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INSIDE

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Federal Wage and Hour Labor Laws May Confuse Healthcare Employers

By the nature of the work in the industry, healthcare employers can find it challenging to comply with the Fair Labor Standards Act (FLSA), the law that regulates fair compensation for working hours and other workforce limitations. There is a complex list of requirements, made even more difficult by state and local labor laws.

Overtime pay and recordkeeping can trip up any employer, but especially healthcare employers, says **Jacqueline C. Hedblom**, JD, partner with the Hirschler law firm in Richmond, VA.

"It has become a favorite weapon of plaintiffs' attorneys because the possible recovery under the FLSA is so huge," Hedblom says. "FLSA provides not only for individuals to recover wages for hours worked but not paid, but it also has a collective action mechanism that is similar to a class action. You can get one disgruntled employee talking to his or her friends, and before you know it, you have 50 people banding together to press a collective action against the employer."

> THE COMPLEX WORKFORCE DYNAMICS WITHIN A 24-HOUR OPERATION MAKE WAGE AND HOUR COMPLIANCE PARTICULARLY COMPLICATED FOR HEALTHCARE EMPLOYERS.

The collective action can grow quickly, creating significant potential liability and a serious threat to the organization's reputation, she notes.

If there is any indication labor laws were not followed, the employee is entitled to back pay, Hedblom explains. There is an option

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for liquidated damages also in an amount equal to the back pay, so the potential liability includes a double recovery of the back pay.

There is a two-year statute of limitations where it was determined the violations were not willful, she says. There is a three-year statute of limitations for willful violations.

"The law also allows for the recovery of attorneys' fees, which often grossly exceed the back pay damage recovery. The FLSA is so heavily slanted in favor of the employee that it is difficult to even defend against what you think are false allegations because attorneys on both sides are racking up charges," Hedblom says. "If there is any recovery at all for the plaintiffs, even a dollar, the attorneys' fees are recoverable and that is a tremendous risk for businesses."

Meal Breaks Are Difficult

Healthcare employers face difficult challenges with labor laws regarding lunch and dinner breaks in particular, says **Robert L. Kilroy**, JD, partner with the Mirick O'Connell law firm in Westborough, MA. Unlike many other working environments, healthcare employers cannot easily ensure that clinicians can take a designated time period for a meal break, he says.

"The nurse may be scheduled for a lunch break at 2 p.m., but she has a patient alarm go off at 1:55 p.m. and before you know it, she has worked through her lunch break. But many healthcare employers have a payroll system that automatically deducts that time from her paid hours whether she actually got to have lunch or not," he says.

"Over time, that happens and nurses get used to it, considering it just the cost of doing business. That works until someone is disgruntled, picks up on how people are being cheated out of their pay, and now you have a collective action FLSA claim on your hands."

The automatic deduction is the culprit in many such cases, Kilroy says. An employee can voluntarily waive a meal break with a written document that acknowledges the waiver is optional and can be rescinded at any time, he notes.

"Another way you get into trouble is with administrative staff who take their lunch at their desk, and while they're eating they're checking emails and answering the phone," Kilroy says. "All that time is compensable, so some employers will have a requirement that you do not eat at your desk because of the

EXECUTIVE SUMMARY

Healthcare employers are especially at risk of violating the Fair Labor Standards Act. Many practices common in the industry could violate the law.

- Clinicians may be incentivized to work longer hours than the amount for which they are paid.
- Meal breaks are a high-risk area and automatic payroll deductions can lead to violations.
- Home healthcare workers are subject to different rules that may pose compliance challenges.

danger that you will be doing some work also."

Financial constraints on an employer can lead to conditions in which employees feel — rightly or wrongly — pressured to work beyond labor law limits or without adequate compensation, says **Amy L. Blaisdell**, JD, an officer and member of the board of directors at the law firm of Greensfelder, Hemker & Gale in St. Louis.

"At the employee level, that corporate pressure can be felt in terms of reducing the workforce or limiting overtime hours. When an employee becomes unhappy, it is easy for the plaintiff's attorney to say the company was so concerned about saving money that it ignored the fact this employee was working off the clock, or discouraged employees from reporting all the time they worked," Blaisdell says.

"The healthcare industry is particularly susceptible to those claims because it is always trying to transform itself and operate in a lean fashion."

Blaisdell notes that the United States Department of Labor is considering changes to the salary levels that make employees exempt from some labor law restrictions, as well as the required duties test that can exempt some employees.

"The last time they changed the regulations in 2004, we saw a huge spike in litigation over the next five to seven years," she says. "We're going to see another resurgence once the new changes go into effect."

Healthcare employers must emphasize to employees by FLSA that they are specifically not allowed to work overtime without pay or to work from home, Blaisdell says.

"Otherwise, you remain vulnerable to the claim that you were so concerned with saving money that you allowed employees to work uncompensated," she says.

Healthcare Demands vs. FLSA

The complex workforce dynamics within a 24-hour operation make wage and hour compliance particularly complicated for healthcare employers, says **Stephanie Dodge Gournis**, JD, partner with the Drinker Biddle law firm in Chicago. Healthcare providers make big investments in expensive payroll systems that they assume will work to appropriately calculate minimum wage and overtime in compliance with state and federal law, she says — but fancy payroll systems are only as compliant as the manual inputs and formulas used by local payroll staff.

"Often, compliant policies get implemented in noncompliant ways by frontline managers. Frontline managers more often are stretched thin with wide spans of control, and may not be in positions to monitor FLSA compliance on a daily basis — or during off-shifts," Gournis says. "More and more managers rely on their administrative staff to monitor and approve employee payroll. Frontline managers are sometimes placed in the unenviable position of having to fill staffing holes to meet patient needs, while adhering to strict budgets and complicated staffing metrics."

Nurses and other healthcare providers are trained to put patients first, and often the stressful and high-stakes work environment of today's hospitals makes it challenging for caregivers to hand off patients or otherwise ignore patient pagers and monitoring devices in order to take necessary breaks, Gournis says.

"This combination of stressors provides incentive for employees and even well-meaning managers in healthcare organizations to turn a blind eye and ignore the occasional compliance transgression, or to get creative in attempts to incentivize employees to take on additional shifts at all costs," she says.

Targets for Plaintiffs

Healthcare systems often are the biggest employers in their localities, Gournis notes, and they commonly are portrayed in the media and by politicians as having deep pockets and being overly profit-driven. Healthcare institutions use common pay practices that make them particularly vulnerable to cookie-cutter class action lawsuits orchestrated by plaintiff attorneys, she says.

"These factors all combine to make healthcare employers most vulnerable to compliance audits and litigation, and the healthcare industry likely will remain in the compliance spotlight for plaintiff's attorneys and DOL [Department of Labor] regulators on a state and federal level," Gournis says.

She notes that in 2010, the New York State Department of Labor announced a statewide healthcare FLSA compliance initiative based on a five-year survey showing that 64% of healthcare employers in the state were not compliant with wage and hour laws.

Common payroll and staffing practices of healthcare employers significantly increase their compliance risk, including the offering of a matrix of complicated shift differentials and incentive payments as a way to combat low staffing issues, Gournis says. Other common but risky practices include the frequent use of travelers, per diem employees,

contract staff, and independent contractors — some of whom may be working a variety of different roles within a single healthcare system.

Another risk comes from fluctuating staffing needs based on patient census, which increases both overtime and low census. There also is the increased use of wearable communication and tracking devices during meal periods and breaks.

Historical payroll practices of deducting meal periods and rounding employee pay also are risky, Gournis says. Home health and hospice companies and long-term care facilities are at particular risk based on their unique pay practices, use of traveling staff, and historical use of a "per-visit" compensation methodology, she says.

Top FLSA Mistakes

Gournis offers the following list of the top FLSA compliance mistakes by healthcare employers:

1. Misclassification of employee exemption and independent contractor status;
2. Failure to include non-discretionary bonuses and incentive pay in overtime calculation;
3. Compliance errors associated with automatic meal deduction policies;
4. Rounding of employee clock-in and clock-out hours;
5. Pushing and pulling of employee work hours to the day of punch-in;
6. Failure to track off-the-clock work, including employee time spent in training, attending conferences, traveling between facilities, and answering calls, texts, and emails when off-duty;
7. Failure to comply with state and local laws regarding pay deductions, expense reimbursement, leave laws, and day-of-rest requirements.

"Managers are the frontline gatekeepers for a healthcare employer's FLSA compliance. Managers need to be educated on wage and hour laws and compliance obligations, and have a working knowledge of their employer's policies and payroll practices," Gournis says. "Managers also need to be knowledgeable about the legal implications and risks which can result from their failure to follow the employer's rules. Managers must be held accountable for FLSA compliance and must lead by example both in complying with policies on a day-to-day basis and in reporting possible compliance errors."

> "MANAGERS ARE THE FRONTLINE GATEKEEPERS FOR A HEALTHCARE EMPLOYER'S FLSA COMPLIANCE. MANAGERS NEED TO BE EDUCATED ON WAGE AND HOUR LAWS AND COMPLIANCE OBLIGATIONS."

The most challenging part of the FLSA for healthcare employers is the complex array of exceptions and options for healthcare workers offered by the regulations issued by the DOL, says **Jennifer L. Curry**, JD, shareholder with the law firm of Baker Donelson in Baltimore. Knowing which requirements apply to your employees can be dizzying, she says, particularly because the healthcare industry is comprised of such a wide variety of businesses, each with a staggering variety of employees.

"Because of the technical nature of the FLSA and the DOL's regulations, it is imperative that healthcare employers understand how their business is defined under the law and which categories of employees they have on their rolls to know what pay-related issues they must be attuned to," Curry says. "Overtime issues and break requirements pose the greatest risks for healthcare employers right now. The home care industry was hit particularly hard by the DOL's decision to remove the 'companionship service' overtime exemption from home care workers employed by third-party providers."

Under the FLSA, certain domestic-service workers were exempt from overtime requirements, including those providing "companionship services" in the homes of individuals who are unable to care for themselves, Curry explains. Previously, the DOL took the position that this exemption applied to all home care workers, whether employed directly by members of the household or by a third-party provider. As a result, many home healthcare companies built their business models around this exemption.

The DOL was relatively dormant for a few years in enforcing its position, but the beginning of 2019 showed the DOL was readying to take enforcement action. It began issuing request for information letters and audit notices to home healthcare entities throughout the country, seeking employee and compensation records, Curry says. For home healthcare employers who have yet to comply with the DOL's exemption

decision, the new enforcement effort has meant facing a host of back pay awards and penalties for unpaid overtime, she says.

"This year has also brought an influx of class action FLSA lawsuits arising primarily in long-term care and hospital settings where nurses and other employees allege that they routinely perform work off the clock, for which they are not properly compensated," Curry says. "The complaints most often focus on the employers' use of so-called 'automatic' meal break deductions, which assumes that the employee received an entire uninterrupted meal period that then goes unpaid."

30-Minute Meal Periods Can Be Tricky

The regulations make clear that an employee does not need to be compensated for a bona fide meal period provided the employee is ordinarily allowed 30 minutes and he or she is completely relieved from duty during that period, Curry explains. Of course, in the healthcare industry, an uninterrupted 30 minutes can be rare.

"As a result, timekeeping systems with the built-in assumption of a 30-minute, unpaid meal break may end up denying an employee a full week's pay or overtime for hours worked over 40 in a workweek," Curry says.

In addition to overtime and break issues, misclassification of nurses remains a major target of both the DOL and employee plaintiffs, Curry says. Under the DOL regulations, registered nurses generally meet the learned professional exemption to the FLSA if they are licensed with the appropriate state examining board and are paid on a salary or fee basis, but the regulations specifically exclude licensed practical nurses from the exemption, she says.

"Specifically, professional certification is not by itself sufficient to support classification as exempt because such status also depends on the duties actually performed by the nurse and whether the nurse is paid on a salary basis," she says. "Therefore, employers focused solely on an employee's certification, and not the work the employee is actually tasked with performing, are likely to run afoul of the overtime exemption provisions."

Review Policies to Ensure Compliance

Every healthcare employer should review its wage payment policies and practices with the utmost scrutiny, and make sure that their managers understand the policies and consistently and accurately apply those policies, Curry says. In conducting this review, employers should actively open lines of communication with employees about meal break policies, including the importance of taking full meal breaks and the means by which interrupted or missed breaks must be reported so employees can be compensated.

"Also emphasize the critical responsibility employees have for following complaint procedures to bring any problems — real or perceived — promptly to your attention," Curry says. "Healthcare employers should also make it a priority to regularly train employees and managers on topics such as certification of time worked and receipt of meal breaks, accurate time reporting, exception reporting, and deduction overrides."

Meal and rest break compliance can be particularly difficult for healthcare employers on overnight shifts when staffing is leaner, says **Laurel K. Cornell**, JD, partner with the law firm of Fisher Phillips in Louisville, KY.

Many states have laws requiring that uninterrupted meal periods be taken within a certain time frame during the employee's shift. This can be difficult to manage depending on the number of employees working on a particular shift and the operational needs of the employer, she says.

Classification of Employees

Appropriate classification of certain healthcare employees also can be challenging, she says. For example, while registered nurses can appropriately be classified as exempt pursuant to the learned professional exemption, this classification is not automatic and depends on the duties being performed by the particular RN, she explains.

Some states have daily overtime requirements, which can easily be triggered in the healthcare setting — particularly when employers experience difficulty finding coverage on less desirable shifts and must resort to asking certain employees to stay later or work double shifts, she says.

"Many healthcare employers, such as hospitals, nursing homes, and assisted living facilities, operate 24 hours a day, seven days a week, 365 days a year. This can pose staffing challenges, which often result in issues relating to, among other things, overtime and meal and rest break compliance," Cornell explains.

"Many healthcare employers have on-call employees. Determining how much of the time an employee spends on call is compensable, as well as ensuring accurate recording of all time worked during an on-call period, can be challenging. This, of course, can also have overtime implications."

One of the most common FLSA violations in the healthcare setting is the failure to pay employees for all hours worked, which often stems from inaccurate time recording, Cornell says. Common scenarios of when hours worked may not be accurately recorded are employees working while off the clock either during meal periods or before or after their scheduled shift, not recording all time spent during mandatory staff meetings or training sessions, and not recording all time worked by an employee during on-call periods, Cornell says.

"Some healthcare employers offer various forms of incentive pay to encourage employees to pick up additional shifts or to agree to on-call duty, or offer attendance bonuses to help ensure adequate staffing," she says. "Both of these forms of additional compensation can impact the regular rate analysis if the employee works overtime in the same work week he or she received the incentive pay or bonus."

Many healthcare employers require employees to wear uniforms of some sort, and assume the costs associated with uniforms can automatically be deducted from employees' pay, Cornell notes. While this practice is not immediately problematic, such deductions depend on the type of uniform employees are required to wear and whether it is of such a character that it may be reasonably worn outside the context of work, she explains.

"Healthcare employers can make themselves vulnerable to FLSA claims by allowing nonexempt employees to perform work remotely," she says. "For example, a non-exempt scheduler charged with responding to call-outs and lining up coverage outside of the scheduler's normal working hours can be problematic, particularly if the amount of time the employee spends taking and addressing such calls is not accurately recorded."

Reducing the risk of FLSA violations depends on the uniform and consistent enforcement of policies related to meal and rest breaks, along with accurate recording of all time worked, Cornell says.

"Monitor time records to ensure employees are clocking in and out and taking required meal breaks during the appropriate time frames as may be required by state law," she says. "Also, consider having employees attest to having received meal and rest breaks before allowing them to clock out for the day."

Factor in State and Local Laws

Like most employers, healthcare employers face not only challenges with FLSA compliance, but also with state and local wage and hour laws, notes **Keith J. Gutstein**, JD, co-managing partner of the Woodbury, NY, office of the law firm Kaufman Dolowich Voluck.

For example, the FLSA mandates that nonexempt employees be paid overtime premium pay for hours worked in excess of 40, and that certain documentation, such as time records, be maintained for employees, he says. States have the same requirements, if not more.

"For instance, New York State requires that certain employees be paid 'spread of hours' pay if their day exceeds 10 hours, and mandates that each employee in New York State have a notice of wage rates as required by the New York State Labor Law," Gutstein says. "Certain healthcare employees may be unaware of these rules and regulations, which may lead to significant financial liability."

For example, Gutstein explains, it is not uncommon for physicians to start a practice and pay little to no attention to compliance with applicable employment laws. In such situations, a physician may hire an employee, then hire another, and

before the physician realizes, the practice is a thriving business with numerous employees on payroll, he says. While some statutes, like Title VII of the Civil Rights Act of 1964, the Americans with Disabilities Act, and the Age Discrimination in Employment Act, have a requisite number of employees for the laws to apply, the FLSA and its requirements will apply regardless of the number of employees, Gutstein explains.

"Additionally, it is not uncommon for doctors' offices to have extended hours one or multiple evenings during the week to accommodate their patients. In such situations, the extended hours would put a normal 9-to-5 employee over the 40-hour threshold," Gutstein says. "Physicians also may be inclined to compensate their employees on a salary basis and not require their employees to punch in or punch out at the start and end of their shifts."

A common mistake that doctors' offices make is compensating nonexempt employees on a salary basis and opting not to track those nonexempt salaried employees' hours, says **Taylor M. Ferris**, JD, an attorney with Kaufman Dolowich Voluck in Woodbury, NY.

Another common issue that arises in physicians' offices is when a nonexempt employee decides to go into work early or stay late to finish their work. These situations can ultimately create exposure for physicians, she says.

The most important thing risk managers can do to reduce the risk of FLSA violations is to educate themselves on the law and the requirements, Gutstein says.

"Risk managers should also keep and maintain records of employees' hours worked, as well as properly classify their employees as exempt or nonexempt. Risk managers should also be mindful of the intricacies of the New York Labor Law, including the spread of hours requirement, as well as the wage notice and wage statement requirements," he says. "It is also beneficial to review your hiring and compensation policies and update them if necessary." ■

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Criminal Charges Can Creep Up on Clinicians, Administrators

Healthcare risk managers must be careful not to risk criminal prosecution of the organization or its members from activities that may seem innocent, legal experts say. Some activities are particularly prone to criminal prosecution if risk managers are unaware of exactly how they are being conducted in the organization.

Although most criminal investigations in the healthcare industry involve companies that were aware of breaking the law and had intent to do so, it is possible for the organization to be drawn into criminal areas by individuals, says **Sarah Hall**, JD, a former federal white-collar crime prosecutor and now senior counsel with the Thompson Hine law firm in Washington, DC. She has extensive experience in prosecuting criminal healthcare fraud.

"An example would be acquiring a physician practice and you do not have good oversight of what these individuals are doing," Hall says. "The organization as a whole may not be willingly and knowingly engaged in criminal fraud, but you could have individuals who are, and that will draw attention from prosecutors."

DOJ Is Watching

The Department of Justice (DOJ) has focused intently on the healthcare industry for several years

now, with the DOJ Medicare Fraud Strike Force convicting thousands of people across the country. The Trump administration's fiscal year 2019 budget request includes $770 million for investigating and prosecuting healthcare fraud, up from the $751 million budget in 2018.

There are certain healthcare activities that are on the radar of prosecutors, Hall says. Opioid prescribing is a hot area, with physicians facing strict prescribing and reporting requirements. *(For more information on the risks from opioid prescribing, see the story in the April 2019 issue of* Healthcare Risk Management*, available at: https://bit.ly/2PMe7bA.)* Other targets for prosecutors include durable medical equipment, home healthcare, upcoding, billing for unqualified workers, kickbacks, and robo-signing.

Robo-signing refers to practicing medicine without individual medical judgment for each order, prescription, or course of medical treatment, Hall explains.

"It is basically an automated course of prescribing without the necessary individual level of medical assessment attached to it," Hall says. "For example, robo-signing can crop up in a clinic setting where forms are prefilled and you have nonmedical professionals ordering drugs. The medical doctor who is responsible for these orders is just presented with documents that have prefilled, predetermined medical outcomes without seeing the patient personally or without exercising the appropriate level of medical judgment for each individual."

From a hospital or corporate level, the risks from robo-signing can be minimized by familiarity with how clinicians operate and clarifying expectations through policies, Hall says. The hospital or health system also may conduct audits to ensure proper procedures are followed.

"If you see that there are 100 prescriptions for oxycodone written on a day when the doctor is on vacation in Aruba, that's an extreme example of the kind of thing that should raise a red flag and prompt further investigation," Hall says. "If it happened that one day you know about, it could be happening other times also. An investigation might include checking time cards to see if the person who was purporting to write the prescriptions was actually reporting to work that day."

Comply With Worker Requirements

Billing for unqualified healthcare workers is another risky area, Hall says. Healthcare employers run afoul of the rules by failing to establish appropriate controls to ensure the person actually treating a patient has the right level of qualifications, she says. Ensuring compliance can be difficult when payers have different requirements, but the employer must have procedures in place to ensure that it is billing for the right level of worker.

Healthcare employers can risk criminal prosecution when, for example, a physician assistant cares for a patient but the hospital bills for care by a physician or someone else with a higher reimbursement rate than the assistant, Hall explains. Fraud also can be alleged when workers are required to be supervised by a higher level worker but are not. In essence, the reimbursement is for both the lower-level and higher-level employees, when in fact the patient was treated only by the lower-level employee, Hall explains.

In the event of an audit or criminal investigation, employers will want to have some way to prove where employees were during the disputed time, using electronic badging or other means to show that they met the requirements for billing, Hall says.

"If a company fails to implement appropriate controls, or if they are not followed, there is a chance that employees and medical professionals can enter the area of fraud. There may not be any criminal intent involved in that type of behavior, but rather just mere negligence or a failure of understanding," Hall says. "That's typically not going to rise to the level that criminal prosecutors will be interested in, but it still represents a problem that may get the attention of payers and other regulators."

Criminal Charges Chill Discussion

Criminal charges also are possible after adverse events, not just fraud allegations. In a current case, a nurse in Virginia is being criminally prosecuted for a fatal medication error, even though state health officials investigated and decided not to discipline her or restrict her nursing license. The nurse made a fatal medication error when she overrode a safeguard on one of the hospital's medication dispensing cabinets. The district attorney's office has said the willful act was key to the decision to indict on charges of reckless homicide and impaired adult abuse.

Although uncommon, such criminal prosecutions can nonetheless be chilling to clinicians who must make critical decisions routinely, says **Elizabeth L.B. Greene**, JD, partner with the Mirick O'Connell law firm

in Worcester, MA. She says criminal prosecution is not the appropriate way to deal with unintentional medical errors.

"Negligence does happen and medical errors do occur. Criminal prosecution is only going to chill the discussion that is necessary to recognize errors and address them," Greene says.

"If people feel that there is a threat of criminal prosecution — even if, in fact, that is a rare circumstance — there is a potential negative impact on all patients. That kind of fear is contrary to everything the medical professional is trying to do addressing medical errors."

If criminal charges are brought against a clinician, that can further shut down the communication process that otherwise might be vital to understanding the medical error and learning from it, Greene says.

"There's a loss of the opportunity to move systems forward and find solutions. We're supposed to be having these healthy conversations in the quality assurance and risk management communities, but what happens if we have more criminal charges coming?" Greene says. ■

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Pediatrics Risk Varies With Age; More Parental Outreach Needed

Pediatricians and other physicians treating young patients face different risks depending on the age of the patient, according to a recent closed claim study by a professional liability insurer. The review also suggests that physicians should more actively engage parents and guardians in the care of the child.

The Doctors Company, based in Napa, CA, analyzed 1,215 claims involving pediatric patients that were closed from 2008 through 2017. They involved physicians in 52 specialties and subspecialties, with a median indemnity payment of $250,000, and a median expense to defend of $99,984.

Neonates had the highest mean indemnity of $936,843 and the highest median indemnity payment of $300,000. This group also had the highest mean expense, $187,117, and the highest median expense, $119,311. *(The study is available online at: https://bit.ly/2GYWTFa.)*

The report notes that 3% of pediatric claims were filed more than 10 years after the injury, indicating the value of good documentation.

Risks Change as Child Grows

The closed claim review clearly shows that the liability risk for physicians varies significantly by the patient's age, says **Darrell Ranum**, JD, CPHRM, vice president, Department of Patient Safety with The Doctors Company.

"Children at different stages of their development and maturity have different vulnerabilities. Neonates are subject to trauma from delivery, and they also are vulnerable to certain conditions like elevated bilirubin — which, if gone untreated, can result in brain damage," Ranum says. "That makes it important to communicate to the parents when they take the baby home that they need to have the new baby visit quickly and they need to recognize that if the baby turns green, they should get the baby seen as soon as possible."

Newborns also are vulnerable to infectious diseases, and they may have unrecognized allergies, he notes. As the child grows older, the nature of their injuries and illnesses change. Young children are susceptible to falls and trauma from their increasing mobility and exploration, whereas teenagers are subject to injuries from car accidents and sports, as well as communicable diseases.

"At each stage, they are exposed to different kinds of risks, and that means the challenges faced by their physicians also change over time," Ranum says.

Communication Is Vital

The study emphasizes the importance of good communication with parents, Ranum says. There were a few cases in which children were born into families with a history of bleeding disorders, but the parents did not recognize that as important information to pass on to the physician, he says.

"Sometimes, if the child is taken to surgery without that knowledge, there can be a problem. Improving communication can minimize that risk," Ranum says. "Or the patient

could have inherited problems like sickle cell anemia. All of those problems need to be communicated to the physician, and unfortunately in some cases they are not."

Improving communication with parents can be challenging. Physicians may deal with parents who have little or no insight on anatomy, physiology, or disease states, Ranum says.

"Parents are trying to communicate on behalf of the child, trying to convey what the child cannot say for himself or herself, which is already a difficult task. The child can't say what hurts or what happened, and the parent may be limited in how they can convey even the minimal information they have about the problem," Ranum says. "If we recognize those limitations, maybe we can do things that help the parents be more effective advocates for their children."

One strategy is to provide parents with questionnaires and other documents before the appointment — not when they arrive with a fussy child and siblings in tow — that will prompt them to think about their child's history and current condition, Ranum says. They might even be prompted to ask grandparents and others for information that could be useful.

"Sometimes, physicians are working in the dark if they don't have this information because the parents don't have it or they don't recognize the clinical significance of this information they should be sharing," Ranum explains. "Prompting parents ahead of an appointment can help parents be a more effective historian for their child and help the physician move through the diagnostic process."

Physicians also can encourage parents to keep a diary of their child's illness. Many times, a physician will ask if the child has been sick since the last doctor visit, and the parents have difficulty remembering when the child had an ear infection or the flu and details of the illness, he says.

"It's also important for physicians to recognize the disparity in knowledge and clinical issues. Physicians have to be very patient," Ranum says. "We've seen data on how quickly doctors interrupt patients and parents when they're trying to convey their clinical concerns, so physicians really need to hold on and give parents and children a chance to express themselves."

When the physician is communicating with the parent, it can be challenging to communicate the treatment plan and the need for particular tests. Ranum recommends the "Ask Me 3" program from the Institute for Healthcare Improvement, which encourages physicians to use cards or other prompts for asking three main questions: "What is my main problem? What do I need to do? Why is it important for me to do this?" *(Resources and more information on the program are available online at: https://bit.ly/2HHqbFm.)*

"You can encourage them to ask those questions and write down your responses. That gives the parent something to take home with them and guide them in the future," Ranum says. "A lot of times, parents just don't know the clinical significance of some signs and symptoms, so having something to take home that reminds them of your conversation can be helpful."

Ranum points out that it also is important to train staff members in how to answer questions from parents, who may ask the staff member who answers the phone about a worrisome situation only to be told to bring the child in if it seems serious.

"In some situations, these children can get very sick very fast, so physicians have to prepare their staff to know what kind of concerns should prompt physician review or telling the patient to bring the patient in immediately," Ranum says. "It's those fine lines of communication that can make the difference in outcomes for some of these patients, particularly postoperatively."

Good Data on ED Visits

There are not many studies regarding pediatric malpractice claims, especially for children seen in the ED, notes **Phyllis L. Hendry**, MD, FAAP, FACEP, professor of emergency medicine and pediatrics and assistant chair for research in the Department of Emergency Medicine at the University of Florida College of Medicine in Jacksonville. Most ED-focused studies lump children

EXECUTIVE SUMMARY

A closed claim study indicates that liability risks in pediatrics vary with the age of the patient. It also suggests the need for more involvement by parents and guardians.

- The median indemnity was $250,000.
- Some parents do not understand what information is important to communicate.
- Provide questionnaires before the appointment to obtain better information.

in with adults in discussing risks, and pediatric studies include a high percentage of newborn and neonatal cases, she says.

"This study is important because it focuses exclusively on children and provides detailed data on the top 10 specialties named as defendants, including emergency medicine physicians," she says. "In the U.S., about 27% of ED visits are for children from zero to 18 years of age. Caring for children presents unique risks and challenges and includes dealing with a wide range of developmental and physiologic stages while communicating with parents or caregivers."

The case studies in the report demonstrate that problems are not usually caused by physician lack of knowledge, Hendry says. Instead, most errors are caused when things fall through the cracks due to system issues, including communication.

"You see in this research that it's not one magic bullet that will cure everything, and it's not one diagnosis that we're missing," Hendry says. "It's multifactorial."

The closed claim study raises a good question regarding how to make parents and caregivers better partners in the medical process, Hendry says.

"Emergency medicine physicians and their teams must be skilled at gathering a lot of new data in a rapid manner while establishing a communication bond and sense of trust with a worried parent or caregiver they have just met," she says. "There is a skill to addressing a parent's fear the first time their child is significantly ill or injured or being given a bad diagnosis."

Red Flags for Pediatrics

Hendry says the study results bring to mind red flags and high-risk scenarios requiring additional time or scrutiny when treating children. She cites the following examples:

- Children who return to the ED or a doctor's office for more than two visits;
- Children who return with post-surgical complaints or complications;
- Parents or families with limited English proficiency, disabilities, chronic medical conditions, or mental illness;
- Unimmunized children;
- High-risk diagnoses or chief complaints such as testicular torsion or fever in an infant less than two months of age.

The study also draws attention to errors that are connected to test results, such as lost results, failure to inform physicians of critical test results, or not understanding normal pediatric lab value variation by age.

"These all relate to system issues," Hendry says. "Having a clear call-back system and policies for reviewing diagnostic test results is key to preventing these system errors. It is important to always confirm the best phone number whereby medical staff can reach the parent to report abnormal results or schedule follow-up appointments after an emergency department or clinic visit."

Clear Policies Necessary

The closed claim study shows that system failures and communication problems are among the top reasons for patient harm, as they are in all malpractice suits, says **Arthur Cooper**, MD, chief of pediatric surgery at Harlem Hospital Center in New York City.

This finding reiterates the need for clear policies and workable procedures that ensure tracking of test results and adequate exchange of information between the physician and the patient or patient's family, he says.

"An interesting finding in this study is the relatively low frequency of claims involving children that arise from the emergency department. Most emergency medicine physicians feel that their decision-making is constantly under the microscope, so to speak," Cooper says. "The finding that only 6% of total claims involve emergency medicine does not appear to support this feeling."

Cooper says his experience has shown that pediatricians tend to be especially solicitous of patient and parent input, but he also is concerned that growing pressure to see more and more patients can interfere with that.

"When there is an employer putting pressure on you to see more patients every day, that can create a dilemma for the physician who wants to nurture that doctor-patient relationship and establish good communication," Cooper says. "This can be especially damaging in pediatrics, where the parent is so eager to help the child but may need more time to accurately convey those concerns and all the relevant information." ■

SOURCES

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HEALTHCARE RISK MANAGEMENT™

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CME/CE QUESTIONS

1. **Why does Jacqueline C. Hedblom, JD, partner with the Hirschler law firm in Richmond, VA, say Fair Labor Standards Act (FLSA) lawsuits are popular with plaintiffs' attorneys?**

   a. The potential recovery is huge.
   b. It is relatively easy to file the lawsuit.
   c. There are so many disgruntled healthcare employees.
   d. There is no statute of limitations for FLSA claims.

2. **How do many healthcare employers run afoul of the FLSA with meal breaks, according to Robert L. Kilroy, JD, partner with the Mirick O'Connell law firm in Westborough, MA?**

   a. Refusing to pay for meal breaks
   b. Using auto-deduct payroll systems that assume the meal break took place
   c. Providing meal breaks that are shorter than the law requires
   d. Not allowing meal breaks for some employees

3. **What does Sarah Hall, JD, senior counsel with the Thompson Hine law firm in Washington, DC, recommend as one possible strategy to avoid robo-signing charges?**

   a. Audits to determine whether a clinician was on site at the time the order was signed
   b. Setting limits for how many prescriptions can be written in one day
   c. Interviewing random employees about signing practices
   d. Forensic analysis of signatures

4. **What is the name of one method suggested by Darrell Ranum, JD, CPHRM, vice president, Department of Patient Safety with The Doctors Company, for improving communication with parents?**

   a. Tell Me More
   b. Ask Me 3
   c. Don't Forget
   d. Write This Down

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

Appellate Court Affirms Newborn's Blindness Not Caused by Physician Negligence

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President and Founder, Healthcare Risk Services
Former Director of Risk Management Services (2004-2013)
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UCLA School of Law, 2018

News: A state court of appeals upheld a directed verdict in favor of healthcare providers whose allegedly substandard care of a newborn with Rh disease had resulted in the child suffering physical injuries, including blindness. The child's parents argued that given the specific risk factors discovered by the obstetrician early and given that the newborn's cord blood indicated Rh positive blood, the physicians treating the child should have used a higher standard of care.

The trial court found that the plaintiff's expert witness had not provided sufficient testimony to satisfy the plaintiff's burden of proof. In particular, the lower court asserted that the plaintiff's expert witness failed to define the required standard of care and to demonstrate familiarity. Thus, the trial resulted in a directed verdict in favor of defendants, and the appellate court affirmed that the plaintiff did not provide sufficient evidence.

Background: In 2004, an expectant mother's obstetrician learned early on in the pregnancy that the mother's blood type was O negative and anti-D positive. This should have led the obstetrician to consult with a hematologist and carefully monitor the condition of the newborn before and during delivery. Within 24 hours of the child's birth, testing on the newborn's cord blood revealed she was Rh positive, indicating a hemolytic disease. Furthermore, a blood test revealed that the child's total serum bilirubin (TSB) was 9.2. The same day, the child underwent phototherapy after she developed jaundice.

Many years later, the child's parents filed suit against the physicians, alleging that the factors indicating their child was at high risk of suffering from severe neonatal hyperbilirubinemia were present before, during, and after her birth. The parents argued that physicians should have acted promptly and treated their child's blood disease before she developed severe neonatal hyperbilirubinemia, which caused her to suffer physical injuries including blindness.

> THE TRIAL COURT FOUND THAT THE PLAINTIFF'S EXPERT WITNESS HAD NOT PROVIDED SUFFICIENT TESTIMONY TO SATISFY THE PLAINTIFF'S BURDEN OF PROOF.

The plaintiffs presented expert testimony to support their claims. Their expert explained that modern-day medical testing allows for prompt diagnosis of Rh disease, and that if treated in a timely fashion, the condition should not lead to the development of such severe hyperbilirubinemia. The expert further testified that the disease is preventable by paying proper attention to bilirubin levels.

However, the expert witness was a pediatric neurologist who had no specialization as either a hematologist or an obstetrician. When asked by the defendant's counsel whether in his specialty he would have ever treated an infant in the above-described situation, the expert replied "absolutely not." When questioned as to what the proper course of treatment should have been and what the applicable standard of care was in such a situation, the expert proffered that the obstetrician should have consulted immediately

with a hematologist and that the nursing staff should have been trained on how to monitor the signs of Rh disease in order to prevent injuries to the newborn.

Also, the expert failed to explain the specific course of treatment that should have been followed and how the defendant physicians' conduct deviated from such standard. The court found that the expert witness' lack of specific expertise in this particular field of medicine combined with his insufficiently detailed testimony did not meet the necessary burden of proof borne by the plaintiffs, as the expert failed to establish the specific duty of care and to demonstrate a breach of such duty. As a result of the expert's deficiencies, the trial court granted and entered judgment in favor of the defendants through a directed verdict, which does not require any jury determination based on a party's insufficient evidence.

What this means to you: The most important lesson to be learned from this case is that choosing the right expert is crucial — and selecting the wrong expert can be fatal to a party's case. The testimony of expert witnesses plays a central role, and all parties involved should select their witnesses with extreme care, knowing that the testimony of a single witness may turn the entire outcome of the matter in one direction or another.

A physician serving as an expert witness will be able to present a more convincing argument if he or she is specialized in the field of medicine at issue in the case, has extensive personal experience treating patients with the same condition or presenting the same symptoms, and is an active member of the medical community at the time of trial. Previous experience as an expert witness and familiarity with the legal processes also are helpful. However, an expert whose livelihood relies solely upon testifying as an expert may be seen as a "hired gun" and undermined based upon his or her lack of actual practicing of medicine. A balance is thus recommended, and this is only one consideration when determining which expert is right for the case.

Another lesson from this case is whether an expert witness testifying in a medical malpractice case needs to be personally knowledgeable as to the applicable standard of care and, further, present some evidence as to such standard that goes beyond mere opinion. The latter is especially interesting given that expert testimony by nature relies on personal opinion of the testifying expert, and there are multiple examples of cases where physicians specializing in the same field of medicine presented contrasting views as to the correct treatment plan that should have been followed.

In its reasoning, the state court of appeals discussed the general standards for plaintiffs in medical malpractice cases concerning the duty of care, breach of that duty, and injury caused by the breach. A standard procedure to review claims of medical malpractice is to have the conduct reviewed by a board of medical experts prior to litigation. Upon conclusion of the review process, the board delivers an opinion as to whether the alleged conduct breached the duty of care. In this case, the board did not find the physician's conduct substandard and concluded no breach of the standard of care occurred. Thus, to satisfy their burden of proof, the plaintiffs should have introduced expert medical opinion testimony to rebut the medical review panel's findings.

However, the expert testimony presented by the plaintiffs merely stated that the expert physician would have treated the condition differently; it did not explain how the defendant's conduct consisted of a breach in the standard of care. Absent testimony to the contrary, it is possible that there are multiple methods for properly treating a condition, and that those multiple methods satisfy the standard of care. Thus, expert testimony about a possible alternative treatment does not necessarily mean that the treatment used constitutes malpractice.

Additionally, the plaintiff's alleged expert admittedly had no practice, experience, or education in obstetrics or hematology, and did not show the necessary level of expertise required for this particular case and circumstances.

The expert made other damaging admissions to the parents' case and to his position as an expert: He admitted he had never handled the handover between an obstetrician and a pediatrician after a child was born; he would not have been the right physician to follow plaintiff's pregnancy and delivery of her child; and he currently was a retired neonatal neuropathologist who primarily offered consultation services.

Taking into account all of the above, the court of appeals found that the trial court did not abuse its discretion in ruling in favor of the defendants. It is plausible that had the parents found a more appropriately qualified expert to support their arguments, the outcome of the case would have been different. While the question as to the required standard of care remained unanswered given the deficient expert testimony, it apparently was not disputed that the child suffered permanent physical injuries including blindness. To the extent that the expert's testimony regarding the preventability of such injuries was accurate, it is likely that a physician specialized in obstetrics or hematology would have been able to provide a more accurate and convincing opinion as to how the treating physicians

violated their duty of care toward the patient.

Ultimately, the defendant physician in this case won by undermining the expertise and appropriateness of the opposing party's expert, which is a significant accomplishment. ■

REFERENCE

Decided on Feb. 21, 2019, in the Court of Appeals of Indiana, Case Number 18A-CT-582.

Defense Verdict Vacated in Case of Patient Death Due to Alleged Negligent Preoperative Care

News: A state court of appeals vacated a defense verdict and ordered a new trial in a suit accusing two physicians and a hospital of negligence in preoperative care, which led to a patient's death. The lawsuit, brought by the patient's surviving spouse and administrator of his estate, alleged that the physicians failed to place a nasogastric tube prior to the administration of anesthesia. This failure led to a number of complications in the days following the surgery, which culminated in the patient's death less than 72 hours after the surgery.

Although the trial court returned a verdict in favor of the defendants, the plaintiffs argued that prejudicial hearsay evidence was incorrectly allowed during trial and that a new trial should be granted. The appellate court agreed and ordered a new trial.

Background: On Dec. 23, 2011, a 41-year-old patient suffering from severe abdominal pain and nausea drove himself to the ED. Upon his arrival, around 8:30 a.m., the ED staff performed a CT scan of his abdomen. The radiologist determined that the images revealed a pattern consistent with small bowel obstruction and immediately reported the case to the general surgeon on call at the time. The patient was immediately admitted, and the surgeon instructed that the patient not be administered anything by mouth. Around 5:30 p.m. the same day, the patient was seen by a physician who changed the diagnosis from small bowel obstruction to gastroenteritis, and instructed that the patient only be administered "clear liquid" by mouth.

However, the patient's symptoms did not subside, and he continued to suffer from severe pain, nausea, and vomiting. Two days later, a new CT scan was taken and a different radiologist found that the images showed a massively distended abdomen consistent with high-grade small bowel obstruction. The radiologist uploaded the new images to the patient's file, reported his findings, and indicated that it was his opinion the patient would benefit from a nasogastric tube, which removes contents from the stomach, helping prevent stomach contents from entering the lungs. A surgeon reviewed the patient's file and after consulting with the radiologist determined the patient required immediate surgery. An anesthesiologist was called in anticipation of the surgery and, together with the surgeon, the physicians decided not to place a nasogastric tube prior to the administration of anesthesia.

During the administration of anesthesia, the patient vomited. The anesthesiologist proceeded to suction the patient's lungs and put the nasogastric tube in place. After surgery, the patient's oxygen levels were abnormal. The patient suffered from respiratory failure and died a few days after the surgery.

The patient's surviving wife filed a medical malpractice action centering around whether the anesthesiologist and the surgeon should have placed the nasogastric tube prior to administering the anesthesia in order to prevent the patient's stomach contents from entering his lungs. During trial, the defendants presented a publication by the American Society of Anesthesiologists (ASA) that included disciplinary proceedings against another anesthesiologist who was an expert witness in a similar case and whose testimony was sanctioned by the ASA because it violated the association's guidelines on expert testimony. The plaintiff contended the publication should not have been admitted as it constituted hearsay — an out-of-court statement offered to prove the truth of the matter asserted — and did not fall within any exception. The court of appeals agreed and granted a new trial.

What this means to you: While this case focused on an important legal procedural question, it reveals the types of evidence that may be properly used against healthcare providers in pending malpractice actions. Certain types of evidence or testimony are inherently suspect, and courts are supposed to exclude those in order to protect the jury from considering such unreliable evidence. This does not mean that healthcare providers should disregard such materials in practice, as there are necessarily different standards for scientific research and journals that may prove useful in practicing medicine but

not in defending against malpractice allegations.

In analyzing this case, the state appeals court was asked to establish whether the defendants' document was admissible under the "learned treatise" exception to the hearsay rule. While the plaintiff contended it did not, defense counsel argued that it amounted to a publication falling under the same exception as published practice manuals or textbooks.

The appellate court found that the publication was not in the same category as practice manuals or textbooks and determined that the trial court erred in admitting the publication. The publication contained the disciplinary proceeding by the ASA of an anesthesiologist who testified in a similar case that the decision not to place a nasogastric tube prior to the administration of anesthesia violated the required standard of care. That testimony was reviewed by a special ASA committee of expert witnesses and later sanctioned as in violation of ASA guidelines. The defendants used the disciplinary findings of the ASA to argue that an expert opinion stating that not placing a nasogastric tube prior to the administration of anesthesia should not be accepted because the same opinion had been previously sanctioned by the ASA. Further, the defendants argued that the ASA committee findings served as a guideline for expert testimony in cases involving anesthesiologists.

The plaintiff argued that the publication should not have been admitted because it consisted of prejudicial hearsay evidence. The appeals court agreed and explained that the ASA publication did not meet the necessary requirements to qualify as an "authoritative exposition of medical theory or principle." Instead, the editorial presented the opinion of a group of experts on a controversial topic which may give rise to litigation. Thus, the defendants should not have been allowed to introduce the publication under the learned treatise exception.

During examination of expert witnesses, the defendants' counsel introduced statements from the ASA publication that had not been attributed to any particular source. Such unattributed statements present problems because there is no method for an opposing party to question the source to determine the accuracy and validity of the statements. This is a tenet of legal procedure: Witnesses must be able to be cross-examined, and an unattributed writing makes such cross-examination impossible.

Given the appellate court's decision, it will be interesting to see how, during the new trial, the defense will try to support its position considering the ASA publication constituted the strongest part of the defendants' arguments. Although the decision to place the nasogastric tube after administering anesthesia could be justified given that the method chosen by the surgeon and anesthesiologist in this case is widely accepted and considered up-to-standard, the particular facts of this case may support a finding that the treating physicians should have opted for a different course of treatment under the circumstances. The radiologist recommended the placement of the nasogastric tube prior to anesthesia, given the severity of the patient's condition.

There is little doubt that a nasogastric tube would have aided in preventing the injuries that led to the patient's death. Even if the question of the preoperative care were to be set aside, the plaintiff may have a strong argument given that the initial small bowel obstruction diagnosed by the radiologist upon the patient's arrival to the ED was dismissed by the surgeon and the patient's condition aggravated for two days before any action was taken to further investigate his situation. A prompt diagnosis and treatment could have minimized harm and saved the patient's life.

Nonemergent surgeries may be postponed if a patient is known to have consumed food or liquids other than sips of water up to eight hours before surgery because of the frequency at which the aspiration of stomach contents into the lungs during and after the induction of anesthesia can occur. The diagnoses of obstruction in the gastrointestinal tract at any level is considered a surgical emergency requiring the immediate placement of a nasogastric tube to suction so that the contents of the gut, including food and normal digestive enzymes, do not find their way into the lungs. In the face of a differing of diagnostic opinions as in this case, the primary surgeon has a duty to discuss the discrepancy with the radiologist and the second physician until agreement is reached. If necessary, a third opinion should be sought. Until a diagnosis is clarified, the most prudent course of treatment is maintaining the nasogastric tube.

Bowel obstruction surgeries are high-risk procedures, and decompression of the bowel itself can cause shock. To proceed with the surgery knowing that the upper gastrointestinal tract has not been emptied is an unnecessary risk to the patient, and may constitute medical malpractice. Given the circumstances in this case, the plaintiff may present similar testimony through a qualified expert physician to argue that the defendants' actions fell below the applicable standard of care. ■

REFERENCE

Decided on March 12, 2019, in the Court of Appeals of Georgia, Case Number A18A1810.

HIPAA REGULATORY ALERT

CUTTING-EDGE INFORMATION ON PRIVACY REGULATIONS

Jussie Smollett Incident Shows Need for HIPAA Training, Audits

A Chicago hospital fired at least 50 employees for violating HIPAA by improperly accessing the medical records of actor Jussie Smollett, according to multiple news outlets.

The actor, known for his recent work on the television show "Empire," was treated there following an incident in which he claimed to have been attacked by two men outside his apartment in January. The case was the subject of extensive media attention and controversy because he claimed the attack was a hate crime. However, two friends told police that Smollett had hired them to fake the attack. The district attorney declined to press charges, a decision which was widely criticized.

Firing employees after improper snooping can be appropriate after the fact, but the better solution would be to stop the intrusions in the first place, says **Vish Davé**, senior associate of Schellman & Company, a global independent security and privacy compliance assessor based in Tampa, FL.

There are different steps that hospitals can take to prevent unwanted snooping by employees. One common method is to implement quarterly training and provide knowledge accessible to employees, including disciplinary action, when policies are not followed, Davé says. Furthermore, technical safeguards can be implemented within the electronic medical record (EMR), including access controls and audit controls.

"Access controls can be implemented so that they limit the amount of information an employee can access based on their authority levels and role type within the organization. For example, an employee working front desk who only needs to enter demographics or update demographics for patients might not need to access the patient's actual medical records and therefore will be assigned a role that prevents them from entering or accessing the medical records based on their role type," Davé explains.

Another technical safeguard, audit controls, provide healthcare organizations the ability to monitor access and activity within the EMR, including user login, logout, what health records are accessed, changed, and any irregularities found. They also provide organizations with audit trails that give them the ability to investigate any improper access, Davé notes.

Still another option available, depending on the type of EMR, can provide healthcare organizations the ability to mark certain patients' charts as confidential, Davé says. When an employee attempts to access the patient's chart, the system prompts the employee to give a justified reason of why the employee is accessing that specific patient's information and logs the reason into an audit trail.

"With the ever-changing technology environment, several other types of solutions are available within the market that work in similar fashions and detect improper access in near-real time based on the type of electronic healthcare record system to minimize employee snooping," Davé says.

Some EMR software offers role-based limitations granular enough that they limit particular categories of employees to certain fields in the EMR, notes **Kristen Rosati**, JD, an attorney with the law firm of Coppersmith Brockelman in Phoenix.

"For example, billing clerks may not need access to the entire EMR to do their job. However, not all EMR software has good technical role-based capabilities," Rosati says. "Even the best role-based limitations can't determine in advance whether a particular employee with treatment access has a treatment relationship with a particular

patient. It would have a very negative impact on patient care to require some type of prior association with the patient to allow access, because you have shift changes, doctors filling in for one another — many situations that would make that unworkable."

Hospitals have to rely on good advance training and after-the-fact auditing to confirm that employee access is appropriate. That makes it nearly impossible to prevent all infractions, Rosati says.

"Hospitals have training modules that explicitly tell employees not to peek at records out of curiosity. They explain how the audit trails will catch them, but they do it anyway," she says. "It comes down to people having shockingly bad judgment."

That was true back in days of paper medical records, too, but it was more difficult to gain access, Rosati notes. If someone famous was undergoing treatment, a nosy employee had to go where the record was stored and physically gain access to it. That was more difficult, but people were successful in their snooping, Rosati says.

"The good news is that in the electronic environment you know who accessed the record. With paper, you didn't," she says. "This problem of people peeking at records isn't new. It's just that we know how much it's happening now."

In the 23 years since HIPAA became law, Rosati says the incidence of snooping in patient records has decreased. She attributes this decline to healthcare employers educating employees about the consequences. "The vast majority of employees are very careful to follow these policies because they know what can happen to them," Rosati says. "There will always be some who can't resist."

Rosati notes that records snooping occurs with more than just celebrities. Access audits also should look for queries for patient records with the same last name as the employee, implying a familial relationship such as an employee seeking information to use against a spouse in a divorce proceeding. Audits also can look for unusual volume of access. If a billing employee typically accesses 50 records a day but then accesses 100 or 200, that could represent someone who is browsing records out of curiosity or to seek specific information for improper purposes.

Budgetary concerns can limit the security options for some healthcare organizations, notes **Brian McPherson**, JD, employment law and commercial litigation shareholder at Gunster in West Palm Beach, FL. Technology exists to limit employee access to records, but not everyone can afford it — especially if it means changing to a different EMR, he notes.

Another problem is that in many healthcare organizations, no one audits the logs showing who accessed patient files.

"HIPAA requires that hospitals and healthcare facilities have a medical record director who is charged with overseeing and auditing patient records. Records are kept of who accessed a record, when, and why," McPherson says. "The problem is that nobody goes back to see what the logs are reporting. The information is there but nobody is paying attention to it because they're so busy with everything else."

One tactic is to flag the records of known celebrity patients or others involved in newsworthy events such as crimes and disasters so that the system sends an alert to the medical record director when someone accesses those records. Also, the auditor can make a point of periodically reviewing the records of those patients for any access that seems unsubstantiated, McPherson says. Oversight like that may be how the Chicago hospital discovered the unauthorized access of Smollett's records.

Some hospitals also assign an alias to celebrity patients so that anyone looking for records under the patient's real name will come up emptyhanded, McPherson notes. Audits may reveal the unsuccessful searches, which still could result in disciplinary action.

"My experience has been that hospitals are not really on top of this until there has been a problem," McPherson says. "You have too many other things to spend time and money on. If your system seems to be working, nobody pays attention to this issue. But once they have a problem and it becomes public, then they're on top of it and implement more controls to protect those records."

On the other hand, some hospitals make a point of offering greater confidentiality for their patients, particularly facilities in communities with a higher percentage of celebrity patients. Sometimes, those hospitals market their enhanced record security to potential patients, McPherson notes.

The Smollett incident illustrates the limitations of simply telling employees not to look at celebrity files, says **Bill Joll**, head of worldwide sales for BlackRidge Technology, a technology security company based in Reno, NV.

"This case is consistent with other common HIPAA violations, where individuals either purposely or inadvertently access unauthorized medical records. It doesn't matter which, as the records are already compromised," Joll says. "Many healthcare organizations lack the

proper security and risk management solutions to prevent this. This is even more true within the broader med-tech solution and service provider ecosystem."

Joll notes that when HIPAA was put in place, organizations scrambled to implement policies and procedures to comply. They often took a simplistic approach to limiting access to patient records, he says.

"We've discovered over the years that many of the policies and procedures implemented stuck to the 'don't do this' or 'don't do that' level. Organizations generally put enough in place to pass HIPAA audits, but compliance with a particular statute does not equal security," Joll says. Many healthcare organizations correlate risk management to compliance. However, compliance audits are only a "point in time" snapshot of some auditor's perception of whether policies are in place and followed, Joll says. Audits do not give any visibility as to what is happening or enforced at every point in between, he says.

While security leaders in the healthcare industry are increasingly embracing a mix of security products to protect the organization, the technologies they deploy often are focused on post-breach detection, Joll says. "Compounding this problem, many hospitals lack the necessary resources to proactively review and monitor much of these solutions. Even if a detection product is in place, an attack or breach often goes unnoticed," he says. "This leaves many organizations in the position of having only policies and procedures in place to deal with [protected health information] and relying on adequate training of employees who are incentivized to focus on patient care rather than cybersecurity. Healthcare organizations must ensure that only authorized access of patient records is allowed by enforcing core internal security and access policies at all times, not just at the point of audit." ■

Microsoft Breach Reveals Risk From Cloud-Based Data Storage

A recent attack on email servers at Microsoft raises questions about the security of protected health information (PHI) on servers that healthcare organizations use.

On April 12, Microsoft sent notification emails to some Outlook account users warning them of a breach that might have compromised their data. Between Jan. 1, 2019, and March 29, 2019, hackers accessed a Microsoft support portal that is used to field customer questions and complaints. The hackers could have accessed and viewed the content of some Outlook accounts, Microsoft said.

"This unauthorized access could have allowed unauthorized parties to access and/or view information related to your email account (such as your email address, folder names, the subject lines of emails, and the names of other email addresses you communicate with), but not the content of any emails or attachments," according to the notice from Microsoft.

Later, Microsoft said the breach might have been worse than it first appeared and that accounts might have been accessed for months earlier than believed. The hackers might have been able to access email content and addresses, the company said.

Patients who may have shared PHI through these compromised accounts could be at risk, says **Mark Bower**, general manager and CEO of Egress Software in Boston. The administrative compromise of the Microsoft customer support portal allowed the attackers to gain full access to email content in compromised accounts as well as email addresses and subject lines, Bower explains. This could enable manipulation of the account owners network with well-constructed phishing emails for direct attacks and potentially more damaging access. "The attack illustrates that dependency on cloud email providers to protect data only means one thing for people: Attacks like this are to be expected, and getting ahead of the more serious risk of email data access requires trusted, third-party email encryption for sensitive emails with built-in smarts and monitoring so users are properly secured and warned when threats emerge," Bower says.

A primary lesson from the Microsoft breach is that anyone can fall victim to an attack, says **Matt Fisher**, JD, partner with Mirick O'Connell in Worcester, MA. Hosting your data with a massive company like Microsoft does not bring any guarantee of safety, he says.

"It's only a matter of when, not if, a breach will occur. Unfortunately, the hackers are steps ahead of people trying to protect the data. This incident shows that even a company as sophisticated as Microsoft is not beyond reach," Fisher says. Healthcare organizations using Microsoft email

servers should contact the company to determine if their data were involved in the breach. If it were, then try to determine if any PHI was compromised. If PHI was involved, one most likely will need to proceed with data breach notification, Fisher says.

Avoiding this type of breach in the future will require a review of security settings and optimizing them when possible, Fisher says. Sticking with the default security settings and options usually is insufficient. Generic passwords are especially vulnerable to outside attackers.

"It's possible sometimes when you look at your setup you will find that not all of the security features have been activated," Fisher notes. "After taking all the right steps up front, you have to constantly monitor and make sure systems are updated regularly. You also have to recognize when the threat environment is evolving and not remain static."

Fisher notes that the healthcare industry is known for its lack of vigilance on cybersecurity, although the level of attentiveness can vary greatly from one organization to another.

"It would be beneficial for most healthcare organizations to pay more attention to this and treat it with the utmost seriousness," Fisher says. "The Microsoft breach is a reminder that these attacks are continuing and can come from areas you hadn't anticipated."

For healthcare providers, this Microsoft email data breach brings to mind the healthcare data compromise in Singapore last year that affected 1.5 million patients and originated with an unpatched version Microsoft Outlook, says **Sam McLane**, chief of the technology services office at Arctic Wolf Networks, a software security company based in Sunnyvale, CA. The hackers in that 2018 case took advantage of a known vulnerability in Outlook, McLane says. The lesson for risk managers involved the need for good security hygiene, including regular vulnerability assessment and patching.

"The most recent Microsoft email episode involves Microsoft-managed email services such as Outlook.com, MSN.com, and Hotmail.com," McLane says. "It is important to note that this episode appears not to have affected Office365, which healthcare providers probably use for communications involving electronic protected health information."

For the healthcare community using Office365, a best practice is to monitor your Office365 login data for suspicious activity, McLane says. "Microsoft provides solid Office365 security and can provide tool security telemetry, but the burden lies with the healthcare organization to monitor Office365 telemetry for anomalous activity," he says. "Monitoring and detecting unauthorized access to Office365 like anomalous sign-in activity from brute-force attacks, concurrent access across multiple geographies, and access from unauthorized geographies are industry best practices that enable you to tighten up security of PHI in the cloud."

The latest Microsoft breach illustrates an important trend in cyber threats, says **Andy Smith**, vice president of product marketing at Centrify, a software security company based in Santa Clara, CA. "This breach is yet another example of the fact that cyberattackers don't hack in anymore. They login using weak, default, or otherwise compromised credentials," Smith says. "Privileged account access provides cyber adversaries with the keys to the kingdom and a perfect camouflage for their data exfiltration efforts." A report from FireEye, a security company based in Milpitas, CA, indicates that the global median dwell time that attackers remain undiscovered in your network is 101 days (as of 2017). Healthcare organizations have to assume that bad actors are in their networks already, Smith says. That is why healthcare organizations must move toward a "zero trust" model of cybersecurity. "Zero trust" is a security concept in which organizations do not trust anything inside or outside its perimeters. Anyone and anything must be verified before granting access.

"Simple static passwords are not enough, especially for sensitive company data. Now is the time for healthcare organizations to move to a zero trust approach, powered by additional security measures such as multifactor authentication, to stay ahead of the security curve," Smith says. "With static passwords, how are you supposed to know if the user accessing data is the valid user or just someone who bought a compromised password from the 21 million that were revealed in the 'Collection #1' breach? You cannot. You can't trust a static password anymore; multifactor authorization is the lowest hanging fruit for protecting against compromised credentials."

Smith says healthcare organizations must take a stronger stance against hackers because the evidence is clear that they are not letting up on trying to get access to valuable PHI and the associated data of patients.

"Zero trust can help companies avoid becoming the next breach headline, including the damage to brand, customer loss, and value degradation that typically comes with it," he says. ■