Risk Rx

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What's in your Emails?

Elizabeth White, JD, CIPP
Chief Compliance and Privacy Officer
Shands Healthcare

Over the last several years, Email has begun to change the health care industry by providing health care providers a convenient and cost effective method to facilitate communication with patients and other business associates. The industry's reliance on email is consistent with the 1998 survey conducted by Ernst & Young, that found email is now the primary communication tool used in business. In fact, the survey showed that only 15 % of the survey respondents reported favoring face-to-face meetings to facilitate transactions. So, it is unsurprising that patients and others associated with the health care industry wish to use email as the primary mode of communication.

However, unlike many other industries, health care providers are subject to heightened standards related to use and disclosure of their patients' information; and, as a matter of practice, should exercise caution when drafting and transmitting information related to their patients and their practices. This article provides a brief overview of the regulatory requirements associated with use and disclosure of patient information, electronic transmission of this information, and other risks associated with utilizing email as a communication tool. Also, this article provides suggestions that a health care provider may use to mitigate such risks.

Requirements Related to the Use and Disclosure of Health Information:

The Hippocratic Oath, state laws, licensing requirements, and Medicare Conditions of Participation have restricted a healthcare provider's ability to communicate information related to the care of their patients for many years. In short, these standards require that the health care provider keep the patient's health information confidential and that the information may only be disclosed to third parties with the consent of the patient or if mandated by law. Due to minor variations in these standards, the Department of Health and Human Services ("DHHS") developed national standards for the use and disclosure of Protected Health Information ("PHI") when the DHHS promulgated regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

In addition to providing specific directives regarding the use and disclosure of patient information (the Privacy Rule), HIPAA's Security Rule requires health care providers to implement technical security measures to guard against unauthorized access to electronic protected health information ("ePHI") that is being transmitted over an electronic communications network. HIPAA's "addressable" implementation specifications state that when transmitting ePHI, a health care provider should implement security measures to ensure that the ePHI maintains its integrity and is not improperly modified without detection until disposed of. The rule states that, providers should implement mechanisms to encrypt ePHI information whenever deemed appropriate.

When applying these standards, each health care provider is responsible for assessing the level of risk associated with the transmission of messages containing ePHI and for ensuring that the risks are minimized to an appropriate level.

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HIPAA provides both civil and criminal penalties for the violations of the Privacy and Security standards. Civil monetary penalties may range from $100 to $25,000. Within the criminal context, in instances where the offense is committed with the intent to sell, transfer or use information for commercial advantage, personal gain or malicious harm can lead to fines of $250,000 or 10 years imprisonment.

Other Risks Associated with Email

Even when the use, disclosure, and transmission of confidential information are authorized and secured, there are numerous other risks associated with email that are often overlooked by health care providers. After all, the most robust security mechanisms for transmission of ePHI do not protect against questionable judgment or carelessness. The paragraphs below itemize just a handful of the risks associated with the use of email.

- **Unintended documentation**. Commentators have stated, "[I]n the litigation environment, it is often email that contains the most damning admissions. . . . [I]n email, people don't take the care they would were they writing formal correspondence, and they tend to say things they don't intend to say." For example, Lawrence Powell, an L.A. police officer involved in the 1991 Rodney King case sent a colleague an email message where he stated "Oops! I haven't beaten anyone so bad in a long time." Clearly, Lawrence Powell didn't intend to have his email serve as an admission in a courtroom.

- **Email never really dies.** Even if an email message has been deleted by the author, the message can usually be retrieved from a variety of locations including backup tapes, the network, local hard drives. Moreover, even if the email had been deleted from all locations where it may have been stored, due to the advanced nature of computer forensics, it can usually be re-constructed. An example of an deleted email that had been restored by a forensic specialist and used in litigation reads, "Did you see what Dr. [deleted] did today? If that patient survives it will be a miracle."

- **Email is usually discoverable in litigation.** Our legal system mandates that both sides in a lawsuit produce documentation that may be relevant to a case during the "discovery" process. Since email is written, time-stamped documentation, it serves as credible evidence with jurors. In fact, due to the usefulness of email in litigation, an entire industry is evolving which conducts analysis of email to assist attorneys with the discovery process by providing "visual representations of relationships evidenced in email, such as time, events, and communication patterns."

- **Forwarded email.** Recipients can easily forward an email they've received to innumerable people without the knowledge or consent of the author. In short, once the author sends the email, the author cannot control who receives the message.

- **Misdirected email.** With one unintended click in the email system's address book, a message intended for one recipient can be sent to an entire organization or an entire internet listserv. In instances where the information within the email may be considered

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confidential or subject to a legal privilege, the ability to assert such a privilege may be jeopardized.

To mitigate against the risks associated with email, health care providers should:

- Ensure email messages containing PHI are transmitted in accordance with HIPAA's Security requirements.
- Consider whether the message may serve as an admission of liability.
- Consider whether you are disclosing confidential information to a party not authorized to receive it.
- Exercise caution when sending an email containing PHI to ensure that the recipient address corresponds to the intended recipient—double check the recipient list!
- Email messages containing PHI should be limited to the **minimum necessary** to accomplish the intended purpose (send only what the recipient needs).
- Disable auto forwarding on your system.
- Enter the recipient's address last, after you've drafted the message to your satisfaction so that you avoid sending an incomplete or embarrassing message.
- Eliminate unnecessary attachments. If an email is forwarded, the attachments may not be readily visible and may accidentally get forwarded inappropriately.
- Do not use email to discuss highly confidential information including peer review or quality information.
- Use the **cc** field sparingly.
- Never send an email when you're tired or angry. Instead, save the draft, review (revise if necessary), and send at a later time.
- READ your email before hitting the send button.

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ABOUT NICA

Kenney Shipley
Executive Director
NICA

Background

In 1988 the Florida Legislature created the Florida Birth-Related Neurological Injury Compensation Association (NICA) in Florida Statute Chapter 88-1, *Laws of Florida.* The Act addresses medical malpractice issues by setting up a no-fault plan for hospitals and doctors that covers specific birth-related neurological injuries typically among the most costly in tort settlements. It was hoped that a

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no-fault system limited to this type of injury would be manageable and funding levels could be statistically predicted.

The FOGS President's Task Force

In November of 2005, the Florida Obstetric and Gynecology Society (FOGS) was asked by its membership to conduct a comprehensive review of the NICA program. The FOGS president assembled a task force in order to assess the current state of the program and make recommendations. The FOGS NICA Task Force met and did a very in-depth review of NICA with respect to its mission and legislative authority, its infant inclusion criteria, the adequacy of its funding, the validity of its actuarial process and reserves, and the feasibility of expanding the program to include a broader class of injuries. After extensive review, meetings, expert testimony and analysis there were a number of findings.

How NICA Helps

The plan offers an immediate remedy to Florida's eligible families without the need for costly litigation. During the period from January 1, 1985 through December 31, 2002, brain-damaged infants were the most expensive and prevalent condition, according to a report by the Physician Insurers Association of American (PIAA). For example, in the period reviewed, of nearly 4,000 total claims, 1,634 resulted in compensation. These included the highest settlement, and the average payout was just over $500,000. Moreover, large judgments were awarded in cases of severe disability even where strong evidence of causality was lacking.

The goal of establishing NICA is that benefits are managed professionally and quickly, removing litigation so that birth-injured infants receive needed care while the financial impact on medical providers and families is substantially reduced. This results in:

- Encouragement for physicians to practice obstetrics and provide obstetrical services.
- Stabilization of malpractice costs and provision of insurance to all physicians.
- Provision of essential care to injured children.

Who NICA Helps

Chapter 88-1, *Laws of Florida,* provides compensation and lifetime care for a specific category of "birth-related neurological injuries." These are defined as injuries to the brain or spinal cord of a live infant caused by the deprivation of oxygen or physical injury imparted during the course of labor, delivery, or the post-delivery period in a hospital. These kinds of injuries, while uncommon, are very significant in terms of cost and system impact as they represent outliers and "uninsurable" injuries. The injury in question must cause the infant permanent and substantial mental and physical damage, and the infant at birth must weigh at least 2,500 grams (5.5 pounds) in the case of single gestation or at least 2,000 grams (4.4 pounds) in the case of multiple gestations. The Plan does not apply to genetic or congenital abnormalities, **and the physician involved must be a participant in the NICA program.**

Barring gross misconduct on the part of the attending physician or midwife, the NICA Act is intended to provide the exclusive remedy for all such cases falling within the above classification. The benefits offered as compensation are manifold:

- All reasonable and necessary medical care
- Training, residential and custodial care
- Needed equipment or facilities

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- Pharmaceutical costs
- Related travel expenses
- A one-time family benefit up to $100,000
- A death benefit of $10,000
- Reasonable expenses incurred in the filing of the claim, including attorney's fees

Although claimants are entitled to recover attorney's fees, an attorney is not needed to file a NICA claim. The savings realized through the reduction of attorney involvement are substantial. In tort settlements, an average of 40% of monies awarded are claimed by attorneys' fees, whereas NICA pays less than 1% of the settlement to plaintiffs' attorneys. As a result, a greater percentage of resources from the NICA plan are channeled directly to the care of the child.

FOGS NICA Task Force Conclusions

The Task Force arrived at the following conclusions among others:

Administration: NICA operations are conducted in a professional and efficient manner. Currently, the program makes a consistent effort to include not exclude potential recipients. The legal activity conducted by NICA administrators and general counsel has been geared toward clarifying admissions criteria and has led to the acceptance of more claims. Recipients are seen to be receiving excellent care and participating families are overwhelmingly satisfied with the level of service and they support the system.

Funding: The current level of NICA funding is adequate to address caseload and operations. The assessment structure, however, exempts a large number of hospitals, some for no apparent, reason and appears politicized and inequitable. This is evident from the fact that 43% of NICA claim payouts stem from obstetrical deliveries occurring at totally exempt hospitals.

Reserves: The level of NICA reserves is adequate and not excessive. Multiple independent audits have concluded that the reserve determination process¾including estimation of life expectancy¾is appropriate and sound. While there is no independent medical examination (IME) as part of the annual reserve review, reserves are well managed and invested with excellent oversight and consultation by the NICA Finance Committee.

Overall, findings and recommendations from the FOGS Task Force have been positive and helpful in providing insight, reflection, and possible direction for expansion.

C-O-N-E-S - a Strategic Guide for Disclosure of Adverse Events

This strategy uses the mnemonic **C-O-N-E-S** (**C**ontext, **O**pening shot, **N**arrative, **E**motions, and **S**ummary) as a guide to disclosure developed by R. Buckman, R.L. Wears and S.J. Perry- (How to Deal with Anger and Other Emotions in Adverse Event and Error Disclosure).

C – CONTEXT. The first step is to ensure the context of the discussion is appropriate. This means getting both the physical and the emotional environment right.

Physical environment. The conversation should take place in a private area, away from distractions and interruptions. The seating should be arranged so there are no barriers between you (and other health professionals, if present) and the patient or family. In particular, this means that you should not be seated on opposite sides of a desk

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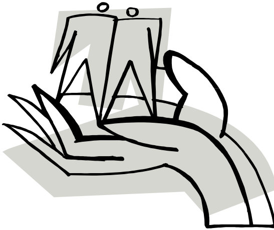

or table. Your eyes should be on the same level as theirs, or lower – never higher.

Emotional environment. First, "take your own pulse;"[10] take a deep breath and identify your own emotional state, which is likely to be a mixture of fear, discomfort, distaste, and embarrassment. It is good to make eye contact unless there is strong anger or emotion in the air, when it might seem either aggressive or intrusive. Discipline yourself to focus on listening. You will often know what the patient or family members are going to say, but do not interrupt – plan to keep quiet and allow them to say it.

O – OPENING SHOT. Begin with an initial statement that sets both agenda and tone for what is coming, for example, "I have something difficult and important to discuss with you…." If the circumstances warrant, now is an appropriate point to insert the "S" word: "I'm sorry to say that…." (Sometimes in the immediate aftermath of an adverse event, it will not be known exactly how it happened, whether there was an error, etc. It is just as important not to fall on your sword prematurely as it is to apologize sincerely when an apology is due.) There are many alternative formulations of this warning shot (e.g., "I've discovered something I have to talk to you about….") and it is important not to try to memorize a set speech; find a way to express this content in words that sound natural coming from you. It is often useful to pause here to allow some response.

N – NARRATIVE. Set out events in order, as best you know them at this time. Go slow! This material will be difficult for the patient or family to understand and absorb, given the circumstances. It may need to be repeated several times. Explain the uncertainties, thinking, and decisions at each important juncture. Sit close and talk softly. Remember that often the initial theories of how things went wrong are not borne out by a fuller analysis, so be careful not to speculate or leap to conclusions. Stick closely to the facts and admit knowledge gaps and uncertainties, but assure the patient or family that you will update them with more information as the analysis proceeds.

E – EMOTIONS. All emotional expressions need to be acknowledged. Health professionals often feel uncomfortable with emotional responses, but failing to acknowledge them makes everyone even more uncomfortable. If no emotional response if forthcoming, it is often useful to be silent for a while. This acknowledges that you recognize it is "their turn" to speak; most people will eventually speak up to fill a long silence. If this does not work, it is permissible to probe a little, not by direct questions (e.g., "How do you feel about that?"), but rather by indirect suggestion (e.g., "You must be shocked to hear this?"). Acknowledge the emotion in an empathic response involving the following steps:

Identify the emotion. Is it fear, anger, shock, embarrassment, etc.?

Identify the source – is it coming from the patient or family, or is it your own emotion you are recognizing? It is okay to refer to your own feelings, es-

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pecially when at a loss – "I don't know what to say…."

Respond in a way that connects the two. You do not need to feel the emotion yourself or even agree with it or think it is legitimate, but you must acknowledge it: "Hearing this must be a terrible shock, be terribly frightening, disturbing, must be awful for you." Some interviewers can skillfully use a repetition technique to acknowledge what the patient or family is feeling. This involves using a word from the subject's last sentence in your next sentence, especially if you can "match up" sensory modes. (For example, if the patient says that they cannot see how this happened, you might respond that you see what they mean, and so on.) It should go without saying that you should never say something like, "I know how you feel." Even if you do (which is unlikely), the patient or family will not know that and will not believe you.

Talking is an important way, but not the only way, to acknowledge emotion. Simple gestures, such as offering a tissue for crying, also acknowledge and legitimize emotional distress.

The goal in all this is to legitimize the emotion and to make it possible to talk about shock, disappointment, and anger. Now the conversation has turned to talking about feelings rather than the facts of the case.

S – SUMMARY Begin closing the conversation by preparing a plan for the future. Establish a time for the next contact and ways to get in touch when new information (e.g., results of an autopsy or further investigation into the mishap) becomes available. The next contact should be reasonably soon, even if there is not likely to be any substantive new information at that point. This will allow the patient or family to digest the information they have been given and raise questions that do not need to wait for further results. Plans for future care, if required, are especially important at this point. The patient and family should be given your contact information and also a contact for the institution's representative. This should be convenient for the patient and family – it should NOT be the main switchboard number or the pager of the resident on call! Finally, elicit questions in a way that does not make the patient or family feel that this is their last chance to ask. For example, "Any questions *for now*? We will talk again later, but anything for now?" Many people will not be able to formulate the questions that are most important to them at the initial disclosure meeting, so it is important to leave the door open. Sometimes, the questions "for now" will lead you to recapitulate the narrative and emotion steps of the strategy again. Several iterations may be required until the conversation can be closed.

Additional Tips from RMLP:

To avoid confusion, only one person should be responsible for disclosure which per Shands policy is the attending physician or physician designee.

<u>Objectively and factually</u> document the unanticipated outcome, to whom and when disclosure was made.

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We are seeking volunteers to join our Risk Management and Loss Prevention (RMLP) Speakers Bureau to provide lectures on the many educational topics developed by RMLP which include but are not limited to:

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- Informed Consent
- Medication Safety Practices
- Fall Prevention
- Baker Act
- Basics in Risk Management
- Pressure Ulcer Prevention

We provide the powerpoints and speakers reference manuals for your convenience and will go over the presentations with you and will assist in customizing to your delivery style.

If you are interested in joining our Speakers Bureau please contact us at rmeduc@shands.ufl.edu.

Wishing you the Happiest of Holidays!

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