Douglas M. Wolfberg, Partner
dwolfberg@pwwemslaw.com

Doug Wolfberg is a founding partner of Page, Wolfberg & Wirth, and one of the best known EMS attorneys and consultants in the United States. Widely regarded as the nation’s leading EMS law firm, PWW represents private, public and non-profit EMS organizations, as well as billing companies, software manufacturers and others that serve the nation’s ambulance industry. Doug answered his first ambulance call in 1978 and has been involved in EMS ever since. Doug became an EMT at age 16, and worked as an EMS provider in numerous volunteer and paid systems over the decades. Doug also served as an EMS educator and instructor for many years.

After earning his undergraduate degree in Health Planning and Administration from the Pennsylvania State University in 1987, Doug went to work as a county EMS director. He then became the director of a three-county regional EMS agency based in Williamsport, Pennsylvania. He then moved on to work for several years on the staff of the state EMS council. In 1993, Doug went to the nation’s capital to work at the United States Department of Health and Human Services, where he worked on federal EMS and trauma care issues. Doug left HHS to attend law school, and in 1996 graduated magna cum laude from the Widener University School of Law. After practicing for several years as a litigator and healthcare attorney in a large Philadelphia-based law firm, Doug co-founded PWW in 2000 along with Steve Wirth and the late James O. Page. As an attorney, Doug is a member of the Pennsylvania and New York bars, and is admitted to practice before the United States Supreme Court as well as numerous Federal and state courts. He also teaches EMS law at the University of Pittsburgh, and teaches health law at the Widener University School of Law, where he is also a member of the school’s Board of Overseers.

Doug is a known as an engaging and humorous public speaker at EMS conferences throughout the United States. He is also a prolific author, having written books, articles and columns in many of the industry’s leading publications, and has been interviewed by national media outlets including National Public Radio and the Wall Street Journal on EMS issues. Doug is a Certified Ambulance Coder (CAC) and a founder of the National Academy of Ambulance Coding (NAAC). Doug also served as a Commissioner of the Commission on Accreditation of Ambulance Services (CAAS).
EMS Supervisors and Managers Workshop

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Three NAAC Certifications...

How Abe Lincoln Would Run Your Ambulance Service

Lessons for EMS Leaders From Our 16th President

We tend to think of Lincoln like this…

But it’s critical to remember that he was an extraordinary leader of people – in his own time and in his own way.

He was a person before he was a statue.

Indispensable viewing…
Why I Am Interested In This…and Why You Should Be Too!

The Four Principles of Lincoln’s Leadership

- People
- Character
- Endeavor (The Mission)
- Communication

Much Insight Into Lincoln’s Leadership Come From His Handwritten Letters

Imagine if Lincoln lived in a time when you had to write in 140-character Tweets…
Lincoln on People

1. Get out of the office and circulate among the troops
2. Build strong alliances
3. Persuade rather than coerce

“His cardinal mistake is that he isolates himself, & allows nobody to see him; and by which he does not know what is going on in the very matter he is dealing with.” ...

Lincoln’s reason for relieving Gen. John C. Fremont from his command in Missouri (September 9, 1861)

1. “Get Out of the Office and Circulate Among the Troops!”
Problems Will Arise.
Leaders Will…
• Explain the problem
• Offer advice on solving the problem
• Be clear on the expected outcomes

The Modern Equivalent
• “Management by Walking Around”
  • Interacting with people, not devices
  • Establishing human contact
  • Facilitates innovation
  • Makes possible the teaching of values to every member of the organization

In EMS, it means…
• Field time
• Attending training sessions
• One-on-one interactions
• Using the equipment
• Observing the challenges first hand

This means “get out of the ivory tower.”
Mingle.
Don’t make everyone come to you just because you are “the boss.”

November 13, 1861
General McClellan
• Appointed to head the Army of the Potomac in July 1861
• Had a reputation for arrogance and contempt for the Commander in Chief (Lincoln)
• Began openly associating with the president's political opponents

‘The President is nothing more than a well-meaning baboon.'

- General George McClellan, in a letter to his wife

Lincoln Visits McClellan
• President Lincoln, his Secretary of War, and his aide went to Gen. McClellan’s house on the evening of November 13, 1861 to discuss urgent war strategy
• They were told that McClellan was out, so the President and his aides waited for over an hour

Lincoln Visits McClellan
• On his return, McClellan was told that the President and his party were waiting to see him
• McClellan decided to go to bed for the night instead of see the President
• Lincoln was kept waiting another half hour before being told the General had retired for the night

Lincoln Visits McClellan
• Lincoln’s aide, John Hay, was furious and told Lincoln should have been greatly offended
• Lincoln’s reply:

“It is better at this time not to be making points of etiquette and personal dignity.”
In Other Words…

• For Lincoln, winning the war was the main goal – and he never lost sight of it
• The commander of the army had just dissed the Commander in Chief, but Lincoln tolerated personal slights for the good of the greater cause

Put Another Way…

“Don’t sweat the small stuff!”

Postscript…

• McClellan became the Democratic nominee for President in 1864 and ran against Lincoln for re-election
• Lincoln – with strong support of the troops - handily defeated McClellan and was re-elected President

He kept his cool and prevailed

2. Build Strong Alliances

Building Strong Alliances

• Both personally and professionally
• Who can you trust?
• Who can get the job done on their own?
• How will people respond in a given situation?
Building Strong Alliances

• Lincoln allowed his subordinates to get to know him as well
• This way, they knew what he wanted, what he demanded, and what he needed

Building Strong Alliances

• If his subordinates knew what he would do, they could make decisions without waiting for direction
• This helped him avoid delay and inactivity

Team of Rivals

• Many of Lincoln’s closest advisers and confidants were political rivals – some of whom even ran against him for President

Modern Translation:

• “Keep your friends close and your enemies closer!”
• In Lincoln’s case, he turned those enemies into friends
EMS Leadership Lessons

- People have phenomenal capacity
- They want to take ownership of problems and offer solutions
- Building alliances helps them see the greater goals and mission of the organization

3. Persuade Rather Than Coerce

“When the conduct of men is designed to be influenced, persuasion, kind, unassuming persuasion, should ever be adopted. It is an old and a true maxim, that a 'drop of honey catches more flies than a gallon of gall.'”

- Abraham Lincoln
  Remarks to the Springfield Washington Temperance Society, 1842

“On the contrary, assume to dictate to his judgment, or to command his action, or to mark him as one to be shunned and despised, and he will retreat within himself, close all the avenues to his head and his heart; and . . . you shall no more be able to reach him than to penetrate the hard shell of a tortoise with a rye straw.”

Making requests vs. Issuing orders

Lincoln’s Language of Persuasion

- “This letter is in no sense an order…”
  - Letter to Gen. McClellan, October 13, 1863
- “I hope you will consider it…”
  - Letter to Gen. Halleck, September 19, 1863
- “It was suggested to you, not ordered”
  - Letter to Gen. Burnside, September 27, 1863
- “If there is anything wanting which is within my power to give, do not fail to let me know it.”
  - Letter to Gen. Grant, April 30, 1864
EMS Leadership Lesson:
Know the Difference!

- **Authority**: The ability to force or coerce someone to do your will, even they choose not to, because of your position or your might.
- **Power**: The skill of getting people to *willingly* do your will because of your personal influence. It is always based on service and sacrifice to others.

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**Lincoln on Character**

1. Honesty and integrity are the best policies
2. Never act out of vengeance or spite

"I am compelled to take a more impartial and unprejudiced view of things. Without claiming to be your superior, which I do not, my position enables me to understand my duty in all these matters better than you possibly can, and I hope you do not yet doubt my integrity."

- Abraham Lincoln, May 26, 1863 letter defending General-in-Chief Henry Halleck

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**Lincoln on Character**

1. Honesty and Integrity are the Best Policies
Honesty and Integrity

- The architecture of leadership, all the theories and guidelines – falls apart without honesty and integrity

Managers vs. Leaders

- Managers do things right
- Leaders do the right thing
- “Divorced from ethics, leadership is reduced to management.”
  » James McGregor Burns

Lincoln’s Integrity Was the Nation’s Integrity

EMS Leadership Lessons

- Your organization must possess strong shared values
- Your values must be “owned” not just by the organization, but by everyone in it
- Leaders instill these values!

EMS Leadership Lessons

- Give your subordinates a fair chance with equal freedom and opportunity for success
- When you make it to the top, turn and reach down to the person behind you
- You must be consistently fair and decent – both personally and professionally

EMS Leadership Lessons

- Stand with those who are right. Part with them if they go wrong.
- Never add the weight of your character to a charge against a person without knowing it to be true.
- It is your duty to advance the aims of the organization and to help those who serve it
2. Never Act Out of Vengeance or Spite

“I shall do nothing in malice. What I deal with is too vast for malicious dealing.”

-Abraham Lincoln, July 28, 1862

Kindness and Empathy

• Followers in virtually every organization respond better to—and are more easily led—by a leader who consistently displays kindness and empathy

EMS Leadership Lessons

• People are more likely to come to you with ideas, suggestions and improvements in a climate that fosters it
• Empathy will create more supporters and fewer enemies
• No purpose is served by punishment merely for punishment’s sake

EMS Leadership Lessons

• Taking a deep breath can help avoid snap decisions or acting out of frustration or anger

Think Before You Send!
Think Before You Send!

- After Gen. Meade failed to pursue Lee’s army after Gettysburg and allowing his escape into Virginia, Lincoln wrote a scathing letter to Gen. Meade
- “I was in such deep distress, that I could not restrain some expression of it.”

Lincoln placed the letter in an envelope. On it, he wrote:

“To Gen. Meade, never sent or signed.”

Lincoln on Endeavor

1. Exercise a strong hand – be decisive
2. Lead by being led
3. Set goals and be results oriented
4. Encourage innovation

1. Exercise a strong hand – be decisive

“We are not enemies, but friends. We must not be enemies. Though passion may have strained, it must not break our bonds of affection. The mystic chords of memory will swell when again touched, as surely they will be, by the better angels of our nature.”

Abraham Lincoln

Lincoln on Endeavor

“Be sure you put your feet in the right place. Then stand firm.”

- Abraham Lincoln

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A Lincoln Story

A lion was very much in love with a woodman’s daughter. The fair maid referred him to her father and the lion applied for the girl. The father replied: ‘Your teeth are too long.’ So the lion went to a dentist and had them extracted. Returning, he asked for his bride. ‘No,’ said the woodman, ‘your claws are too long.’ Going back to the dentist, he had them drawn. Then he returned to claim his bride, and the woodman, seeing that he was unarmed, beat out his brains.

Everyone Gave Advice

Lincoln was constantly badgered by people – both inside and outside of the government – on how to better run the war. The country was in chaos. When a delegation of politicians from the Western U.S. invaded his office making excited demands, Lincoln replied:

Gentlemen, suppose all the property you were worth was in gold and this you had placed in the hands of one man to carry across the Niagara River on a rope.

Would you shake the cable and keep shouting at him: ‘Stand up a little straighter; stoop a little more, go a little faster, go a little slower, lean a little more left?’

No, you would hold your breath, as well as your tongue, until he got safely over.

The Government is carrying an enormous weight. Untold treasure is in their hands. Don’t badger them. Keep silent and we will get you safely across.

EMS Leadership Lessons

• Take advantage of confusion and urgency to exercise strong leadership
• Seize the initiative
• When making a decision, understand the facts, consider various solutions and their consequences, make sure the decision is consistent with your objectives, and effectively communicate your judgment

2. Lead by being led

Lincoln’s Attributes

• Lincoln often disavowed taking the lead – but he made the decisions
  • “I claim not to have controlled events, but confess plainly that they have controlled me”
• Lincoln was able to listen to people without being threatened by them
Example: Lincoln and Sherman

- “Many, many, thanks for your Christmas gift - the capture of Savannah. When you were about leaving Atlanta for the Atlantic coast, I was anxious, if not fearful. . . . Now, the undertaking being a success, the honor is all yours. . . But what next? I suppose it will be safer if I leave Gen. Grant and yourself to decide.

  » Lincoln to Gen. Sherman, Dec. 28, 1864

Example: Lincoln and Sherman

- “I am gratified at the receipt of your letter, especially to observe that you appreciate the division I made of my army. . . I am ready to move again as soon as I can learn of your preference of objectives.”

  » Gen. Sherman responding to Pres. Lincoln’s letter

EMS Leadership Lessons

- Obtain “buy in”
- Listen to subordinates’ suggestions, and if they make sense, let them proceed with the knowledge and belief that it was their idea

EMS Leadership Lessons

- Try not to feel insecure or threatened by your subordinates
- Let disputing parties work out their differences by bringing them together and guiding their dialogue
- Give the honors to subordinates if they succeed, take the blame if they fail

Listening is Critical!
EMS Leadership Lessons

• When your subordinates come up with good ideas, let them try, but monitor their progress
• If your people in the field can’t be successful, neither can you

3. Set goals and be results-oriented

Lincoln on the Union & Slavery

“If I could save the Union without freeing any slave, I would do it; and if I could save it by freeing all the slaves, I would do it; and if I could do it by freeing some and leaving others alone, I would also do that. What I do about Slavery and the colored men, I do because I believe it helps to save this Union.”

-Abraham Lincoln

Goal-Oriented

• History books teach us that Lincoln freed the slaves – and he did, for which he deserves the lasting respect of history
• But he never made any secret that his primary goal was to preserve the union
• He saw this as his Constitutional duty

You have no oath registered in Heaven to destroy the government, while I shall have the most solemn one to preserve, protect and defend it.”

-Abraham Lincoln, First Inaugural Address, March 4, 1861

Goal-Oriented

• Focusing on the big picture – the outcome – and not every detail about the process – allowed Lincoln to guide the nation through its most perilous time

EMS Leadership Lessons

• Unite your subordinates with a mission
• Set specific goals that can be focused on by everyone
• Sometimes it is better to go around obstacles than to plow through them
• Remember that half-finished work proves to be labor lost
4. Encourage Innovation

"Still the question recurs "can we do better?"
The dogmas of the quiet past are inadequate
to the stormy present. The occasion is piled
high with difficulty, and we must rise with the
occasion.

As our case is new, so we must think anew,
and act anew."

-Abraham Lincoln,
December 1, 1862

Lincoln’s Attributes

• “If we never try, we never succeed”
• Recognized that mistakes were
learning events and steps in the right
direction
• The last thing his subordinates needed
was a depressed or brooding leader

Innovation

• Lincoln always showed interest in
innovation
• In fact, he is the only U.S. President to
hold a patent
• U.S. patent # 6469, a device for lifting
boats over shoals

EMS is in Flux

• Shift from episodic, fee-for-service
based care to population health
• Payment for performance
• Shift from transport-based commodity
to community healthcare
EMS Leadership Lessons

• Rise to the occasion. Think anew.
• Don’t lose confidence in people when they fail.
• Let your subordinates know you are always glad to have their suggestions.
• The best leaders never stop learning.

EMS Leadership Lessons

• Surround yourself with people who know their stuff
• Avoid “yes men”
• Be quick and decisive at employing new advances

Lincoln on Communication

1. Master the art of public speaking
2. Communicate a vision and continually reinforce it

Lincoln’s Attributes

• Some of Lincoln’s speeches are still regarded today as some of the best in all of American history
  • “House Divided” speech
  • Cooper Union speech
  • The Gettysburg Address
  • Second Inaugural

1. Master the Art of Public Speaking
The Gettysburg Address

• The occasion was the dedication of the cemetery at the Gettysburg battlefield
• The main speaker was Edward Everett – President of Harvard University and former governor of Massachusetts
• He gave a broad, sweeping oration about the war

Edward Everett spoke for 2 hours – over 13,000 words.
Not one word is remembered today.

Lincoln spoke 272 words in about two minutes.
The speech became immortal.

EMS Leadership Lessons

• Be brief, and be seated!
• Be your organization’s best stump speaker
• Jokes, anecdotes and stories – when appropriate – can bring listeners to your side
• Never consider anything you write to be final until it’s delivered
2. Communicate a Vision and Continually Reinforce It

Lincoln “preached a vision” that was a clear, concise statement of the direction of the country and justification for the Union’s actions.

At Gettysburg, Lincoln Communicated:

- The past
- The present
- The renewal
- And the future of our nation

Why Can’t We Communicate That Vision to Our Own People?

EMS Leadership Lessons

- Remind people of our history of public service - our proud roots!
- Tell them what is going on now
- Tell them what is being done to fix and improve things
- Communicate a vision for the future

In conclusion…

- Lincoln is regarded as among our greatest Presidents
- He was also an extraordinary leader
- Wisdom, humor, humility, and goal-orientation served him – and the nation – well
- These lessons should serve to inspire EMS leaders
EMS Law School – Part I

Liability, Lawsuits and Staying Out of Court

The Legal System

• Tort Law
  • Unintentional torts
    − Malpractice actions
    − Other Negligence actions
  • Intentional torts
    − False imprisonment
    − Assault/Battery, etc.

The Legal System

• Criminal vs. Civil Law
• Criminal Actions in EMS
  • Vehicular
  • Health care fraud and abuse
  • Embezzlement
  • Patient abuse

Key Areas of Liability

• What do you think is the single biggest area of liability for EMS organizations?

Key Areas of Liability

• Patient Care Issues
  • Airway management issues
  • Spinal immobilization issues
  • Equipment failures or inadequate equipment
Key Areas of EMS Liability

- Getting Lost
  - Bad dispatch information
  - Crew unfamiliarity with service area
- Bad Refusals (Abandonment)
- Stretcher Drops

EMS Malpractice: Defining Negligence

NEGLIGENCE

- “The failure to act as a reasonably prudent EMT or paramedic would act under similar circumstances.”

DUTY TO ACT

- Legal duty vs. moral duty
- When does duty arise?

DUTY TO ACT

- Hypotheticals
  - Driving by scene of accident?
  - If you stop and render aid?
  - On the way to work?
  - When the pager goes off?
  - When you're enroute?
BREACH OF DUTY

- Failure to uphold standard of care
- In other words, failure to act as a reasonably prudent EMT or paramedic would under the circumstances

BREACH OF DUTY

- What is the “standard of care?”
- Evidence of the standard of care:
  - Scope of practice
  - National standard curriculum
  - Local or regional protocols or standing orders
  - Expert witnesses

DAMAGES

- Compensable losses
  - Medical expenses
  - Pain and suffering
  - Lost wages
  - Funeral expenses
  - Loss of consortium
  - Punitive damages

PROXIMATE CAUSATION

- Foreseeable consequences
- Actual vs. Legal causation
- Example

Case Study 1
Write it All Down – the Good, the Bad and the Ugly!

The Case

Alleged Facts

• On July 14, 2002, Shirley Johnson experienced an anaphylactic reaction to peanut oil after eating Chinese food
• Began having trouble breathing
• Her husband took her by car to an immediate care center (ICC)
• ICC called 911 immediately

Alleged Facts

• EMS dispatched at 1653, arrived on scene at 1656
• Upon arrival, found pt seated in passenger seat of her car, in severe respiratory distress

Patient Assessment

• Parties disagree over key aspects of the pt's condition
• EMS says pt’s jaw was clenched, plaintiff says it wasn’t
• Plaintiffs say that the ICC doctor told EMS that pt needed immediate intubation and that the doc offered to intubate, EMS denies these allegations

Transport

• Parties also disagreed on several key facts about the loading and transport of the pt
  • Failed IV attempts
  • Failed intubation attempts
  • Amount of time before intubation was attempted
  • Whether the tube was misplaced

Documentation Discrepancies

Providers Testified:  • Epinephrine was administered

BUT, PCR Says:  • No such indication in the PCR

Documentation Discrepancies

Providers Testified:  • Pt was in the ambulance 3-5 mins before intubation was attempted

BUT, PCR Says:  • Pt was on board the ambulance for 12 minutes before first intubation attempt was made
## Documentation Discrepancies

**Providers Testified:**
- Intubation was successful at 1722 hrs and tube placement was verified with end tidal CO₂ capnography and auscultation

**BUT, PCR Says:**
- No documentation of capnography or stomach/lung auscultation in the PCR

## Arrival at Hospital

- Upon arrival, pt was in cardiac arrest, abdomen distended
- E.D. physician determined that E.T. tube was in the esophagus instead of the trachea

## Arrival at Hospital

- EMS asserted that tube became displaced when her head “jostled” while taking pt out of the ambulance
- Plaintiffs assert that the 60 seconds or so for offloading would not be enough time for a misplaced E.T. tube to cause marked abdominal distention

## Court Ruling

- The EMS agency made a “motion for summary judgment” asking the court to rule in their favor in the case
- Court must view all evidence in favor of the nonmoving party (in the case, the plaintiffs)
- Court may grant the motion only if there are no “genuine issues of material fact”

## Battle of the Experts

- Both sides produced expert reports regarding the standard of care
  - Plaintiffs experts allege that it was negligent for EMS not to intubate immediately; not to accept ICC doc’s offer of assistance; failing to follow intubation protocols, etc.
  - Defendants experts assert that care was within accepted standards and not “willful or wanton”

## Applicable Law

- In Illinois, as with most states, EMS providers enjoy “qualified immunity” from civil liability
- No civil liability as long as the providers act in good faith, and not with “willful and wanton misconduct”
- Issue: what is “willful and wanton?”
Applicable Law

• Illinois Supreme Court: must have been intentional, or the act must have been committed under circumstances exhibiting a reckless disregard for the safety of others
• It is a “hybrid” between negligent and intentional behavior

Court Ruling

• Court denied the motion by the EMS agency
• “The case law strongly suggests that a fact-finder can find that a defendant’s conduct is willful and wanton if the defendant fails to follow applicable guidelines and procedures”

Court Ruling

• Disputed issues of fact:
  ▪ Whether epi was given (crew says yes, but PCR doesn’t document it)
  ▪ Whether tube placement was verified (crew says yes, but PCR doesn’t document it)
  ▪ Whether crew unduly delayed intubation attempt (crew says it tried in 3-5 minutes; PCR says it was closer to 12 minutes)

Lessons Learned

• All interventions must be documented – whether successful or unsuccessful
• Absent documentation, the “after the fact” testimony can appear to be self-serving and an attempt to “cover up”

Lessons Learned

• Airway and cardiac arrest cases especially need to have “protocol-compliant documentation”
• Critical to document steps taken to verify E.T. tube placement; dangerous to allow others to “assume” it was done

Lessons Learned

• A court cannot grant summary judgment in your favor when there are any “disputed issues of material fact”
• Contradictions between the PCR and the crew’s own subsequent testimony can easily raise “disputed issues”
Case Study 2
The Difficult Choice

The Case
• Susan Ross Green as Executrix of the Estate of Walter Green v. City of New York, Paul Giblin and St. Luke’s-Roosevelt Hospital Center
• Decided by U.S. Court of Appeals for the Second Circuit, October 5, 2006

Case Summary
• “EMS personnel who respond to a medical emergency involving a person who refuses to accept medical treatment do face a difficult choice between honoring the person’s refusal and offering treatment or transportation for treatment that they feel is necessary.” Court’s opinion, p. 27

Case Summary
• “Because medical professionals are trained to heal, absent proper training, they may well believe they should override the ill or injured person’s refusal.” Court’s opinion, p. 27

Case Summary
• Unfortunately, persons who are severely physically disabled are often perceived as incompetent.” Court’s opinion, p. 20

Facts
• Walter Green had ALS (Lou Gehrig’s Disease) and was vent-dependent
• Could not speak
• Communicated via blinking and by computer
• Had a bout of pneumonia in 2000
### Facts

- **March 19, 2000,** had respiratory episode; caregiver began performing mouth-to-trach
- **Pt’s daughter** arrived and found him unconscious, eyes rolled back, “green skin” and cold to touch
- **911** called at 2:40 p.m.

### Facts

- **Daughter** told the dispatcher her father’s vent was not working and “we need help”
- A few minutes later, her mother (Susan) arrived and began using an ambu-bag and suction
- **Walter regained consciousness**

### Facts

- **Daughter** told the dispatcher her father’s vent was not working and “we need help”
- A few minutes later, her mother (Susan) arrived and began using an ambu-bag and suction
- **Walter regained consciousness**

### Facts

- **St Luke’s EMS personnel** and police then arrived on scene
- **Walter blinked “no”** when asked if he wanted to go to the hospital and typed out “no, because I fine” on his computer, which spoke the words for him

### Facts

- **Base hospital** determined that they could not help determine if Walter was competent since he could not speak with them
- **Lt. Giblin** announced that he was in command and told Susan “we are taking him in” while the words “no hosp” appeared on Walter’s computer screen  *(Court’s opinion, p. 7)*

### Facts

- “**Susan begged Giblin to ask Walter questions**, so that he could observe his answers, but Giblin refused to look at Walter.” *(Court’s opinion, p. 7)*
- “**Giblin could not tell whether Walter was oriented to time, place and person,** and did not assess his decisional capacity” *(Court’s opinion, p. 9)*
Facts

- Susan called her family attorney, who also came to the scene while EMS was present
- Attorney determined Walter to be competent and told Lt. Giblin that
- Attorney asked “if Walter could talk and say no, he didn’t want to go, would you still take him?”
- Giblin replied that he would not

Facts

- By this time, the daughter erected a makeshift barrier of furniture to prevent the EMS personnel from moving Walter
- Officers and EMS began to move Walter for transport, and in the process Susan was knocked down

Facts

- “We are going to the hospital whether you like it or not.”
  - Lt Giblin

Facts

- Susan then asked if Walter could be taken to Columbia Presbyterian since it had a unit for the treatment of Lou Gehrig’s Disease
- Giblin responded “no we are going to St. Luke’s Roosevelt”
- Susan asked: “Why?

Facts

- “Because I said so.”
  - Lt Giblin

Walter’s Deposition

- “How to express in words the depth of pain I experienced that day. And it was by far the worst physical pain I’ve ever endured….I cried in my wife’s arms for an hour. For 40 years I have protected my family…I watched my wife get knocked to the floor…I saw my daughter manhandled by large men who claimed to be helping. My home was violated, my self-respect crushed…I couldn’t look at my wife and children. I felt ashamed, and for the first time an utterly helpless man, worthless.”
### The Lawsuit

- ADA and NY Human Rights Law violations
- Violation of constitutional rights
  - 4th Amendment “unreasonable seizure”
  - 14th Amendment violation of right to refuse unwanted medical treatment

### The Lawsuit

- State tort actions
  - False imprisonment
  - Civil assault/battery
  - Negligence

### District Court’s Decision

- Dismissed all of plaintiffs’ claims in favor of all defendants
- Ruled that Walter was “in extremis”
- Seizure was not unreasonable
- The family called 911 and asked for help

### District Court’s Decision

- Walter could not breathe on his own
- EMS had an interest in protecting its employees from liability for abandoning Walter
- Walter could not make an informed and competent decision regarding his treatment in the “crisis atmosphere”

### Appeals Court Decision

- Overturned the District Court’s dismissal of several of the claims
- Found that the EMS personnel violated Walter’s rights under the Americans With Disabilities Act (ADA) and state anti-discrimination law

### Appeals Court Ruling - ADA Claim

- The on-scene family attorney testified that he asked Lt. Giblin if he would transport Walter if he could speak and Lt. Giblin said he would not
- “Reasonable jury” could find that this was discrimination based on disability (his inability to speak)
Appeals Court Ruling – Constitutional Claims

• “In order to constitutionally seize a person to transport him to a hospital, the person must be dangerous…to himself or others”
• “For a competent adult, dangerousness to oneself justifying such a seizure does not include a refusal to accept medical treatment”

Appeals Court Ruling – Constitutional Claims

• Court swayed by the fact that Lt Giblin never personally assessed Walter’s competence
• Giblin claimed he was informed by other EMS personnel on scene that Walter was incompetent
  • However, the EMS PCR indicated that Walter was “conscious and communicating”
  • Pt’s GCS went from 3 to 15

Lessons From This Case

• A competent patient has a right to refuse medical care and/or transportation
• Competent patients can express their refusal in both verbal and non-verbal ways

Lessons From This Case

• The decision on a patient’s competence must be made by assessing the patient – not merely the circumstances!
• Severe physical disability does not equate to decisional incapacity!

Case Study 3:
The Privacy Police Strike Again!

Maier v. Green
U.S. District Court for the Western District of Louisiana
(March 30, 2007)
Facts

• April 9, 2005, a female victim of domestic violence presented to ED of Lafayette General Medical Center (LGMC) and was admitted
• Nurse on duty called 911 to report incident of domestic violence
• Police officer dispatched to LGMC to investigate and nurse informed officer that pt reported to hospital that injuries were caused by her husband

Facts

• Police officer attempted to speak with victim
• A case manager denied access to the patient, claiming 1) she asserted her right to privacy and 2) that for the hospital to allow the police to interview her would be a HIPAA violation

Facts

• Police instructed case manager to contact them when the patient was discharged
• Pt was eventually discharged into the care of her husband, without any notice being given to the police department

Facts

• The hospital case manager was arrested for obstruction of justice
• However, DA ultimately did not file charges
• Case manager then filed a civil rights lawsuit against the police for “false arrest”

The Lawsuit

• The police asserted that they had probable cause and a valid arrest warrant to arrest the case manager for obstruction of justice
• Police claimed the arrest was proper and the case manager’s actions were not justified under HIPAA

Court Analysis

• The case manager could not identify any HIPAA provision that would prohibit a police officer from asking a patient who is a victim of a crime to identify the perpetrator of the crime
Court’s Ruling

• “HIPAA prohibits hospital personnel from disclosing protected health care information to third parties.”
• “It does not bar police officers from obtaining information related to a perpetrated crime directly from a patient nor does it prohibit hospital personnel from allowing police officers access to a patient who was a victim of a crime.”

Court Ruling

• “[H]er mistaken belief, even if sincere, that her actions were not only justified but required under HIPAA is immaterial.
• The court ruled that regardless of plaintiff’s understanding of HIPAA, the police department had probable cause to arrest Maier for obstruction of justice.

Lessons Learned

• Know the law!
  • State laws may require reporting of certain types of injuries or conditions
  • HIPAA contains a provision permitting disclosures of PHI where “required by law”
  • New breed of state laws (e.g., Kansas) actually require EMS providers to draw samples when police demand it

Case Study 4: The Liability of Apathy?

The Case

• Joseph Ziccardia, Esq., as Administrator of the Estate of James Smith v. City of Philadelphia, Roger Morfitt; Joseph DiFrancesca and Roger Morfitt, 288 F.3d 57
  • Decided by the U.S. Circuit Court of Appeals for the Third Circuit, 2002

Alleged Facts

• Early morning hours of May 16, 1998
• James Smith, 24 yrs old, went to his aunt’s residence after a night of drinking
• Couldn’t get into the house
• Sat down on a wall in front of the house and fell asleep
• Fell from the wall and dropped 8 feet to the sidewalk below
Alleged Facts
• After he fell, several neighbors heard him yelling
• By all accounts he was moving his arms and legs
• Paramedics DiFrancesca and Morfitt responded to the 911 call

Alleged Facts
• Medics approached pt and asked him his name and what was wrong
• Pt responded that he hurt his head and said several times that he hurt his neck
• One medic said: “Get up. Are you drunk?” and “Get up or we’re going to call the police.”

Alleged Facts
• After nudging pt a few times, each medic grabbed one of pt’s arms
• They “snatched him up and threw each arm over their shoulders and dragged him to the stretcher”

Alleged Facts
• One witness said that after the medics lifted the pt by the arms, “his head jerked back”
• Also said: he “sort of got real limp after that, like everything started hanging on him”

Alleged Facts
• Pt did not move his arms or legs after this point
• In pt’s own words, his neck “snapped back” and “it was like somebody hit a light switch and I just went completely numb” below the neck

Medical Expert Testimony
• Treating physician stated as follows:
  
  It is a medical certainty that the paramedics should have immobilized his cervical spine prior to moving him. To have, instead, lifted him by his arms and then by his shoulders and legs in unconscionable. Mr. Smith’s quadriplegia is directly attributable to the actions of the paramedics.
Medical Expert Testimony

• A second expert testified:
  *The paramedics demonstrated incredible and shockingly deliberate indifference to Mr. Smith and to his needs as an injured person.*

Case Outcome

• Paramedics made a motion to dismiss the case on the basis of “qualified immunity”
• Trial court denied the motion
• Appeals court affirmed the denial of the motion

Lessons From This Case

• Liability can also arise under civil rights laws (public agencies)
• Don’t count on immunity statutes to save your bacon

Lessons From This Case

• Sometimes we worry about retention too much
• Retention is not always a virtue, and turnover is not always a vice!

What if I have to Testify?

Surviving the courtroom experience

When might I have to testify?
### Testifying

- Testimony can take a variety of forms
  - Discovery
  - Hearings (including video, telephone or in person)
  - Trials

### Testifying

- Proceedings can be:
  - Administrative
  - Civil
  - Criminal

### What is a Deposition?

- Testimony given during the “discovery” phase of a case
- Used in conjunction with other discovery methods
  - Document requests
  - Written interrogatories

### Where are Depositions Taken?

- Lawyers’ offices
- Your workplace
- A courthouse conference room
- Still under oath!

### What's the Purpose of a Deposition?

- Learn the facts of a case
- Allow lawyers to assess strengths/weaknesses of a case
- Identify other potential witnesses

### What's the Purpose of a Deposition?

- Determine if any additional parties need to be brought into the suit
- To “lock in” a witness to his story and impeach them at trial if needed
If I’m Deposed, Am I in Trouble?

• Usually, the answer is NO
• Most depositions are of fact witnesses
• Being a witness is not the same as being a defendant!
• But keep in mind that deposition testimony could lead to liability if evidence of negligence is uncovered

Some tips on testifying…

Don’t be intimidated!

Subpoenas

• If you’ve been served with a subpoena, make sure you inform your agency
• Typically does not mean that you’re the one being sued
• You may simply be a fact witness with information useful to one or more parties to the lawsuit

Subpoenas

• Is it a “records request” only, or is your testimony specifically being sought?
• Is it for a deposition, hearing, trial, etc.?

“Under Oath”

• Remember, regardless of the type of proceeding – hearing, deposition, trial, etc., you are probably going to be testifying under oath
• All responses must be truthful!
**Preparation**

- You are permitted to review your PCR, deposition testimony and other documents prior to your testimony
  - In fact, it may be a good idea to do so!
  - However, it’s *not* a good idea to meet with other witnesses or potential witnesses and “get your stories straight!”

- If it’s a hearing or trial, and you’ve already given a deposition or other sworn statement, your prior statements can be used to “impeach” your testimony!

**Preparation**

- Do not try to memorize your testimony
  - Over-rehearsed or over-prepared testimony can impair credibility
  - Testifying in your own words in a direct, conversational manner is best

- It testifying in court, try to familiarize yourself with the courtroom beforehand
  - Location of the witness stand, etc.
  - Allows you to confidently approach when called to testify

**What Do I Wear?**

- Typically business attire – “dress like you’re going to church”
  - Studies have shown that black for men and blue for women are best colors for “looking believable”
  - Uniforms?

- Avoid flashy, gaudy jewelry
  - No buttons, ties or other insignia that try to “make a statement”
  - Leave your political commentary at home!
Professionalism
• Above all, behave like a professional who inspires confidence, trust and credibility

Voice
• Speak in a loud, clear and confident voice
• Starting with “I do” when you are sworn in

Posture
• Don’t slouch, fidget or look distracted
• Keep your hands on your lap
• Keep hands away from your mouth
• Sit up straight

Eye Contact
• If testifying in a trial, make eye contact with jurors
• Don’t focus on the lawyer asking you the questions, he or she is not the one you want to convince of your truthfulness
• “If you look up, you don’t know”
• “If you look down, you’re lying”

Unclear Questions
• Never answer a question if you’re unsure of what’s being asked!
  • Ask that the question be repeated, clarified or restated if necessary!
• Do not attempt to understand a question until you are certain you understand it

If it’s the honest answer, then it’s OK to say . . .
• “I don’t know”
• “I don’t remember”
• Don’t guess!
Mistakes
- If you make a mistake, or mis-speak while under oath, correct it!
- Do NOT try to cover it up

Compound Questions
- A question that actually asks several things which might require different answers
- Example: "Did you determine the point of impact from conversations with witnesses and from physical marks, such as debris in the road?"

Compound Questions
- Typically, the opposing lawyer will object to compound questions, but otherwise be careful how you answer them
- It's ok to ask that the question be broken into parts or rephrased

Answer Only What is Asked
- Make them ask the question they really want to know!
- Example: "were you wearing a watch?"
  - The answer is not "yes, it was 3:30 when we arrived on scene"
  - The answer is "YES" or "NO"

Types of Questions
- Direct examination: open-ended questions
  - Goal is to allow witness to fully explain facts
  - Build credibility and goodwill with jury

Types of Questions
- Cross examination: leading questions
- Questions are typically asked in "yes or no" manner
- So, answer only "yes" or "no" when asked a leading question
Verbal Responses

- Court reporters can’t record nods or shakes of the head, shrugging of the shoulders, etc.
- Ensure all responses are verbal

Objections

- If an attorney makes an objection, STOP TALKING immediately until the objection is resolved

Avoid Speaking in Absolutes

- Watch words such as “I always” or “I never”
- May come back to haunt you if an exception ever arises

Be Polite and Courteous

- Sometimes, attorneys may deliberately try to push your buttons
- Maintain a calm, businesslike, professional demeanor at all times
- Be well-rested

Be Polite and Courteous

- Don’t let your temper get the best of you when testifying
- Let the jury dislike the lawyers, not you!

How to Address the Judge

- “Your Honor”
- “Judge”
Jokes

• Treat a courtroom, the judge and the attorneys with seriousness and respect
• Do not attempt to minimize the case or make it seem trivial
• Avoid jokes, lighthearted comments as a general rule

Conclusion

EMS Law School – Part II

The Changing Workplace Scene

• New Laws +
• New Attitudes =
• “Skyrocketing” Workplace Litigation

The Legal Side of Managing Your People

Employment at Will

• Unless there is a contract, may be terminated for a good reason, a bad reason, or no reason at all!

Exceptions

• Public Employment
• “Public Policy” Exceptions
• Employment Agreements
  • Includes union contracts!
“Just Cause”

- Common in union contracts, the employer must have **good cause** or a **good reason** to terminate the employee.

Toward a “Just Cause” Standard

- Erosion of “employment at will”
- New Legislation
- Changes in societal attitudes
- Changes in employee expectations

“Fairness”

- Employer’s actions should be understandable, credible and **not just legal**, but fair to the employee and to outside persons.

Why Be Fair? . . .

- “Feelings about you and your organization drive the motivation to sue
- Jurors in employment lawsuits don’t care about evidence!
- Abrupt adverse action without prior warning, chance to correct behavior, and “due process” are extremely suspect!

Juries In Employment Cases Will “Second Guess” Your Decision and They Often Feel that Employers Will Lie To Win a Lawsuit!

Bottom Line: Were You Fair?

Legal Issues

- Federal and state laws govern employment relationships
- “Common Law” also applies
- New remedies available to plaintiffs
- Bottom line: most organizations are subject to numerous workplace laws
State Laws

• State human relations laws also prohibit discrimination in employment on the basis of race, religion, color, national origin, ancestry, sex, age or disability. (Some include sexual preference)

Americans With Disabilities Act

ADA Applicability

• All employers
• Including state and local governments
• With 15 or more employees

Who Is Protected?

• Under the ADA, a person is “disabled” if they have a “physical or mental impairment that substantially limits a major life activity”

ADA Amendments

• “Emphasizes that the definition of disability should be construed in favor of broad coverage of individuals to the maximum extent permitted by the terms of the ADA and generally shall not require extensive analysis.” – EEOC website

Who Is Protected?

• The ADA also protects individuals if:
  • They have a history of such a disability,
  • Or if an employer believes that the individual has such a disability, even if they don’t
Who Is Protected?
• To be protected under the ADA, an individual must:
  ▪ Have
  ▪ Have a record of, or
  ▪ Be regarded as having a substantial, as opposed to a minor, impairment.

Who Is Protected?
• A “substantial impairment” is one that significantly limits or restricts a major life activity such as:
  ▪ Hearing
  ▪ Seeing
  ▪ Speaking
  ▪ Walking
  ▪ Breathing
  ▪ Performing manual tasks
  ▪ Caring for oneself
  ▪ Learning
  ▪ Working

Who Is Protected?
• To be protected under the ADA, the individual must also be qualified to perform the essential functions or duties of a job, with or without reasonable accommodation

Who is Protected?
• An employer cannot refuse to hire an individual because his or her disability prevents them from performing duties that are not essential to the job

Employer Obligations
• Discrimination in the workplace against qualified individuals on the basis of disability is prohibited
Employer Obligations

• Employers must reasonably accommodate applicants and qualified individuals with a disability
  ▪ Employee should inform employer of their disability if they require reasonable accommodation
  ▪ No reasonable accommodation required if employer is not aware of the disability

What is “Reasonable Accommodation”?

• Any change or adjustment to a job or work environment that permits a qualified applicant or employee with a disability to:
  ▪ Participate in the job application process
  ▪ Perform the essential functions of a job, or
  ▪ Enjoy benefits and privileges of employment equal to those enjoyed by employees without disabilities

What is “Reasonable Accommodation”?

• Examples
  ▪ Providing or modifying equipment or devices
  ▪ Job restructuring
  ▪ Part-time or modified work schedules
  ▪ Reassignment to a vacant position
  ▪ Adjusting or modifying examinations, training materials, or policies
  ▪ Providing readers and interpreters
  ▪ Making the workplace accessible by people with disabilities

What is “Reasonable Accommodation”?

• An employer is required to provide a reasonable accommodation to a qualified applicant or employee with a disability
  ▪ Unless the employer can show that the accommodation would be an undue hardship
  ▪ Undue hardship is one that would require significant difficulty or expense

Illegal Drug Use

• Current illegal drug use is not protected under the ADA

Threats to Health and Safety

• An employer is not required to hire an individual if he or she poses a direct threat to the health or safety of the individual or others
Threats to Health and Safety

• Example:
  - Susie Smith suffers from hemiparesis on her right side due to an old injury sustained in an MVI
  - She is otherwise a qualified EMT, but cannot safely lift a stretcher with a patient

Threats to Health and Safety

• Susy's disability might pose a direct threat to the health and safety of your patients
• Employer can choose not to hire her due to the direct and substantial threat posed by her disability

Physical Exams

• Physical and mental examinations – including drug testing – cannot be required prior to a job offer
  - Must first determine if the individual is qualified
  - Exams can only be given after a conditional offer of employment is made

Physical Exams

• Must be related to the job
• Must be given to all employees in that job category

The Age Discrimination in Employment Act (ADEA)

• Prohibits discrimination against “older” workers (age 40 or over) in all aspects of employment, including hiring and benefits
Age Discrimination in Employment Act

• There is a de facto case of age discrimination when:
  ▪ Employer discharges an employee over 40,
  ▪ And replaces him or her with an employee under 40

Age Discrimination in Employment Act

• In these cases, the burden shifts to the employer to prove that the discharge was not due to the employee’s age, but to other, legitimate factors

Age Discrimination in Employment Act

• If the employer proves that there are legitimate, non age-related reasons, the burden shifts back to the employee to show that the employer's reasons were pretextual

The Family Medical Leave Act

Key FMLA Provisions

• Provides up to 12 weeks of unpaid job-protected leave for employees for:
  ▪ The birth and care of a child
  ▪ Placement of a child for adoption or foster care
  ▪ The serious health condition of the employee or a family member

FMLA Applicability

• Covers all employers with 50 or more employees within a 75 mile radius
New FMLA Regulations
• Provide employers new tools in administering FMLA more effectively
• Employers have more notice obligations
  ▪ General
  ▪ Specific

Sexual Harassment in the Workplace

Sexual Harassment
• “Sexual Harassment” is sex discrimination under the law
• Public safety workplace seems to be an environment prone to sexual harassment allegations

79 Percent of Women Surveyed Reported They Were Sexually Harassed in The EMS Workplace!

Linda Honeycutt, Girl Talk, JEMS (Jan. 1999)

• $ 1 Million Each Awarded to 2 Salt Lake City Paramedics . . .
• $ 5.25 Million Suit filed by Paramedic in Dayton, OH . . .
• 825 Pittsburgh firefighters ordered to undergo sexual harassment training . . .

Types of Harassment
• “Quid Pro Quo”
  ▪ Demands for sexual favors in return for job benefit
• Hostile Work Environment
  ▪ Unwelcome attention or remarks of a sexual nature that interferes with ability to work
Who Can Be “Harassed?”

- Male supervisor vs. female subordinate
- Female supervisors vs. male subordinate
- Coworker vs. coworker
- Non-employees vs. employee
- Same sex harassment

Other Claims

- Sex discrimination other than “harassment”
- Criminal action is possible!
  - Aggravated Assault
  - Battery
  - False imprisonment
  - Indecent exposure
  - Corruption of the morals of a minor

Sexual Harassment Defined

- Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature that:
  - Affects a term or condition of employment
  - Are a basis for employment decisions
  - Unreasonably interferes with work or creates an intimidating, hostile, or offensive working environment

CONDUCT

- Sexually Explicit Photos, Magazines
- Offensive or unwelcome sexual stories, comments, jokes or innuendoes
- Gestures, “Leering”, “Ogling”
- Unwelcome touching/physical contact/detaining
- Unwelcome Propositions
- Sexually orientated gifts
- Mail/Phone Calls/E-mail/Internet Access

The Workplace Computer Crisis

- E-Mail is “Evidence Mail”
- Should have specific policies regarding use of company computers
  - Work-related use only
- Policies can also regulate use of non-company computers
  - Webmail access

Harassment by Supervisors

<table>
<thead>
<tr>
<th>Tangible Job Detriment:</th>
<th>No Tangible Job Detriment:</th>
</tr>
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<tbody>
<tr>
<td>Employer automatically liable</td>
<td>Employer defense of reasonable care and employee failure to report it</td>
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Coworker Harassment

• Liable if Co. “knew or should have known of the harassment” and failed to stop it
• Defense if:
  ▪ Co. acted with “reasonable care”
    – Policy
    – Properly handled the complaint
  ▪ Victim did not report it

Third Parties/Patients

• Liable if Co. “knew or should have known of the harassment” and failed to stop it
• Defense if:
  ▪ Co. acted with reasonable care
    – Policy
    – Properly handled the complaint
  ▪ Victim did not report it

Keys to Avoiding Liability

• Policy with clear-cut reporting procedures and options
• Distribute and post the policy
• Train and sensitize everyone
• Train managers who investigate (consider outside investigators)

Keys to Avoiding Liability

• Prompt Investigation
• Prompt corrective action
• Do Not retaliate for good faith reports
• Train/Revisit annually and for all new hires

State “Common Law” Claims

Possible State Law Claims

• Contract Rights
• Invasion of Privacy
• Defamation
• “Wrongful Discharge”
• Federal and State Constitutions
• Negligent Hiring/Rentention/Supervision
Constitutional Rights

- Private sector employees
  - May have little or no “constitutional” rights in the workplace
- Public sector employees
  - Constitutional protections may apply

Reference Checks

- Some states provide immunity to employers in providing reference checks
- If no such immunity in your state, consider “authorization and release” provisions in your employment application

More on Reference Checks

- Even with a release, some employers will only release “name, rank and serial number” information
  - Confirmation of employment
  - Position held
  - Dates of employment
- Fear of liability under defamation laws

After You Hire

- “Introductory” Period
- Written Policies and Procedures
- Progressive Disciplinary Procedures (Praise in Public/Correct in Private)
- Performance Reviews

After You Hire

- “Problem Solving” Procedures and feedback/input systems
- Document, Document, Document Progress & Behavior!!
- Confidentiality and “Need to Know”

Workplace Conduct

- No Jokes Or Comments About Age, Sex, Religion, National Origin, Race, Disability
- Recognize And Correct Inappropriate Behavior
- Establish A “Non Discriminatory Culture”
- Be Fair And Consistent
Employment Law Workshops

Are these interview questions LEGAL or ILLEGAL?

Are you an American citizen?

Illegal.
Can be a pretext for national origin discrimination.

Instead ask:
“Are you authorized to work in the United States?”

What year did you graduate from high school?

Illegal.
Can be a pretext for age discrimination.

What year did you graduate from high school?
Instead ask:
Are you a high school graduate or do you hold a GED?

Can you provide us with a copy of your driver’s license?

Illegal.
If you ask for it in the interview, you can determine the applicant’s age.

Instead ask:
Do you have a valid driver’s license?

Legal.

Are you over 18?

Are you over 18?
Do you have any physical or mental disabilities, diagnosed or undiagnosed, that would prevent you from performing the essential functions of the job, with or without reasonable accommodation?

Illegal.
You can’t ask about disabilities in an interview

Instead ask:
Are you able to perform the essential functions of the job, with or without reasonable accommodation?

Sign up for our free EMS Law Bulletins at www.pwwemslaw.com

The Top Six Threats Facing Your Ambulance Service
And How to Effectively Manage Them

OK, let’s look at the Top 6 Ambulance Industry Threats…
Threat Number

Aggressive Healthcare Compliance Enforcement Against the Ambulance Industry

Enforcement

- Governmental agencies that pay for healthcare services are cracking down like we've never seen before
  - Medicare
  - Medicaid
  - Other governmental payers

Enforcement

- Enforcement actions can run the whole gamut, including:
  - Administrative: payer audits, benefit integrity audits, OIG reviews
  - Civil: false claims act/whistleblower cases
  - Criminal: health care fraud cases

The Ambulance Industry

- Ambulance payments comprise less than 5% of all Medicare Part B expenditures
- But there is a disproportionate amount of enforcement activity in our industry

Why?

“Historically, Medicare has been vulnerable to fraud involving ambulance transports.”

How we see ourselves is not how the government sees us

It’s Not Just the Government
• The most common type of whistleblower in false claims cases are current or former employees

Specific Risk Areas
• ALS billing
  ▪ Particularly overbilling for ALS1-Emergencies based on ALS Assessment rule
• BLS Non-Emergency transports
  ▪ Especially dialysis/repetitive transports

Specific Risk Areas
• Discounts and other potential kickbacks to facilities and referral sources
• Utilization and billing patterns that stand out from your peers

Strategies to Mitigate These Risks

Managing the Risks
• No single magic bullet
• No way to guarantee you won’t be audited or targeted with a false claims case or other investigation
• But, taking certain important steps can help
Compliance Program

- There's no longer any excuse: a functioning compliance program is a must
- More than just a written compliance plan
- It's an active process of top-down engagement

PWW Ambulance Compliance Program Toolkit

- Model compliance plan
- Model compliance forms and policies
- Ready-to-use compliance training presentation

Key Issues

- Compliance officer (who has real authority within the organization)
- Compliance hotline
- Employee background/exclusion checks
- Regular audits
- Refunding overpayments promptly after they are identified

Key Issues

- Job-specific compliance training
  - Billers and coders – CAC
  - Compliance officer – CACO
  - Field personnel – Documentation training

Preventing Whistleblowers

- “Hire for attitude, train for skills”
- Always reinforce honesty, accuracy, ethics and integrity in every word and deed
  - This especially includes in staff meetings and in all e-mail communications

Preventing Whistleblowers

- Obtain employee feedback
  - Ask employees if they have any concerns about documentation, coding, billing or other business practices
  - Make this a part of regular employee evaluation process
- Conduct exit interviews
  - Retain documentation in employee’s file
Monitor Your Billing and Utilization Data

- Use the publicly available Medicare data
- Track high-risk areas (ALS vs. BLS billing percentage, BLS non-emergencies)
- Monitor critical KPIs

Threat Number

Privacy Pitfalls

But lucky for you, this really isn’t going to be about HIPAA…

It’s About Your People…

And the foreign concepts of ethics, integrity and human decency!

And of course, social media has changed the privacy landscape completely…

How would you feel if that patient was a family member, friend or loved one?

It doesn’t matter that the posting didn’t specifically identify the patient by name. There was more than enough information that some could use to reasonably identify the patient.
Ethical Obligations

• Our patients’ information is not ours to give out
• It belongs to the patient
• Effective health care depends upon trust in the provider-patient relationship

Georgia Firefighter Suspended for Taking Video of Dead Woman
Associated Press
Updated: 10/21/2010 08:06:26 AM CDT

GRIFFIN, Ga. — A Georgia county has suspended a firefighter for using his personal cell phone to take gruesome video of a woman killed in an SUV crash that was later received by the dead woman’s parents.

Spalding County officials said in a statement that the firefighter has been placed on “investigatory suspension” while an outside firm determines whether any laws or internal policies were broken.

The firefighter, who was not identified, took a video of the injuries suffered by 23-year-old ……, who died July 17 when her car crashed into trees. She died instantly. The video spread after the firefighter shared it with his co-workers and others outside the department.

Images and Videos as PHI

• Photos and Videos that identify patients (or could reasonably be used to identify) must be protected in the same manner as any other PHI, such as:
  ▪ Patient care reports
  ▪ Hospital face sheets and facility records
  ▪ Physician certification statements

Strategies to Mitigate These Risks

Privacy Risk Assessment

• Make sure you have a current, up-to-date privacy risk assessment on file
• This is the first thing that OCR investigators will ask for when investigating a privacy complaint

Personnel Training

• Critical to train personnel and provide periodic reminders of the importance of maintaining patient privacy
• Have a social media policy in place for all your employees
  ▪ This includes even off-duty conduct
PWW Social Media Survival Kit

Includes:
• Sample Social Networking Policy
• Staff training materials
• Approved for CEU credit
• Detailed explanation of the law and your rights

Order at pwwmedia.com

Portable Electronic Devices
• Prohibit use of personal cell phone cameras
• Prohibit copying or downloading of any PHI onto portable media
• Secure all laptops, tablets and other devices with encryption
• Protect data at rest, in motion and on disposal

Threat Number

A Changing Health Care System That Will Pass Us By if We Don’t Adapt

The Post-Reform Healthcare System
• It’s a whole new world
• In addition to the post-ACA healthcare fraud crackdown, there is also an emphasis on payment reform

Payers Are Changing Focus
• From “fee for service” to “pay for performance”
• This means that we can expect reimbursement only for things that are shown to work
The “Triple Aim”

Does EMS Make a Difference?

- We’re asking the wrong questions, like:
  - What are our response times?
- What we should be measuring are things like:
  - Improvement in outcomes
  - Affect on overall patient health
  - Reduction in hospital stays
  - Prevention of readmissions

Strategies to Mitigate These Risks

Adapt or Die

Recognize the Competitive Shift From Internal to External

Old EMS Competition: INTERNAL
- Public vs. Private
- Hospital-based vs. Independent Ambulance

New EMS Competition: EXTERNAL
- Home Health Agencies
- Visiting Nurse Associations
- Urgent Care Clinics/Freestanding E.D.s

EMS → Integrated Healthcare

- Position your EMS agency as a participant in the total healthcare of your community’s patients
  - Not just a transportation commodity
Ignite a Cultural Shift in Your Agency

- From a “public safety” culture to a “population health” culture

Find Opportunities in Integrated Care

- Partner with hospitals, hospices, health plans and others to effectively manage patients’ out-of-hospital healthcare needs

Threat Number

A Workforce That Votes With its Feet

“Job Hopping Millennials”

EMS Workforce Issues

- Low pay
- Stress
- Personal health and safety concerns
- Limited opportunities for advancement
Job Hopping

• The average person will change careers up to 7 times during their working life
• The average worker has already had 10 jobs by the age of 42

With an Inadequate Workforce…

• We can’t meet our mission
• We can’t grow our companies
• We can’t innovate
• We can’t compete

Strategies to Mitigate These Risks

Improve Workplace Safety

• Employees want to know that they have a workplace that cares about their safety, health and well-being
  ▪ Ambulance vehicle safety
  ▪ Operational policies to prevent injury and accidents
  ▪ Employee health and fitness

Recognize and Reward

“Note to Personnel File”

• Much of what motivates employees is non-monetary
• Don’t overlook the value of simple recognition for good work

• “We received a call from the patient’s daughter, stating how much she appreciated your taking the extra steps to care for her mother. She said you even took the time to feed her cats before you left the house since she lives alone and wouldn’t be able to. This personal attention was very important to our patient and her family and you deserve special thanks for being so caring and considerate. Keep up the great work!”
Innovate and Excel

• Employees want to be a part of an organization that is doing something new and vital
• Give employees and opportunity to improve the organization
• Allow them to contribute to innovation and learn new skills

Create the Right Culture

• Foster a workplace culture that is positive, encouraging, respectful and rewarding

Threat Number

Facility Partnerships Raising New Compliance Risks

DOJ is Pursuing New False Claims Theories

• It is the ambulance service’s responsibility to properly code its claims for ambulance transportation
• However, in several recent cases, the DOJ has also gone after hospitals and other healthcare facilities for their role in ambulance utilization

Facilities and Ambulance Services

• Often the documentation on a PCS from a facility is intended to get you to move the patient –
• It’s not always an accurate record of the patient’s condition at the time of transport!

PCS Form

This patient needs a ambyoolance.
Trust me I’m a doctor.
Signed,
A. Doctor
You can’t just look the other way

Remember . . .
• The presence of the signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary.

42 CFR 410.40(d)

Other Risks in Facility Arrangements
• “Swapping”
  ▪ This is the OIG’s term for giving discounts to the facility on Part A business in exchange for Part B referrals

Strategies to Mitigate These Risks

Improve Call Intake
• It’s critical to practice proper non-emergency deployment
• Ask more questions than simply “what time is the pickup and where are we going?”

Revamp Medical Necessity Screening
• Ambulance services and facilities have to be partners in compliance
• Ensure that the shared goal is making sure that only those patients who truly require transport by ambulance are the ones being transported
Use Care With PCS Forms

• PCS forms can be a big liability trap
• Ambulance services should **not**:
  ▪ Complete PCSs for the facility
  ▪ Alter any PCSs that have been completed
  ▪ Tell the facility what to write

Use Care With PCS Forms

• Only the authorized clinician who completes the form should document the patient’s medical information
• Be sure to verify signatures and credentials of the signer
• If the PCS doesn’t accurately describe the patient’s condition, it’s invalid

Perform a Cost Analysis

• Having a documented cost analysis
  ▪ Ensure that facility contracts and other business is priced appropriately – and that you can prove you are not charging facilities less than your cost
  ▪ “Cost” means fully-loaded, average cost per transport – **not** marginal cost or unit-hour cost

PWW Facility Contracting Tool Kit

**Includes:**
- Model facility contracts for SNFs, hospitals, hospices
- PWW Cost Analysis Tool
- Facility Education Packet
- Detailed explanation of pricing compliance strategies

Order at pwwmedia.com

Threat Number

Damn Lawyers

Liability in EMS

• We’ve already talked about FCA and AKS liability
• But don’t forget about:
  ▪ Tort liability
    – Medical malpractice
    – Vehicle accidents
    – Other personal injury cases
Strategies to Mitigate These Risks

Your Lines of Defense

• Defense # 1 – Good patient care
• Defense #2 – Good lawyer
• Defense #3 – Good insurance policy

Reduce Patient Care Liability

• Keep clinical protocols current
• Active medical oversight
• Meaningful QI programs
• Continuing education – especially on skills you don’t use very often

Reduce Operational Liability

• Always revisit operational procedures to ensure they are as safe as possible
• This involves rethinking everything we do and assessing evolving threats
  • Driving
  • Infectious disease precautions
  • Scene safety
  • Terrorism

Do an Insurance Checkup

• Sometimes the Main St. insurance agent isn’t the best option
• You might be surprised what activities may not be covered
• Consider dealing with a business insurance broker to review and insure against the entire range of risks

Conclusion
CDI for EMS: Clinical Documentation Improvement and Why it Can Save Your Service

Overview

• The “Context” and CDI Defined
• Benefits of a CDI Program
• Five Elements for Effective CDI
• CDI Checklists
• CDI Queries
• CDI Implementation

The Context

• The healthcare environment has changed – greater scrutiny of our services requires a high level of documentation
• Shift from “occasions of service” to “value”

The Context…

• A good “Legal Record” of the patient encounter helps minimize liability from negligence suits and other actions
• Accurate and complete documentation is required to ensure proper – and legally compliant - reimbursement

Patient Care = Accountability

• A “collaborative” process where accountability is critical!
• Accountability is a shared circumstance
• Accountability includes accurate, honest and complete documentation of our actions
  ▪ Response, assessment, treatment, etc.

“I Got Into EMS Because I Love to Document!”
“I Got Into EMS Because I Love to Document!”

Said no medic ever!

More Than Just Part of the Job

- Good documentation is critically important because…
  - …it is an essential part of patient care!
- We need better processes to ensure that our patient care documentation is at the highest possible level

Clinical Documentation

- Defined: A digital or analog record detailing the EMS patient encounter to include accurate, timely and specific descriptions of the patient assessment, medical history, physical condition of the patient, and treatments/services provided

Why So Tough?

- Because each patient has his or her own unique combinations of medical conditions that your EMS agency must somehow standardize for data comparison and to ensure compliant reimbursement
### What is CDI?

- A process for improving the quality of clinical documentation – to facilitate an accurate representation of the services provided through complete and accurate reporting of patient assessment, procedures, and transport performed.

### The Goal

- **Clinical documentation** that accurately and as precisely as possible reflects the patient’s condition and services performed, so we can have…
- **Billing codes** that accurately and precisely reflect that patient’s condition and the services performed.

### CDI Bridges the Gap!

| Field Providers Document in Clinical Terms | Billers Code Claims in Diagnostic Terms |

### CDI Benefits

- Positive patient outcomes through improved continuity of care
- Accurate reflection of the level of care provided
- More precise information for quality improvement and public health purposes

### CDI Benefits

- Improved clinical documentation (required for ICD-10) and enhanced care for all patient conditions
- A **team process** that sharpens the focus on obtaining the most thorough and accurate documentation possible

### CDI Benefits

- CDI increases the accuracy of clinical documentation to:
  - Improve patient care
  - Reduce compliance risks
  - Minimize audit vulnerability
  - Defend providers in quality of care cases
In Today’s Audit and Enforcement Climate a CDI Program is Essential

We’ve Seen a Huge Rise In...
• Audits, reviews and inspections
• Overpayment demands
• False Claims Act cases
• Investigative demands
• Subpoenas
• Exclusions
• Civil Penalties

The PCR is Critical!

Incomplete, False, or Misleading Documentation is a Compliance Risk?

Here’s why...

The provider billed for ambulance service: Basic Life Support (BLS), emergency transport from a residence to a hospital (Methodist Hospital). The criteria for medical necessity requirements were not met. A generalized statement was that the “patient had been diagnosed with stroke the day before.” The documentation failed to describe the extent of the pain, pain ratings or pain interventions. The documentation was not sufficient to paint a clear picture of acute signs and symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy. The documentation failed to disclose specific monitoring and/or treatments. The documentation indicated the reason for transport was “the patient had no means of transport.”
And another…

The provider billed for ambulance services Basic Life Support (BLS), emergency transport from an accident or an acute event to a hospital. Generalized statements documented were the patient “had a stroke today” and “did not feel well.” The documentation failed to describe specific monitoring and/or treatments for any medical condition. There were no pain relief or pain interventions documented. The information was inconsistent as one ambulance group documented “no treatment needed,” and the other group transported the patient because of “patient choice.” There was incomplete transport documentation that did not provide an adequate description of the beneficiary’s condition at the time of transport to meet the benefit criteria for ambulance transport.

“The trip sheet does not contain an objective description of the beneficiary’s physical condition in sufficient detail to demonstrate that the beneficiary’s condition or functional status at the time of transport meets Medicare’s limitation of coverage for ambulance services”

Medical Necessity

• “Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated.”
  ▪ 42 CFR 410.40(d)

CMS on Medical Necessity

• “It is always the responsibility of the ambulance supplier to furnish complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria.”

Federal Register Vol. 77, No. 222 November 16, 2012
What CMS is Looking For . . .

• “…a clear picture of the beneficiary’s current condition requiring ambulance transport”

What CMS is Looking For . . .

• “Capture the “what” and “why” of a beneficiary’s condition that necessitates the transports”
• “Support the diagnosis or the ICD codes on the PCS with clinical assessment data and objective findings”

What Can We Learn from the Following Example? . . .

“Patient is an 80 y/o white male with history of ESRD being treated with hemo-dialysis at ABC Dialysis Center. Wegener’s Disease, Atrial Fibrillation, severe osteoporosis, and spinal stenosis all treated by Dr. Smith. Recently, patient has had “bouts” of pneumonia. Patient has extremely fragile bones, to the point that any lifting of the patient even with a “Hoyer Lift” can and has resulted in dislocations and fractures. Patient has a bilateral elbow fusion of 30 degrees, reduced planter strength with a max of 1 out of 5 bilaterally and 0 degree max hip flexion bilaterally. Bilateral knee flexion is 0 degree. Patient is alert and oriented x4 at baseline with a GCS of 15.

Patient requires assistance in the areas of bathing, dressing, toileting and cleaning himself, transferring, unable to get up from bed, and feeding. Patient does not exercise any control over urination or defecation.”

According to CMS, This Documentation Identifies the “What” and “Why” of the Patient’s Condition That Necessitates Ambulance Transport

The Key to High Quality PCR Documentation is a Complete, Thorough and Well Documented Patient Assessment!
A Systematic Approach to Patient Assessment Leads to a Systematic Approach to Patient Documentation

The Five Elements of the CDI Process

- Identify Common Conditions
- Define Documentation Requirements
- Communicate Documentation Standards
- Audit Documentation Practices
- Constantly Review the CDI Process

Step 1: Identify Common Conditions
- ALS and BLS treatment protocols
- CMS Condition Code list
- Evaluate historical run data by chief complaint
- Statewide or regional protocols

Examples - Emergency
- Chest pain
- Abdominal pain
- Nausea and vomiting
- Emergency childbirth
- Hemorrhage
- Possible stroke
- Fall victim

Examples - Nonemergency
- Interfacility transport
- Hospital-SNF discharge
- Dialysis patient transport
- Transport for interventions (radiation, etc.)
- SNF to hospital transport (direct admit)
- Psych transports

Step 2: Define Documentation Requirements
- Review texts, curricula, treatment protocols
- Obtain medical review committee and medical director input
- Involve field staff
Bottom Line

• Develop list of key elements that must be assessed and documented for most common patient conditions encountered
• Audit PCRs based on these elements
• Provide feedback, constructive counseling and training to promote improvement

If You Don’t Measure It . . .

• You can’t manage it
• You can’t control it
• You can’t improve it

If you don’t measure it, you can’t know it. If you don’t know it, you can’t control it. If you can’t control it, you are at the mercy of chance!“

Step 3:

• For key patient conditions
• Integrate CDI training into all aspects of leadership and staff training
  ▪ Initial orientation
  ▪ Continuing education
  ▪ Remedial education

Step 4:

• Audit PCRs using standard documentation elements for each condition
• Identify strengths and weaknesses
  ▪ On an individual basis
  ▪ On an agency basis using “trends” to target additional documentation training
Audit Documentation Practices

- Provide follow up concurrently
  - Initiate a CDI Query on inadequate documentation
- Provide follow up retrospectively
  - Communicate audit stats
  - Model additional training based on identified weaknesses

Step 5:

- Evaluate common strengths and weaknesses
- Modify approach as necessary
- Evaluate appropriateness of CDI Queries to ensure focus is on the clinical documentation
- CDI Oversight Team to meet at least quarterly

CDI Checklists

EMS Patient Conditions

- Every primary patient condition encountered by a field provider should have an established checklist of issues that must be addressed in the documentation

Example Condition: “Pain”

- Issues that should be documented:
  - Onset
  - Provocation
  - Quality
  - Radiation
  - Severity
  - Time

Common EMS Documentation Condition – Abdominal Pain
Abdominal Pain

• Initial Assessment?
  ▪ ABCs and Chief Complaint

• Focused History and P.E.?
  ▪ How and where was patient found?
  ▪ Skin color, temp, condition
  ▪ Location and quality of pain
    − Associated Symptoms
    − PQRST

Abdominal Pain

• Abdominal Assessment
  ▪ Tenderness
  ▪ Rebound tenderness
  ▪ Rigidity
  ▪ Guarding
  ▪ Pulsatile masses
  ▪ Surgical scars

Abdominal Pain

• Back pain? (location, quality, radiation, etc.)
• Female – menstrual period normal?
• Nausea and vomiting?
• Bowel movements?
• Urination (pain, color, amount, frequency)
• Position of comfort?

Abdominal Pain

• Oral intake and meals?
• Fever?
• Other signs and symptoms?
• Allergies?
• Medications?
• Pertinent past medical history?
• History of present illness?
• Vital signs

Abdominal Pain

• Interventions?
  ▪ Oxygen
  ▪ Cardiac monitor
  ▪ IVs or saline lock
  ▪ Medication administration
  ▪ Position of transport
• Response to treatments?
• Condition enroute and at hospital?

Common EMS Documentation
Condition –
Altered Mental Status

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Altered Mental Status

- Patient oriented to time?
  - Knows time of day?
- Patient oriented to place?
  - Knows where they are?
- Patient oriented to person?
  - Knows who they are and others around them?
- Patient oriented to situation?
  - Knows what is happening?

Altered Mental Status

- Syncopal episodes?
- Glasgow Coma Score assessed and documented at intervals?
- Neurological assessment completed?
- HPI and PMH obtained?
When You Need More: Proper Use of “CDI Queries”

CDI Query Process
- Key element of CDI is provider communication
- A “CDI Query” is a routine communication and education tool used to advocate complete and compliant documentation and to ensure accuracy of the PCR

Types of CDI Queries
- Written Queries
  - Based on established documentation elements for specific patient condition
  - Helps avoid miscommunication on “why” the query is being made

Types of CDI Queries
- Verbal Queries
  - Usually for elements that are simply missing or for minor issues
  - More likely to be “misconstrued”

When to Query?
- Lack of clinical indicators of an undocumented condition (e.g., suspected shock as a “provider impression”)
- Need for further specificity or degree of severity of a documented condition (e.g., pain)

When to Query?
- Clarifying a potential cause and effect relationship
- Missing fundamental information necessary for that particular “condition” or “chief complaint”
The Proper Query

- When additions, clarifications or amendments are required, it is critical to reinforce that proper documentation is the goal
- Avoid even the appearance of “suggestive” documentation

Compare

**Improper**

“Your PCR fails to document medical necessity. Please document bed confined status so we can bill this.”

**Proper**

“This PCR does not document patient mobility — including whether the patient could ambulate, sit in a chair/wheelchair or get out of bed unassisted and why. Please complete PCR accurately according to what you observed and assessed.”

Compare

**Improper**

“In the narrative you state that patient is disoriented and lethargic. But in the vital signs section, you indicate “A&Ox4” and GCS of 15. Please change the vital signs to A&Ox2 and GCS of 13.”

**Proper**

“In the narrative you state that the patient is disoriented and lethargic. But in the vital signs section, you indicate “A&Ox4” and GCS of 15. These are inconsistent PCR entries. Please review and clarify/correct based on the assessed pt. condition.”

The Effective “CDI Query”

- Critical to be precise, not only in what you say but how you say it
- Communicate these requests in a way that your intent cannot be misconstrued
- Always emphasize importance of accuracy and honesty in documentation!

Why Must You Emphasize Honesty, Accuracy and Completeness?

Billing Investigations

- Investigators may interview your crew members
- This often happens even before your agency knows of the investigation
“Have you ever been asked to change your patient care reports for billing purposes?”

“Have you ever been asked to put down that the patient was bed confined when the patient was not bed confined?”

“Have you ever been asked to write an addendum to add things that you knew were not true?”

“Have you ever been told never to write that a patient walked to the stretcher?”

Points for Providers

• Being asked to clarify, amend or append documentation to make it more accurate does not mean you are being asked to falsify documentation
• Providers should never be told to document anything that isn’t true, and they should not be directed on what to write for billing purposes

Points for Providers

• The focus of any documentation query must be on improving clinical documentation
• If a PCR is incomplete or unclear, field providers should be asked to make it complete and accurate – that is the provider’s job!

Points for Providers

• “Having a complete and accurate PCR that paints a clear picture is an essential part of patient care”
• “If you failed to document key points for the patient’s complaint, we have an obligation to make sure the record is complete and accurate”

CDI Tips for Implementation, Training, Auditing and Evaluation

Don’t yell at your kids!

Lean in real close and whisper, it’s much scarier
Training Must Change

• QA staff and supervisors need to focus on CDI
• Communicate the documentation standards for each key condition
• Involve front line staff in finalizing the CDI Checklists before they are implemented

Training Must Change

• CDI must be incorporated into the feedback and evaluation process – the 360 degree feedback loop
• This re-emphasizes the critical importance of CDI in your agency

Conducting CDI Audits

• Consistently track compliance with CDI checklists over time
• These key elements can be quantified into numbers
  • Example: “Your PCRs with a chief complaint of "abdominal pain" documented the specific location of the pain (quadrant) and the severity of the pain 76% of the time”

Conducting CDI Audits

• Tracking these objective documentation indicators over time is critical
• That which is observed is improved

Evaluating the CDI Program

• The CDI program itself must constantly evolve and adapt
• Changes in clinical practice, new protocols, new providers, new medical directors, etc. can all necessitate changes in your CDI program

Summary

• CDI is a systematic and objective process to measure and improve documentation effectiveness
• It removes subjectivity, guesswork and inconsistency
Legally Structuring Your QA Program to Manage Risk

Overview
• HIPAA and QA/QI Activities
• Discoverability of QA/QI Records
• Properly Structuring a QA/QI Program
• Admissibility of QA/QI Evidence
• Essential Elements for QA/QI Reviews

HIPAA and QA/QI Activities

Who is Covered?
• HIPAA applies to covered entities:
  ▪ Health plans
  ▪ Healthcare clearinghouses
  ▪ Healthcare providers that transmit health information in electronic form

Who is Covered?
• Also, under the HITECH Act, some HIPAA provisions will apply directly to “business associates” – regulations on the horizon

Who is Covered?
• Most ambulance services meet the HIPAA definition of a healthcare provider, so they are covered entities (CEs) under HIPAA
  ▪ Most services submit electronic claims for reimbursement
What is PHI?

- Individually identifiable or demographic information
  - Name, social security #, condition, address, age, image, etc.
- Regarding past, present or future physical or mental health or the provision of care to an individual
- Created or received by an ambulance service

What is PHI?

- PHI includes health information in any form!
  - Written – paper PCRs
  - Electronic - email
  - Digital – ePCR data
  - Facsimile
  - Photographic
  - Videographic
  - Verbal

What is Not PHI

- Information that does not pertain to the health condition of an individual or the provision of healthcare
- Where there is no reasonable basis to believe the information can be used to identify an individual

If it’s Not PHI

- The ambulance service has no duties under HIPAA regarding the information
- HIPAA does not dictate to how the information is used or disclosed

If it is PHI

- Ambulance services have a duty to safeguard all PHI they create or receive
  - Once obtained, it is the PHI of the ambulance service
- Ambulance services can only use or disclose PHI if HIPAA expressly permits or requires them to do so

General Permissive Uses

- HIPAA permits ambulance services to use or disclose PHI for purposes of:
  - Treatment
  - Payment
  - Healthcare operations
- These are the so-called “TPO” uses
- These uses are permitted without patient authorization
Ok, clearly HIPAA allows services to use patients’ information to treat them or file claims for payment, what about QA/QI activities?

In-House QA/QI
- Under HIPAA, “healthcare operations” include: “Conducting quality assessment and improvement activities”

In-House QA/QI
- So, QA/QI activities are considered “healthcare operations,” and ambulance services are permitted by HIPAA to use PHI to conduct their own QA/QI

Limitation on In-House QA/QI
- When using PHI for in-house QA/QI purposes, ambulance services are required by HIPAA to follow the “minimum necessary” rule

“Minimum Necessary” Rule
- This says that when using or disclosing PHI, covered entities (i.e., ambulance services) must make reasonable efforts to limit PHI to the minimum amount necessary to accomplish the purpose of the intended use or disclosure

“Minimum Necessary” Rule
- This means that only the information that is truly necessary to effectively perform in-house QA/QI should be used
- Ambulance services are also required to limit exposure of PHI to only necessary parties involved in QA/QI
“Minimum Necessary” Rule
• Currently, the HIPAA regulations do not specify precisely what PHI can and cannot be used for the purposes of performing QA/QI activities
• However, HHS guidance is expected on this sometime in 2011

“Minimum Necessary” Rule
• At present, it is up to ambulance services to determine how much PHI is necessary to perform their in-house QA/QI activities
• Services should have written policies and guidelines for this as part of a HIPAA compliance program

“Minimum Necessary” Rule
• Example:
  ▪ It is not necessary to have a patient name, address, SSN, phone number or DOB to perform effective clinical QA/QI
  ▪ But, it is necessary to know the date, the times, the chief complaint, treatment, etc.

Best Practices
• Clinical documentation should be redacted before being used for in-house QA/QI
• Any copies distributed to in-house QA/QI review committee members should have any unnecessary, identifying information removed or blacked out

Discoverability of QA/QI Records

Are the Records “Discoverable”?
• One fear expressed by many EMS organizations:
  ▪ “Anything you say – or write – can and will be used against you in a court of law”
• Can the QA/QI records be used against the service in court?
"Doctrine of Subsequent Remedial Measures"

- Example:
  - Man falls on a cracked and broken sidewalk and breaks his arm
  - The next day, the property owner is seen fixing his sidewalk
  - Courts will generally not allow evidence of the repairs to be used as evidence of negligence

Why?

"Doctrine of Subsequent Remedial Measures"

- The property owner would have no incentive to repair his broken sidewalk!
- The dangerous condition would persist!

But, It Must Do it Properly!

- QA/QI must be a formal, established process in accordance with EMS Act and regulations
- It cannot be an ad hoc, haphazard or inconsistent process
- It should be structured as a formal "peer review" program
- Regional QA/QI committees are

Properly Structuring a QA/QI Program

- Can the same thing be said of medical care?
- There is a strong "public policy" argument to allow health care providers to fix things without the fear of it being used against them in litigation!
Keep 'Em Separated!
• Services should keep QA/QI records physically separate from PCRs and other medical records

Use a Big Red Stamp!

PRIVILEGED AND CONFIDENTIAL PEER REVIEW DOCUMENT

Avoid Inadvertent Production!
• Services who receive a routine subpoena for medical records, etc.—should be sure not to make a practice of disclosing QA/QI or peer review records in response to these requests!
  ▪ Note: this is one reason why QA/QI records should be kept physically separate from medical records!

De-Identify!
• To the maximum extent possible, all patient identifying information in QA/QI documentation should be redacted
• This reduces the chance that an adverse QA/QI document can be “linked” with a specific patient

The more services respect the records as peer review records, the more a judge is likely to as well!

But Doug, Will These Steps Guarantee That QA Records Won’t be Discoverable?
No, They Won’t
• But….the patient care risks of not doing QA/QI far outweigh the legal risks of doing it properly!

No, They Won’t!
• And….there is a difference between whether a document is discoverable and whether it’s admissible

Admissibility of QA/QI Evidence

“Discoverability”
• This merely means whether the other party is entitled to see the document or obtain a copy of it
• Standard for discoverability: is it reasonably calculated to lead to admissible evidence?

“Admissibility”
• This refers to whether the evidence can be used in court and whether it can be considered by the jury or the finder of fact
• Standards: is the evidence relevant, and does its probative value outweigh its prejudicial effect?

How it Usually Goes Down
• STEP ONE: Plaintiff makes a broad “discovery request” - basically for “any and all” records
  • May even specifically request QA/QI records
How it Usually Goes Down

• STEP TWO: Defendant objects to the discovery request
• STEP THREE: the parties attempt to resolve their differences about the discoverability of the disputed evidence

How it Usually Goes Down

• STEP FOUR: when that doesn’t work, the plaintiff’s attorney will file a “Motion to Compel” the production of the records
• STEP FIVE: the judge may ask to review the records and then rule on discoverability

Protecting QA Information

• Formal peer review may be entitled to protection….but informal reviews are probably not protected

What Does All of This Mean?

• Courts usually allow an “original source” exception
• This means that certain records aren’t protected from discovery merely because were run through the QA/QI process!

Example

• Medic improperly intubated the patient
• Resulted in a period of poor oxygenation while the patient was in the care of EMS
• This must be part of the PCR (in addition to any separate incident report)
Example

• The case is reviewed at the EMS Agency’s monthly peer review committee meeting
• Just because the case was peer reviewed, it doesn’t mean the PCR is protected from discovery!
• It also doesn’t mean the medic can be prevented from testifying about the call!

Example

• Merely running a case through the peer review committee doesn’t erase the incident!
• The patient is entitled to a copy of their medical records – warts and all!

Essential Elements QA/QI Reviews

“That Which is Observed, is Improved”

Documentation

• Critical elements on PCRs:
  • Description of scene
  • Chief complaint
  • Provider impressions
  • Treatment
  • Transport
  • Disposition

Documentation

• Documentation should enable committee to conduct effective reviews
Equipment and Supplies

• Appropriate vehicles (ambulance v. wheelchair van) utilized
• Supplies and devices are adequate, available and in working order
• Medications carried on board meet requirements and they are both needed and effective

Personnel Issues

• Appropriate personnel being dispatched (minimum staffing requirements being met)
• Are higher level (ALS) personnel making a difference in outcomes
• Are the current personnel requirements cost effective
• Are staff being properly trained and disciplined

Proper Communication

• Services are properly communicating with PSAP
  ▪ Unavailability
  ▪ Delayed responses
• Communication with other providers
  ▪ Request for higher level of care when needed
  ▪ Proper “cancellations”

Proper Communication

• Services are communicating with medical command in appropriate situations
  ▪ Refusals
  ▪ DNR
• Services are properly reporting:
  ▪ Accidents
  ▪ Fatalities

Call Management

• Calls handled appropriately based on condition of patient
• Dispatch protocols being utilized
• Appropriate use of lights and sirens

Scope of Practice Issues

• Skills being performed by appropriately certified personnel
• Adherence to protocols
• Communication with medical command and PSAP when necessary
Goal: Meaningful Results

• Important to compare apples to apples in your QA efforts
• Establish a baseline and then compare subsequent results to the baseline
• Use consistent methodology so that comparisons are meaningful

Example – Response Times

• If you are evaluating response times, use a consistent definition!
• Examples:
  • Time dispatched to time responded
  • Time responded to time on scene
  • Time from dispatch to patient contact
  • Time call received to patient contact

Hope this wasn’t too painful to sit through…

Questions

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