Accountable Care NEWS

Will ACOs Raise (or Lower) Liability Risks for Physicians?

By Julian D. ("Bo") Bobbitt, Jr., JD

As readers of this newsletter know, there is significant potential for accountable care organizations to improve both the quality and efficiency of health care delivery for patient populations. The clinical and economic incentives are aligned for all stakeholders to promote higher patient satisfaction, population health, individual health, and waste reduction. However, for an ACO to be successful, physicians in ACOs must practice in a new way, be financially and clinically interdependent with other providers across the continuum of care, adhere to practice guidelines, be "patient-centric," and access broad new bodies of electronic health care data.

As theories of legal duties associated with these changes emerge, thoughtful opinions differ as to whether the net impact will be for heightened liability exposure for physicians or reduced liability risk. This article explores the emerging theories and suggests strategies which ACOs and their physicians should follow to mitigate these risks. We will focus primarily on the emerging professional malpractice liability risks facing physicians, but then touch briefly on the other more settled and predictable areas of potential liability, but which still require compliance vigilance.

Yes, it is a legal minefield, but while creative theories of liability will surely be raised in our litigious society, at the end of the day, we conclude that physicians providing better care, better patient engagement, and utilizing available tools and clinical knowledge through ACOs should feel confident that they will navigate that minefield successfully. In fact, since mal-occurrences stand to be reduced by following best practices and by better accessing patient information, liability exposure may well be less for physicians within ACOs relative to those without. For those mindful of the new areas of potential exposure and who adopt practical mitigation strategies, the outlook should be even brighter.

Potential New Risks. These are new and untested waters. Potential new areas of risk include the following:

A. **Joint, Several, and Vicarious Liability**. A fundamental goal of an ACO is to remove care from fragmented silos to integrated care across the full continuum. There are new and enhanced roles for allied providers, such as nurse navigators and coordinators, who are encouraged to practice "at the top of their licenses" but pursuant to physician supervision. Primary care physicians will access specialist knowledge and judgment directly and electronically. Practices, health systems, and ACOs are being restructured into new frameworks.

With multiple providers touching the patient, and more providing clinical input, there will be some novel challenges in sorting out who actually was responsible for the patient. If there was a failure of the standard of care, whose was it, and did it proximately cause the injury?

For a patient in an ACO population litigating injury alleged from treatment, it is logical to expect a professional negligence complaint to use the "shotgun" technique. The shotgun approach includes any provider, employer, or related entity even remotely connected with the mal-occurrence. It will claim that they should all be held liable and be jointly and severally liable for the alleged damages.

With multiple providers touching the patient, and more providing clinical input, there will be some novel challenges in sorting out who actually was responsible for the patient. If there was a failure of the standard of care, whose was it, and did it proximately cause the injury? Or, was it truly a joint care event and all involved should be held jointly and severally liable? When two or more persons are "jointly and severally liable" for a tortious act, each party is independently liable for the full extent of injuries stemming from the tortious act.

Vicarious liability is liability that a supervisory party, such as an employer, bears for the actionable conduct of a subordinate based on the relationship of the parties. Hospitals are employing more and more ACO participating physicians. Allied providers of health systems, group practices, and ACOs are assuming greater direct patient care responsibility. In most states, regardless of employment status, these increasingly active providers must be under the supervision of a physician, meaning that the physician retains legal responsibility for adequate supervision.

ACOs will be tempted to hold themselves out as providing better high-value care, which likely raises the chances of them being held vicariously responsible should those claims not be met in every case.

Lawsuits are foreseeable against a physician who never saw the patient. It may have been because of the acts of an employed or supervised provider.

B. **New Duties to Patients?** Will "patient centeredness" create a heightened duty of informed consent? Will new duties (i.e., required individual care plans) lead to new claims for breach of those duties?

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The regulations of the Medicare Shared Savings Program ("MSSP") require ACOs to "Promote…beneficiary engagement…, adopt a focus on patient centeredness…, and have defined processes to fulfill these requirements." [1] Clinical knowledge must be communicated to patients in a way that is understandable to them. [2] Shared decision-making must take into account the patient's "unique needs preferences, values, and priorities." [3] The ACO must submit a description of its individualized care program.[4]

It is foreseeable that a plaintiff might try to convert these requirements into independent legal standards. Will a physician be held liable for failure to have sufficiently involved the patient, failed to have a care plan, or even if so, failed to document same? Will this patient engagement notion heighten the standard for obtaining informed consent? How can you prove that the patient "understood?"

C. **Heightened Standard of Care?** The MSSP requires ACOs to define processes to promote evidence-based medicine.[5] This could be viewed as creating a heightened standard of care owed by the treating physician to the patient.

D. **Conflict of Interest Allegations?** Remembering the litigation during the capitation era when complaints against physicians and managed care organizations commonly alleged that appropriate care was withheld because the physician negligently prioritized their financial success over the health of their members, some predict a similar wave of claims because of the ACO's shared savings incentives. Since ACOs have mandatory and explicit quality standards and processes that are prerequisites to savings distributions, this author believes the capitation litigation is distinguishable and such claims will not be successful. This assumes that the quality benchmarks mirror or exceed the relevant legal standard of care.

E. **Defensive Medicine No Longer an Option?** – What happens when that defensive medicine extra test does not compare with the ACO's best practice guidelines?

F. **e-Health Liability Risks** – ACOs are encouraged to use digital technologies to gather, sort, and transmit patient data, including the use of electronic health records. These are intended to be available at the point of care along with best practice decision support to assist the physician in optimum patient treatment. These activities raise interesting malpractice issues:

1. *Duty to Consult Medical Records.* Because the standard of care in medical malpractice cases is based upon medical expert testimony, it is an evolving, normative measure of physician performance. Failure to consult electronic medical records may not be viewed as negligent today, but as the standard of care evolves, failure to consult may constitute negligence in the future. Thus, a claim for malpractice involving failure to review an electronic health record ("EHR") would have to show that: (1) the standard of care included a duty to consult the medical record, and (2) the electronic technology involved was the medium dictated by the standard of care to access the medical record in question. However, the case law on the basic question of whether physicians have a duty to consult a medical record is inconclusive. Relatedly, how much of a potentially voluminous digital medical record must the physician review?
2. *The Duty to Adopt New Technology.* New technology is sought by an ACO to give physicians access to more records and tools to promote better health care. Should that new technology (such as a database allowing access to a patient's information) change the standard of care and thereby enhance medical liability exposure for laggard adopters of a given technology? However, by their nature, standards of care change rather slowly. Those involving a duty to use a particular technology will, as well.
3. *Negligence in EHR Use.* Malpractice risks may stem from improper data entry, with later reliance on that data resulting in patient harm. Even with good data entered, there could be user error or a system-wide EHR failure. There can be negligent documentation gaps caused by the interface between payor and electronic records. These risks can be mitigated by prudent system design, training, and monitoring.

   "With EHR systems, clinicians may find it extremely difficult to process the plethora of information that floods their computer screens. Yet, those who miss a critical detail could be held liable for negligence because the fact in question was likely just a few clicks away when the physician was reviewing the patient's EHR." [6] Another side of the same coin is when the physician does review the information but overrides the decision support best practice guidelines in protest over "cookbook medicine."

Other Risks. Though beyond the scope of this article, other more predictable and settled potential liability risks for physicians participating in ACOs include the following: cyber liability, antitrust, contractual liability, Director and Officer liability, self-referral and anti-kickback regulatory compliance, Civil Monetary Penalties law, tax exemption and inurement, corporate practice of medicine, and insurance, business, and intellectual property laws.

Potential Reduced Risk. Here are two areas which might represent reduced risk.

A. **Following Evidence-Based Best Practices**. Following evidence-based best practices will likely reduce risks in two ways. First, there should be fewer claims since following best practices will result in fewer mal-occurrences. Second, abiding by an aspirational nationally-recognized standard of excellent care can serve as a shield in the physician's defense. An example of this is when anesthesiologists in North Carolina agreed to follow treatment guidelines. This was somewhat controversial at the time, as debate ensued concerning the fate of the physician who did *not* follow the guidelines.

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We asked the opinion of Dale Jenkins, CEO of Medical Mutual Insurance Company of North Carolina, who confirmed that "No doubt this specialty impacted their claims experience with guidelines, and their malpractice insurance rates, which went down." Dr. Grace Terrell, President of Cornerstone ACO, put it another way. She said, "Despite the hoopla that ACOs would increase liability, I have seen no evidence of it. Doing the right thing for patients is never the wrong thing to do."

The infant ACO movement is now ushering in ubiquitous adherence to clinical guidelines. Liability statistics for physicians in ACOs are almost nonexistent, and the professional liability benchmark of community standard of care evolves slowly. Notwithstanding, there is a solid basis to predict that patient outcomes will improve, mal-occurrences will decline, juries will view the physician following guidelines as not being negligent, and the overall net professional liability exposure for physicians will be reduced.

B. **Access to Clinical Knowledge**. A physician in an ACO can call in specialty expertise on a troublesome issue, virtually or actually. The previously overwhelmed physician, working in his or her silo, did not have the same access to real-time clinical judgment. One example is the change in risk exposure for emergency physicians. They often had no ongoing physician/patient relationship for the patient entering the Emergency Department, limited or no medical information, and usually no follow-up appointment arranged before discharge. It is understandable that the urge to practice defensive medicine is great in that setting. Contrast that with the care of an ACO patient. The emergency medicine physician will likely have the relevant medical history and an opportunity for consult, and every ACO patient walking out should have a follow-up appointment to see the ACO's primary care physician in his or her hand. That patient will be seen in a few days, greatly reducing the chance of a mishap. Some ACOs are posting cardiologists and other specialists in EDs, to provide real-time support. Quality goes up, costs go down, and the chances of a mal-occurrence are reduced.

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Strategies to Manage Professional Liability Risks. There are several opportunities to reduce professional liability risks for ACO participating physicians.

A. **Best Practices as Shield**. Obviously, to obtain the defense shield noted above, it is important for ACO physicians to establish, understand, and follow clinically-valid evidence-based best practices that meet or exceed the relevant standard of care. Mr. Jenkins cautioned that a physician choosing not to follow guidelines should carefully document the clinical rationale for that decision.

B. **Prudent System Design**. Prudent policies, data protection plans, systems, and training will go a long way to mitigate risks. The goal of this article is to target those risks to allow system design to avoid them.

C. **System-wide Risk Management**. The ACO should consider employing real-time adverse event management utilizing the ACO's data collection capabilities. Some ACOs may have the critical mass to compliment the risk management system by forming a captive insurance company and/or becoming a Patient Safety Organization ("PSO"). Pursuant to the Patient Safety and Quality Improvement Act of 2005, PSOs may receive medical information on a privileged and confidential basis, for the aggregation and analysis of a patient safety event.[7]

D. **Informed Consent Process**. The notions of patient engagement and patient centeredness imply an ongoing two-way relationship. The same can be said for the process whereby the patient becomes informed. It is not a single-shot discussion, but a process whereby the patient gains understanding over time. The process should be thoroughly documented and an informed consent document should be signed by both parties.

E. **Insurance**. Insurance products are being created to address the uniquely different professional liability risks for ACOs and their providers. These probably should be combined in an insurance product that covers the full range of exposure of ACOs and their participants. The package may include: health care professional liability, directors and officers liability, business errors and omissions ("E&O"), including managed care, cyber liability, privacy, and social media.

Conclusion. Transformative new interaction will be required between physicians and their patients in ACOs. On one hand, it presents a legal minefield that is partially uncharted. On the other, as Dr. Terrell said: "Doing the right thing for patients is never the wrong thing to do." Physicians in ACOs that have identified the new risks and adopted prudent best practices, systems, and policies stand a fair chance to practice in an environment of better patient experiences and reduced liability exposure.

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References:

[1] 42 C.F.R. § 425.112(a)(1)(iii).
[2] 42 C.F.R. § 425.112(b)(2)(iv).
[3] 42 C.F.R. § 425.112(b)(2)(v).
[4] 42 C.F.R. § 425.112(b)(4)(ii)(A).
[5] 42 C.F.R. § 425.112(a)(1)(i).
[6] Hoffman, S., *et al., E-Health Hazards: Provider Liability and Electronic Health Record Systems*, 24 Berkley Tech L.J. 1523, 1541 (2009).
[7] Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 42 U.S.C. 2996-21-b-26, see 42 C.F.R. Part 3

