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PRACTICALHEALTH

Code Red Charting for Health Care Providers

A facility can defend against "not documented, not done" by demonstrating the level and consistency of care that was given to a resident.

Every lawyer has a deep-seated desire to replicate the drama and quotable one-liners from *A Few Good Men* in his or her next trial. The 1992 blockbuster combined top-notch acting and well-placed legalese with...helpful charting tips for health care providers? You may have missed that last part. In the movie, Captain Jack Ross (Kevin Bacon) cross-examines Corporal Jeffrey Barnes (Noah Wyle) and asks him to find the term and definition of "Code Red" in the Standard Operating Procedures for Rifle Security Company, Guantanamo Bay, Cuba. Cpl. Barnes informed Capt. Ross that "Code Red" is not to be found in the SOP. At Ross' urging, the jury is left to conclude since "Code Red" is not in the SOP, it must not exist, or, more importantly, it didn't happen. The quick-witted Lt. Daniel Kaffee (Tom Cruise) swoops in, snatches the SOP from Capt. Ross and asks Cpl. Barnes to identify where the mess hall is in the SOP. Befuddled for a moment, Cpl. Barnes testifies with a smirk on his face: "That's not in the book either...I guess I just followed the crowd at chow time, sir."

Year after year, and case after case, this same scene is played out in courtrooms across America in which Capt. Ross is played by a plaintiff attorney, and Cpl. Barnes is played by a doctor, nurse, CNA, or other health care provider. Plaintiff attorneys will stress to the jury that the federal regulations dictate the requirement that clinical records for every nursing home resident must be complete, accurately documented, readily accessible, and systematically organized. But if your facility's chart is incomplete, plaintiff attorneys may create further acts of negligence by highlighting holes in documentation, and by asserting their mantra of "not documented, not done." What can you do if your facility is caught in this "Code Red" situation? Show the plaintiff attorney, the judge, and the jury that giving care is your priority. A facility can defend against "not documented, not done" by demonstrating the level and consistency of care that was given to a resident: CONTINUED ON PAGE 2

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Code Red Charting for Health Care Providers (Continued)

- Reconstruct the care given to the resident. Look at the rest of the chart to fill in gaps in documentation. For example, if a nurse is being criticized for not assessing bowel sounds, look at the rest of the nurse's charting, as well as the charting from shifts before and after, to determine that the bowel sounds were actually assessed. Ask the nurse about his/her routine—would he/she take vital signs, palpate the abdomen, observe the size of the abdomen, and document that a resident was "resting comfortably" without assessing bowel sounds?
- Look at documents not typically included in a chart—such as 24-hour reports, controlled substance records, personnel files, schedules or punch detail—in order to determine what was actually done.
- Examine other providers' records to determine issues that may have been omitted from the resident's chart.

- Create a "touch chart" to show the number of times per day that care was provided to a resident by a nurse, CNA, dietician, therapist, activities director, social services member, etc. Show the jury how many documents each staff member must fill out per resident per shift, and emphasize that your facility gave exemplary care to the resident. Perfect care does not exist!
- Stress that your facility puts people over paperwork.

There is no need to wait for a lawsuit to actually be filed before you implement good charting habits. However, with a little knowledge of what savvy lawyers like Capt. Jack Ross look for, the health care provider can help defend his/her actions through his/her documentation should a lawsuit be filed:

- Narrative entries should include "P.I.E."—that is, Problem, Intervention, and Evaluation.
- Attorneys like to focus on such things as dehydration, skin breakdown, weight loss/malnutrition, falls, lack of communication, and lack of consistency. Their objective is to make the issues seem simpler than they really are. Therefore, the health care provider MUST document when these key issues are in play.
- Consider charting "positively." If a patient or family member compliments the care provided, document it. For instance, "Wife at bedside and thanked this nurse for 'wonderful' care given to patient whom she admits is 'a bit of a handful.'"
- Document notifications to attending/consulting physicians, at what time the notification took place, and what action was taken as a result.
- Employ checks and balances. Have the later shift check the earlier shift's documentation. Encourage staff members to report deficiencies, even with standard forms.
- Be careful relying too heavily on e-charting, as it only allows the provider to see a limited portion of the chart.
- Late entries are sometimes necessary, but they should be the exception, not the rule.

Although "not documented, not done" will continue to be the rallying cry of attorneys for years to come, health care providers can avoid being a victim of a "Code Red" by applying these useful principles. If your staff members ever take the stand, they will be prepared to defend their documentation, instead of testifying in desperation, "You can't handle the truth!" [3] ■

Steiner v. Bonanni and the Future of Protected Health Information in Michigan

On April 7, 2011, the Michigan Court of Appeals issued a ruling in Steiner v. Bonanni that, if upheld and interpreted broadly, could have a significant effect on health care providers and access to records in that State.

THE CASE

Plaintiff, Isidore Steiner, DPM, PC, brought suit against a former employee, Dr. Marc Bonanni, for breaching his employment contract by soliciting or servicing corporation patients. Plaintiff sought disclosure of Defendant's patient list, and Defendant objected based upon HIPAA and state physician-patient privilege.

The Court began by noting that HIPAA permits disclosure for judicial proceedings with either notice to the patients or a protective order. However, HIPAA applies only if there is not a State law related to privacy that is more stringent than the HIPAA requirements. The Court then compared HIPAA to MCL 600.2157, Michigan's physician-patient privilege statute. The Plaintiff argued that HIPAA was more stringent, as patients can waive the Michigan physician-patient privilege. The court rejected the argument and, in so doing, included dicta that could, if followed, create a multitude of questions about the use of protected health information in Michigan, and perhaps in other States if they find the reasoning persuasive.

ANALYSIS

The Steiner ruling is perhaps most significant for the breadth of the dicta, the language the Court used to explain its reasoning. This is best demonstrated by breaking down the basis for the Court's conclusion, both to show the breadth of the dicta and to analyze the ruling and potential legal conflicts created by it. The following was the explanation of the Court's decision:

> There are no exceptions under Michigan law for providing random patient information related to any lawsuit. Unlike HIPAA, MCL 600.2157 does not provide for disclosure in judicial proceedings. Also, HIPAA, unlike Michigan law, makes disclosure exceptions for public health activities, victims of abuse, neglect, or domestic violence or for health oversight activities.

The Court appears to have gone beyond the first sentence of the above paragraph. The matter before the Court was production of documents in a lawsuit. The Court could have stopped with this sentence but opted not to do so.

Rather, in the second sentence, the Court compared MCL 600.2157 to HIPAA. This is arguably a flawed analysis, for MCL 600.2157 does not exist in a vacuum, but rather is only one of many statutes related to the use of health records. MCL 600.2157 states:

> Except as otherwise provided by law, a person duly authorized to practice medicine or surgery shall not disclose any information that the person has acquired in attending a patient in a professional character, if the information was necessary to enable the person to prescribe for the patient as a physician, or to do any act for the patient as a surgeon. If the patient brings an action against any defendant to recover for any personal injuries, or for any malpractice, and the patient produces a physician as a witness in the patient's own behalf who has treated the patient for the injury or for any disease or condition for which the malpractice is alleged, the patient shall be considered to have waived the privilege provided in this section as to another physician who has treated the patient for the injuries, disease, or condition. If a patient has died, the heirs at law of the patient, whether proponents or contestants of the patient's will, shall be considered to be personal representatives of the deceased patient for the purpose of waiving the privilege under this section in a contest upon the question of admitting the patient's will to probate. If a patient has died, the beneficiary of a life insurance policy insuring the life of the patient, or the patient's heirs at law, may waive the privilege under this section for the purpose of providing the necessary documentation to a life insurer in examining a claim for benefits. (emphasis added.)

A potential problem lies in that the Court gave no effect to the phrase "(e)xcept as otherwise provided by law." This could lead to conflict and confusion.

The Court opted not to balance the deferring clauses of HIPAA and MCL 600.2157. HIPAA defers to more stringent State laws, but MCL 600.2157 defers to anything "otherwise provided by law." The lack of any discussion of the interaction of the two clauses indicates either that the Court effectively struck the opening phrase from MCL 600.2157, or that it reached a conclusion without explanation. The conclusion it reached, if it considered the matter, would be a relatively narrow interpretation of the introductory clause "(e)xcept as otherwise provided by law." The term "law" does not just mean statutory, but includes judicial and regulatory law. The term "law" does not just mean state law; it means federal law as well. CONTINUED ON PAGE 4

Steiner v. Bonanni (Continued)

This conclusion is also an unusual interpretation of HIPAA's preemption clause. Given that MCL 600.2157 acknowledges and defers to other laws, the Michigan bar has never considered this law to preempt HIPAA. Please see HIPAA Privacy Rule Preemption Analysis Matrix, prepared by the Michigan State Bar Health Care Law Section and the Michigan Society of Health Care Attorneys.

The significance of this case will have to be evaluated on a case-by-case basis. Courts have historically determined whether information is material to a case, considered patient privacy, and then issued protective orders where appropriate. Steiner appears to potentially wipe out any authority of a court to make such determinations in the future.

The Court's conclusion that Michigan law does not make "disclosure exceptions for public health activities, victims of abuse, neglect, or domestic violence or for health oversight activities" may also create confusion. While MCL 600.2157 does not explicitly make those disclosure exceptions, other Michigan statutes do. MCL 333.5111 similarly authorizes the health department to maintain a list of reportable diseases, infections, and disabilities, and MCL 333.5114 explicitly requires that positive results of HIV tests be reported to the local health department within seven days, and that such report include identifying patient information. MCL 722.623 specifically requires that physicians report child abuse or neglect. MCL 333.20155 requires that Michigan Department of Health surveyors be given access to patient records. These are public health, disclosure, and health oversight exceptions of the sort the Steiner Court appears to assert do not exist. Assuming the court was aware of these other statutes, it determined the first phrase of MCL 600.2157, making the physician-patient privilege, relates only to exceptions contained within that statute, superceding all other medical records law in Michigan. If intended, this is certainly a sweeping conclusion, which would appear to effectively veto other explicit Michigan statutes.

APPLICATION TO OTHER STATES

The Steiner decision raises questions for the reasons noted above. However, the conclusion is a tempting and attractive one, placing a patient's assurance of physician-patient confidentiality above all other considerations. There is no physician-patient privilege in federal questions, and several States do not recognize the privilege. Those that do find the privilege either through common law or specific statutes. Some of the statutes appear to be even more restrictive than MCL 600.2157, lacking the "(e)xcept as otherwise provided by law" language. See, e.g. Kansas Statute 60-427(b), Idaho Code 9-203, and Maine Ch. 22-4015. The Maine statute is an excellent example of how, were the Steiner reasoning applied, the application might change completely. The statute states the privilege exist, with certain specified exceptions, "to the extent allowed by applicable federal law." 22 M.R.S.A. §4015. Were a Maine Court to evaluate "to the extent allowed by applicable federal law" under Steiner's strict interpretation, it would find that 22 M.R.S.A. §4015 is stricter than HIPAA, and therefore, HIPAA's exception would not apply. A similar analysis would be required of every state with a statutory physician-patient privilege (or a psychologist-patient privilege or counselor-patient privilege in an appropriate case).

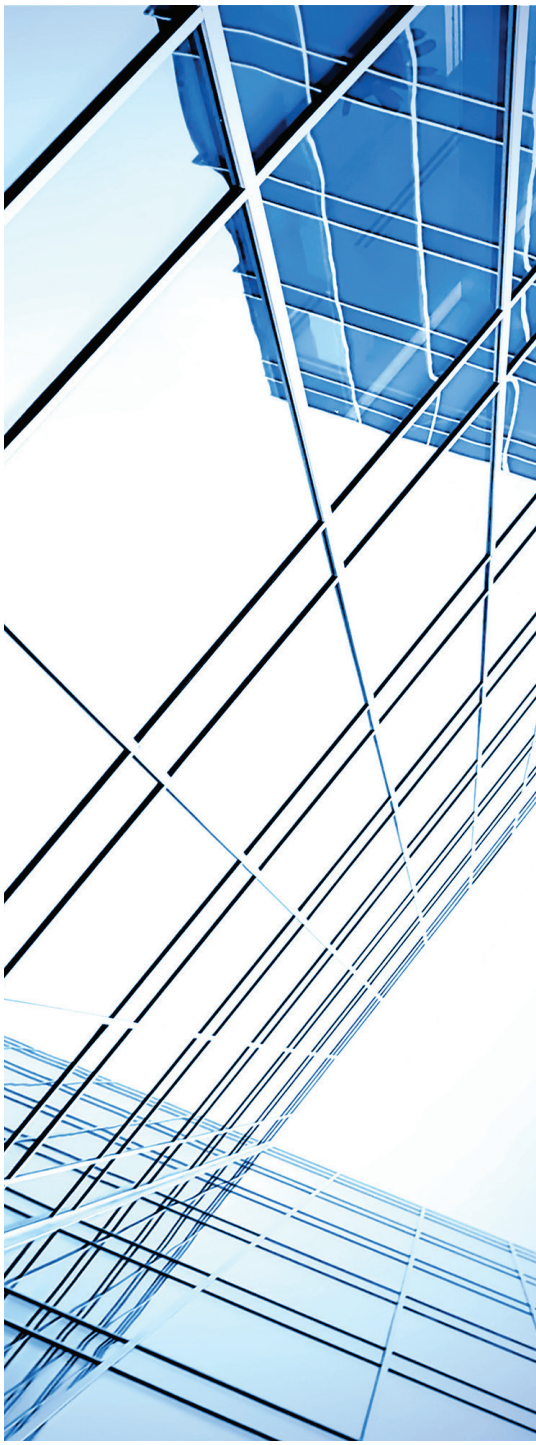
CONCLUSION

The Court's decision in Steiner appears to contradict both commonly accepted interpretations of HIPAA and its interaction with MCL 600.2157, and of other Michigan statutes in direct conflict with the language of the case. The only two ways to interpret the Court's decision are that it applied the phrase "(e)xcept as otherwise provided by law" to only the language MCL 600.2157 itself and not other statutes or regulations, or that it is wrong. The Steiner analysis is facially attractive to other courts seeking to maximize the protections of the physician-patient privilege and, if applied, could significantly change the application of the privilege where it is created by statute. ■

Electronic Health Records: New Challenges for Professional Liability and Peer Review Litigation

It is well-known that many health care providers have begun to implement and use Electronic Health Records (EHR). These changes have come about due to public demand for increased quality and use of evidence-based medicine arising from greater connectivity of providers, as well as very substantial public funding provided for under the Health Information Technology for Economic and Clinical Health Act [HITECH] provisions of the American Recovery and Reinvestment Act of 2009. However, with the implementation and use of new technology, health care providers must be mindful of the new and additional risks and challenges that will be posed with regard to litigation in both the professional liability and peer review contexts. While the law governing the technology and liability is in its infancy, there are some specific areas that are anticipated to be potentially problematic. These are as follows:

- "Legal Medical Record" – What exactly constitutes the legal medical record for a particular patient for purposes of responding to requests for production, subpoenas, etc.? Are audit trails part of the legal medical record? Many facilities currently maintain medical records in both written and electronic formats, and thus, in several locations. It is important to have a policy or procedure in place to ensure all requisite information is captured in the response to a request for production or subpoena, and also that responses are made consistently from patient to patient and case to case.
- Education – Providers should ensure all individuals that will be accessing and working with the EHR are familiar with its capabilities and instructed that the medical records still need to convey the same information that paper records did. In particular, providers need to know that generally all of their actions taken within the EHR can be tracked with regard to user, time, date, etc., so that entries are made to appropriately reflect the care provided. Caution should be used with regard to check boxes, drop-down menus with limited selections, cut and paste functions of some EHR, etc.
- Standard of care issues – Attorneys may argue that the standard of care applicable to professional liability cases is evolving and that providers need to be aware of a patient's prior medical history due to greater availability to the provider.
- Maintenance of information – Since the EHR is generally not maintained in paper format, it is important for providers to ensure appropriate mechanisms are in place for safe and reliable storage of the electronic information to avoid claims for loss of the records and/or spoliation of evidence.
- Peer Review Privilege – Most states provide a statutory privilege to protect information/documents regarding peer review proceedings from disclosure in litigation or other administrative actions. However, the governing statutes also frequently contain a provision that strictly limits the individuals who may have access to or be provided with this information. It is anticipated that providers will see more requests for information regarding the electronic history of the documentation to evaluate whether or not it was viewed by individuals not authorized to see the documents, thus negating application of the privilege. ■



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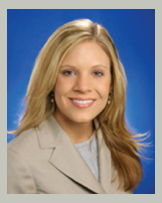

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