard Umbdenstock
President and Chief Executive Officer
325 Seventh Street, N.W.
Washington, DC 20004

Federation of American Hospitals
Charles N. Kahn, III
President and Chief Executive Officer
750 9th Street, NW, Suite 600
Washington, DC 20001-4524

Association of Academic Health Centers
Steve Wartman
President and Chief Executive Officer
1400 Sixteenth Street, NW, Suite 720
Washington, DC 20036

Association of American Medical Colleges
Darrell G. Kirch, M.D.
President and Chief Executive Officer
2450 N Street, NW
Washington, DC 20037-1126

National Association of Public Hospitals and Health Systems
Bruce Siegel, MD, MPH
President and Chief Executive Officer
1301 Pennsylvania Avenue, NW
Suite 950
Washington DC 20004

Dear Chief Executive Officers:

As leaders in the health care system, our nation's hospitals have been at the forefront of adopting electronic health records for use in coordinating care, improving quality, reducing paperwork, and eliminating duplicative tests. Over 55 percent of hospitals have already qualified for incentive payments authorized by Congress to encourage health care providers to adopt and meaningfully use this technology. Used appropriately, electronic health records have the potential to save money and save lives.

However, there are troubling indications that some providers are using this technology to game the system, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it's illegal. These indications include potential "cloning" of medical records in order to inflate what providers get paid. There are also reports that some hospitals may be using electronic health records to facilitate "upcoding" of the intensity of care

or severity of patients' condition as a means to profit with no commensurate improvement in the quality of care.

This letter underscores our resolve to ensure payment accuracy and to prevent and prosecute health care fraud. A patient's care information must be verified individually to ensure accuracy: it cannot be cut and pasted from a different record of the patient, which risks medical errors as well as overpayments. The Centers for Medicare and Medicaid Services (CMS) is specifically reviewing billing through audits to identify and prevent improperly billing. Additionally, CMS is initiating more extensive medical reviews to ensure that providers are coding evaluation and management services accurately. This includes comparative billing reports that identify outlier facilities. CMS has the authority to address inappropriate increases in coding intensity in its payment rules, and CMS will consider future payment reductions as warranted.

We will not tolerate health care fraud. The President initiated in 2009 an unprecedented Cabinet-level effort to combat heath care fraud and protect the Medicare trust fund, and we take those responsibilities very seriously.

Law enforcement will take appropriate steps to pursue health care providers who misuse electronic health records to bill for services never provided. The Department of Justice, Department of Health and Human Services, the FBI, and other law enforcement agencies are monitoring these trends, and will take action where warranted. New tools provided by the health care law authorize CMS to stop Medicare payments upon suspicion of fraud and to mine data to detect it in the first place. These efforts have contributed to record-high collections and prosecutions. Prosecutions in 2011 were 75 percent higher than in 2008. That said, we will continue to escalate our efforts to prevent fraud and pursue it aggressively when it has occurred.

The nation's hospitals share our goal of a health system that offers high quality, affordable care. We thank you for your relentless work toward this goal which can be better achieved once all Americans have privacy-protected electronic health records. The health information technology incentive program promotes electronic health records that go beyond documentation and billing and towards meaningful use as a foundation for new payment and delivery models. The Affordable Care Act has accelerated the spread of such models like Accountable Care Organizations, patient-centered homes, and value-based purchasing which shift the incentives away from volume and towards value. As we phase-in electronic health records, though, we ask for your help in ensuring that these tools are not misused or abused.

Sincerely,

Kathleen Sebelius
Secretary
U.S. Department of Health & Human Services

Eric H. Holder, Jr.
Attorney General
U.S. Department of Justice

Electronic Health Records

Thoroughly understand the operation of the EHR that you are using.

Assure that each patient encounter is accurately portrayed in the documentation.

Driving: Liability to Third Parties

Two lines of cases imposing liability:

1) Controlled substance (usually methadone) was ADMINISTERED despite risks that were known or should have been known

2) Controlled substance was PRESCRIBED without warning patient of known side effects that could impair driving

Medical Marijuana

Recommended reading list - for all:

- *Contemporary Routes of Cannabis Consumption: A Primer for Clinicians*
  - Peters and Chien, Journal of the American Osteopathic Association, Feb. 2018
- *Medical Marijuana: Do the Benefits Outweigh the Risks?*
  - Gupta and Phalen, Current Psychiatry, Jan. 2018
- *Marijuana and the Psychiatric Patient*
  - Woodward, Psychiatric Times, Apr. 10, 2017

MBC: Medical Marijuana Guidelines

Guidelines

- Physician-Patient Relationship
- Patient Evaluation
- Informed and Shared Decision Making
- Treatment Agreement
- Qualifying Conditions
- Ongoing Monitoring and Adapting the Treatment Plan
- Consultation and Referral
- Medical Records
- Physician Conflict of Interest

www.mbc.ca.gov/Publications/guidelines_cannabis_recommendation.pdf

Questions?