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Special Report: Air Ambulances

Recent crashes highlight risks that come with medical helicopters

Providers at great liability risk, must take precautions

(Editor's note: This is the first in a two-part series about the hidden risks and liabilities of medical helicopters. This month, Healthcare Risk Management *explores the risks and reviews recent crashes. Next month's issue will provide more advice and profile one hospital that has revamped its medical helicopter system after experiencing two crashes over several years.)*

A medical helicopter can be invaluable when desperately ill or injured patients need to be transported quickly from remote locations, but risk managers may underestimate the liabilities that come with those benefits. Even a well-run air ambulance program carries significant risks simply by the nature of the activity — flying a helicopter in less-than-ideal situations — and a program that is not optimized in every way can

EXECUTIVE SUMMARY

A surge in the number of medical helicopter crashes over the past year is bringing more attention to the pros and cons of using these high-profile, high-risk tools. Health care providers face significant liability after a crash, which often results in multiple deaths and multimillion-dollar payouts.

- An air ambulance service requires extensive oversight and supervision, a burden that you must consider before participating.
- Medical helicopters may be overused, exposing crews and patients to unnecessary risks.
- Carry significant insurance coverage for crashes, even if the helicopter is leased.

increase those risks exponentially.

The past year has highlighted the risks and the tragedies that can result when a medical helicopter crashes. Thirty-five people were killed in nine medical helicopter tragedies in 2008, the deadliest year ever for such crashes. **(See p. 16 for a review of some of the recent crashes.)**

Federal regulators are concerned. The National Transportation Safety Board (NTSB) is focusing on a series of recommendations it has been pushing since the January 2006 release of its call for tighter restrictions on medical helicopters. The Federal Aviation Administration (FAA) is responsible for implementing those changes, but in October 2008, the NTSB board called FAA progress on the recommendations in the last three years "unacceptable." The NTSB is holding a three-day hearing in February to discuss the recent spate of accidents and possible improvements.

The cause of the recent surge in medical helicopter crashes is not yet known. It could be coincidence, experts say, but it also may be that the growing number of medical helicopters is making flaws in the system more apparent. The number of air ambulance programs in the United States has climbed from about 100 in the 1980s to more than 900 now, according to several sources. Some of those medical helicopters (and airplanes, in some instances) are owned and operated by hospitals, while others are operated by independent companies that lease their services to the hospitals.

The NTSB has investigated 65 fatal medical helicopter crashes since 1989. Those data revealed that two-thirds of the helicopters began the mission at night — and half in inclement weather or with reduced visibility. The NTSB found that the most common nonmechanical cause for air ambulance crashes was a collision with obstacles, such as mountains and power lines, often related to the weather conditions. Pilots in 21 of the crashes flew too low or directly into terrain. Ten of the pilots were disoriented by fog, snow, or rain.

A majority of the fatal crashes occurred on the way to pick up a patient, rather than on the return. This is an important finding, because current FAA regulations allow helicopters carrying only crew members to fly under less stringent flight rules than those with patients on board.

Some flights unnecessary

One of the most troubling aspects of the medical helicopter crashes is that the flights were sometimes unnecessary. Emergency personnel on the ground often are eager to call on the helicopter because they think, with the best intentions for the patient, that the faster transport will save lives. That is undoubtedly true in many cases, but not always.

Academic studies have concluded that, in many cases, a patient's injuries were not serious enough to have required the faster transport. And even in some serious cases, a medical helicopter actually may offer little or no advantage over ground transportation. It can take time to dispatch the helicopter, find a landing site, load, and return, but one important factor often overlooked

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in risk/benefit analyses is that the ground transportation still is used in many cases. Many patients are injured in locations where the helicopter cannot land close by, so it lands elsewhere and a ground ambulance takes the patient to the aircraft. Then the helicopter flies to a hospital that does not have its own landing pad, so the helicopter lands in a parking lot or on another building nearby and the patient is loaded into a ground ambulance again.

After all those delays, sometimes the patient would have been better off just taking ground transport, studies have found. In one 1998 incident, a helicopter crashed while en route to pick up a truck driver injured in an accident near La Gloria, TX. The pilot and two technicians were killed. Even after the delay caused by waiting for the helicopter that never showed up, the truck driver fully recovered after being taken to a hospital by a ground ambulance.

There also is concern that medical helicopters are overused and flown in overly dangerous conditions because of financial pressures and marketing concerns. When a hospital spends millions on its own helicopter or the costs associated with outsourcing the service to a charter company, there can be substantial pressure to use it — either to recoup costs or simply due to the line of thinking that because the facility has it now, the helicopter should be used. If the facility owns the helicopter and has its logo emblazoned all over it, there can be pressure to use the helicopter as a marketing tool, to get it out there in front of the television news cameras.

The flight crews, who must make the final decision whether to fly in adverse conditions, often feel pressure to take risks because they think a patient's life is at stake. Many pilots will fly "mercy missions" under conditions they never would risk otherwise. And they sometimes are eager to log more flight hours.

All of those factors can result in a medical helicopter flying in conditions that result in a tragedy.

Substantial liability risks

Health care providers face substantial liability from any lawsuits following a crash, says **Don Maciejewski**, JD, an aviation attorney with the Jacksonville, FL, law firm of Zisser Robison. He also is a certified aircraft accident investigator, and before practicing law, he was a U.S. Army helicopter pilot. He now specializes in litigation related to helicopter and airplane crashes.

Though 2008 was a particularly bad year for medical helicopter crashes, Maciejewski says medical helicopters always have had a higher accident rate than that of military or nonmedical civilian helicopters. Risk-taking explains the disparity, he says. The crews flying medical helicopters take more risks, often flying in more dangerous conditions, he says.

"2008 was bad, but it's a trend," he says. "What happens is you have a patient who may not really need urgent transport, you make the decision to fly in crummy weather, into an area that may have all kinds of hazards — wires, mountains — and you fly the mission at night. So instead of one person injured, you end up killing four people — the pilot, co-pilot, nurse, and patient."

Maciejewski points out that the risks are not uniform. For a hospital in an area with flat terrain, good weather, and its own landing pad, the risks will be lower than for a hospital in a mountainous region, frequently beset with fog and storms, and with no dedicated landing pad at the hospital. The recent accident of two helicopters that crashed into each other near Flagstaff (AZ) Medical Center illustrates how medical flights can be far more hazardous than other aviation. In that incident, two medical helicopters were approaching the hospital to land and simply crashed right into each other. Medical helicopters take off and land without the aid of air traffic control, and Maciejewski says the only possible explanation he can imagine is that the pilots were overeager to land what they thought were critical patients and became distracted.

"There's this false sense of urgency when you don't have critical patients on board," he says. "That's what's driving this trend."

Once a tragedy occurs, the hospital's liability will depend in part on whether the helicopter was owned and operated by the hospital or leased from a separate company. The most common scenario is that the aircraft is leased, the flight crew are independent contractors to the hospital, and the medical personnel are employees of the hospital, he says. If leased, much of the liability will fall to the helicopter owner and not the hospital, but that does not mean the hospital gets off scot-free. **(See the article on p. 18 for more on adequate insurance coverage.)**

"A lot of times we find that the insurance of the leasing company is inadequate, particularly when someone is catastrophically injured or

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killed, to compensate the family for that loss," Maciejewski says.

Risk manager must step up

Steve Marks, JD, an attorney with Podhurst Orseck in Miami and one of the nation's leading aviation attorneys, cautions against contracting with local helicopter pilots for ad hoc flights. This can be tempting, particularly for smaller rural hospitals that can't afford their own helicopter services.

"Sometimes a local helicopter pilot will offer to do an emergency flight for a few hundred dollars whenever you're desperate, and it can sound like a good idea. The pilot's trying to be a Good Samaritan, and you're trying to save your patient," he says. "Don't do it. It's easy to lull yourself into thinking it's safe and fine, but it can go terribly wrong — and then you're the one responsible in the aftermath."

The downside of having a medical helicopter often is underestimated, Maciejewski says. In the excitement of being able to get such a high-profile, life-saving service, the risks can be minimized. Part of the reason is that people apply the same mentality to medical helicopters that they apply to commercial air travel: "Sure, accidents do happen and they're tragic," they think, "but they are so rare that there's no need to worry about it."

That is not the case with medical helicopters, and Maciejewski says it is the risk manager's responsibility to explain the facts.

"We see hospitals go out and get a helicopter and think, 'Wow, it's a great marketing tool; we've got to use it as much as possible, and our PR is going to go through the roof,'" he says. "The risk managers aren't involved. The [individual] who has the master's degree in safety and risk reduction has to step up and say, 'Wait a minute. There's a lot of liability here. There's a lot of crashes.'" ■

Recent crashes show risk of emergency flights

These are details of some of the most recent medical helicopter crashes:

• **On June 29, 2008, seven people died when two helicopters crashed into each other near Flagstaff (AZ) Medical Center**. One helicopter ferrying a patient with a medical emergency from the Grand Canyon collided with another chopper carrying a patient, leaving seven people dead and critically injuring a nurse. The collision, at 3:45 p.m., was a few hundred yards away from a neighborhood that was spared the falling debris, but it sparked a 10-acre brush fire. An explosion on one of the aircraft after the crash injured two emergency workers who arrived with a ground ambulance company.

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The National Transportation Safety Board (NTSB) report on the crash says the recorded transmissions made between both medical crews and the hospital revealed that both of the medical crews contacted the ED at the hospital and provided medical reports on their respective patients: "At the time Angel 1 contacted the hospital, they provided an estimated time of arrival in 15 minutes. The Classic Helicopter Services medical crew reported an estimated time of arrival of 18 minutes. The hospital staff that received the phone calls from both aircraft did not provide any information about the other helicopter that was also en route to the Flagstaff Medical Center helipad."

Several people witnessed the collision of the helicopters as they approached the hospital helipad and reported seeing both helicopters descending into wooded terrain about ¼ mile from the heliport. A surveillance camera, mounted on a parking garage at the hospital, captured the collision on digital video. The video depicted one helicopter approaching from north and one helicopter approaching from the south, and shows both aircraft descending after the collision.

• **A helicopter crashed on an isolated ranch in a national forest near Huntsville, TX, on June 6, 2008, killing a patient and three crew members.** The aircraft, operated by PHI Air Medical Helicopter, was taking a 58-year-old patient from a hospital in Huntsville to another facility in Houston for surgery. The helicopter left the first hospital at 2:45 a.m., and the hospital lost contact with it after only two minutes.

• **A medical helicopter crashed on Sept. 28, 2008, after the pilot lost his bearings in foggy weather near Andrews Air Force Base in District Heights, MD.** The crash killed four of the people on board — the pilot, a paramedic, an emergency medical technician, and one of the two traffic accident victims being transported. The second patient survived the crash but was in critical condition.

The helicopter was returning to the hospital when it was diverted to the Air Force base because of fog. The pilot radioed that he was having difficulty assessing his surroundings, twice asking for assistance with landing. Then air traffic controllers lost contact with him, and the helicopter crashed about 1:15 a.m., three miles from the base. ■

Pressure to fly often leads to helicopter crash

When a medical helicopter goes down, there often is more than one cause. Bad risk assessment, insufficient technology, and pilot error can combine to create a tragedy.

Risk managers should remember that medical helicopter crashes are almost always preventable accidents, says transportation accident and liability attorney **Jeffrey Kroll**, JD, in Chicago.

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"Hospitals are putting these pilots at risk, because medical helicopters are not equipped with the kind of technology that can help pilots avoid crashes," he says. "Commercial aircraft have terrain awareness warning systems, military pilots use night vision goggles, and hospitals are asking their pilots to fly into dangerous conditions without this equipment."

Much of the risk comes from the way medical helicopters are dispatched, Kroll says. Rather than an air traffic controller determining whether it is safe to fly, the decision often comes from a 911 dispatcher or a medical professional with no knowledge of risk assessment related to flying conditions. The pilot ultimately decides whether to take off or not, but he or she can be influenced to take unwise risks, he says.

"Take a look at how your flights are dispatched, who makes that decision, and what kind of training they have," Kroll says. "It's not just a matter of saying the patient is injured and then looking out the window to see how hard it's raining. The local airport uses some specific criteria for determining when it's not safe to fly and so should the hospital."

Many civilian emergency air crews also do not have adequate experience to fly the high-risk missions they are attempting, says **Don Maciejewski**, JD, an aviation attorney with the Jacksonville, FL, law firm of Zisser Robison and a former Army helicopter pilot. Some of the missions, often in poor weather and difficult terrain, would challenge even highly experienced military pilots, he says. The crews often feel pressured to fly against their better judgment, Maciejewski says.

"The hospital says, hey, we're paying insurance, maintenance fees, crew fees; why not use the helicopter? If they have the asset, they feel like they have to use it," he says. "There's a level of prestige associated with using these aircraft, and that clouds the judgment of when it is appropriate to use them. It's one thing to use the helicopter on a bright, clear afternoon when there are no particular hazards, even if it's not really necessary, but it's different to do that at two o'clock in the morning in bad weather."

Night vision goggles, which allow pilots to see terrain in the dark and in bad weather, can greatly improve safety, and nearly all helicopter pilots say they want them, Kroll says. But only about 25% have them, he says, mostly because they cost about $120,000 for the equipment and training.

Another risk is that many medical helicopters are flown by only a single pilot. Maciejewski calls that a recipe for disaster. Without a co-pilot, the pilot can become "task overloaded" by trying to fly the aircraft, talk on the radio, navigate, keep track of the patient's status, and many other tasks.

Steve Marks, JD, an attorney with Podhurst Orseck in Miami and one of the nation's leading aviation attorneys, says you should look for crews that are experienced specifically in medical flights and not simply helicopter flying. The medical missions can be much more challenging, and the very nature of flying a medical helicopter is different, he says. Most pilots are used to flying

in a relatively calm environment with few distractions. But a medical helicopter can be full of distractions and stressors.

There also is the additional hazard of people entering and departing a helicopter in dangerous conditions, Marks says. This is a risk that people do not generally encounter in commercial aviation, so it is easy to overlook in medical helicopter programs.

"I had a case in which a woman was decapitated because the helicopter had landed on uneven ground, and the rotors were lower than she expected," Marks says. "Everyone who will be around the helicopter has to be trained in these hazards. It is so easy for people to be focused on their patient or other tasks and walk right into a dangerous situation." ■

Carry extensive insurance in case of helicopter crash

If you are going to use medical helicopters, **Don Maciejewski**, JD, an aviation attorney with the Jacksonville, FL, law firm of Zisser Robison, recommends that risk managers be prepared for the worst. Make sure you are adequately insured to cover the payouts from a crash that kills five people on a nonurgent mission, he says.

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Even if you lease the helicopter, he suggests having an umbrella insurance policy to cover liability beyond what the helicopter leasing company has.

"If they have a basic liability policy of $3 million, you might want to go out and buy a $10 million umbrella policy that never even kicks in until their $3 million is eaten up," Maciejewski says. "The beauty of that is that the umbrella policy is usually cheaper than the underlying basic policy and, unless you have a catastrophic event, you're never going to have a claim."

Also watch out for too many exclusions in a leasing company's insurance policy, warns **Steve Marks**, JD, an attorney with Podhurst Orseck in Miami and one of the nation's leading aviation attorneys. He has handled several medical crash cases. Hospitals often think they are protected because the leasing company has insurance, but then they find out that there are so many exclusions that the hospital still is liable when a crash happens.

He agrees with Maciejewski that leasing the helicopter instead of owning it helps reduce liability for the hospital, but he says leasing still leaves you with significant obligations to ensure that the company is safe.

The hospital must confirm that the vendor is adequately insured, that the pilots are insured, and the pilots' training and annual certifications are current. Marks says he has been involved in aviation litigation that revealed the pilots' qualifications were not up to date, and ultimately, the hospital can be held liable for not investigating that prior to leasing the service.

If the hospital owns the helicopter, it is responsible for maintaining the aircraft — no small feat and not inexpensive. Marks suggests that for liability reasons, not to mention striving for the highest level of safety, the hospital should follow the strictest standards — known as Part 121 in the Federal Aviation Regulations.

"Those standards are intended for commercial carriers, but a plaintiff's attorney could argue that you were running what amounted to an unscheduled charter service, and therefore, you should have followed those guidelines," he says. "I'd follow the highest standards just to be safe."

Plaintiff's attorney: Be wary

A plaintiff's attorney says the crash of a medical helicopter always will come back to the hospital involved, says transportation accident and liability attorney **Jeffrey Kroll**, JD, in Chicago. If the helicopter is owned by the hospital, the institution will be responsible for negligent actions that led to the crash. In that sense, he says, the litigation will be similar to a malpractice case in which an employee physician committed an error leading to patient harm.

But even in the case of a leased helicopter, the hospital can be sued if the helicopter and its crew were seen as an "apparent agent," Kroll says. An apparent agent is one that the public could reasonably assume is an employee of the hospital.

"Even though the helicopter is not owned by General Hospital, and the hospital does not employ the flight crew, it can be an apparent agent; because when I called for help from the hospital, they sent that helicopter, and I assumed I was getting the General Hospital helicopter," he explains. "So, you can never just rubber stamp the credentials check and assume you won't have any liability."

Lawsuits following a crash will hinge on showing that the hospital had a duty to deliver the

patient safely or, if no patients were harmed, that the hospital had a duty to provide a safe operating environment for the crew. Then the plaintiff will show causation and point to some failing by the hospital in training, maintenance, policies and procedures, or individual performance.

"The hospital's defense sometimes is to say that the patient was badly injured — that even if we hadn't crashed the helicopter and killed him in that field — this young boy would have died anyway after we got him to the hospital," Kroll says. "I can tell you that doesn't go over well with a jury. But it's the only thing they're left with when they're at fault and they're desperate."

Kroll says the settlements or jury awards will be quite large in helicopter crashes.

"I can't tell you the amounts of settlements in the cases I've handled, but suffice to say this is about the worst thing that can happen to these families," he says. "They put their trust in you and that helicopter, and this is about as big a tragedy as you can present in a lawsuit." ■

Not reporting gun wound draws fire for hospital

A hospital in New York is at the center of a storm of criticism, bad publicity, and possible criminal charges after an employee failed to report the gunshot wound of NFL star Plaxico Burress, as required by law.

New York Presbyterian Hospital spokeswoman **Kathy Robinson** issued a statement soon after the incident, saying the employee has been suspended. (The hospital did not identify the employee or his or her position.) Burress had gone to the hospital after accidentally shooting himself with a gun that police say he took into a crowded New York nightclub. Burress shot himself in the thigh. He was treated and released from the hospital that night.

EXECUTIVE SUMMARY

A hospital is facing severe criticism and the threat of criminal charges after an employee failed to report a gunshot wound. The patient was a prominent professional football player.

- The hospital has suspended the employee who did not report the gunshot wound.
- Authorities are considering criminal charges against the hospital and employee.
- Risk managers should ensure that celebrities do not receive preferential treatment that violates the law.

Hospitals must report all gunshot wounds

Hospitals in most jurisdictions are required to report all gunshot wounds to the police, but the unnamed employee at New York Presbyterian Hospital did not do so — and now the hospital is finding out just how serious the authorities take that requirement. The district attorney's office reports that the hospital is under investigation, and even the mayor of New York City is calling for the hospital to be punished. The hospital spokeswoman says New York Presbyterian is investigating the incident and promised to cooperate with authorities. Robinson acknowledged that "not reporting a gunshot wound is a clear violation of our policies and procedures."

The 31-year-old football player faces two counts of criminal possession of a weapon in the second degree and could face up to 15 years in prison, according to the Manhattan district attorney's office. New York Mayor **Michael Bloomberg**, who has long fought against handguns and illegal firearms in the city, had harsh words for both Burress and the hospital, saying the NFL star should be prosecuted to the fullest extent of the law for possessing an illegal firearm.

But the mayor was just as angry at New York Presbyterian Hospital for failing to inform police about the incident. The police learned about the incident from a TV report, Bloomberg said and added that the state attorney general should "go after" the hospital for a "chargeable offense." Noting that the law requiring notification of police is essential to detecting and prosecuting crimes with firearms, Bloomberg said officials at New York Presbyterian "didn't do what they're legally required to do."

"It's a misdemeanor," he said of the hospital's failure to report the gunshot wound. "It's a chargeable offense, and I think that the district attorney should certainly go after the management of this hospital."

Bloomberg added that the hospital should fire the staff responsible for reporting the gunshot wound.

"I would question why the management didn't

have training in place and didn't discipline them immediately. It's just an outrage," he said at a news conference.

Compliance training questioned

Patrick Egan, JD, a partner in the health law practice group of the law firm of Fox Rothschild in Philadelphia, says incidents such as the failure to properly report the Burress shooting happen for one of two reasons.

"Either the institution has failed to provide thorough compliance education and disseminate information to its staff, or a rogue employee has ignored clearly stated institutional standards," he says. "The hospital appears to be attempting to get out in front of the story by disciplining the employee. It remains to be seen, however, if the hospital had a meaningful compliance program in place and had adequately trained its staff regarding the underlying issue."

If there is a well-documented compliance initiative that concretely demonstrates to employees the hospital's strong commitment to responsible conduct and identifies criminal and unethical conduct, the hospital's reputation will be upheld, and it will not suffer legal repercussions," Egan predicts.

"If not, the employee could use the failure of the institution to provide adequate training as a basis for seeking reinstatement, and the hospital will end up with egg on its face," he says.

Steven A. Eisenberg, JD, a partner with the law firm of Baker Hostetler in Cleveland, also says that a failing like that typically occurs because of an insufficient awareness of the disclosure requirements

"But it also can be an employee or physician trying to cover something up," he says. "When you have an employee or physician who doesn't follow rules and requirements, there needs to be a process to take action against the employee or physician."

The potential legal repercussions for the institution will depend on whether there is a pattern of this behavior, Eisenberg says. If there is, there may be institutional culpability. If not, and the institution acts against the individuals who committed the wrongdoing, it is more likely that only the individuals would have legal repercussions, he says.

"Of course, when there is such a high-profile case, things tend to take strange turns," he says.

The patient's celebrity almost certainly was at the root of the failure to report the injury, suggests **Patrick J. Hurd**, JD, senior counsel in the tort defense group at the law firm of LeClairRyan, based in the firm's Norfolk, VA, office. But that doesn't mean that the same problem doesn't occur with everyday patients.

"While some hospital staff may succumb to idol worship and refrain from contacting law enforcement, a more frequent problem is confusion over the privacy and disclosure provisions of the Health Information Portability and Accountability Act [HIPAA]," he says. "Licensed health professionals in most states can be charged with a misdemeanor for failing to report injuries associated with certain weapons, including guns. Should the person pulling the trigger remain at large due to the failure to report and others suffer injury as a result, one might argue that the hospital and its staff are liable for such injuries."

Hurd says hospital risk managers can prevent such failings by educating physicians and staff on their obligations to report such injuries. Equally important, he says, is spending adequate time teaching what can be disclosed under HIPAA and to whom. "Myth must be replaced with reality," he says. **(See p. 21 for more advice on how to avoid similar problems.)**

Celebrities complicate matters

Martin Kalish, MD, JD, a partner with the law firm of Arnstein & Lehr in Miami, notes that New York state law is quite specific regarding the reporting of bullet wounds. A physician is required to report any bullet wound he or she treats, and in a hospital setting, the report is made by the person in charge. Failure to make a report to the police is a Class A misdemeanor. Additionally, the *Legal Manual for New York Physicians* states that all treating physicians must report a bullet wound to the police and references the penal law.

"New York state law does have a physician-patient privilege," Kalish says. "However, it would appear that the reporting obligation for bullet wounds would trump this privilege similar to obligations to report certain communicable diseases."

Risk managers must ensure that the physicians working in EDs (or any other facility) that are likely to treat victims of bullet wounds are aware of their obligations and understand how their reporting obligations are to be handled. For instance, they should know if they are expected to make the report directly to the police, or to the department administrator, or fill out a specific form. Hospitals must have in place procedures and protocols explicitly dealing with their legal obligations.

Celebrity patients can throw a monkey wrench

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into the system, he says. Staff and physicians may be star-struck and are willing to extend a favor to the celebrity, clearly a violation of law and hospital policy, but that is not the only way the system can fail. The physician or staff member may have the best intentions but become flummoxed about how to protect the celebrity's privacy, comply with HIPAA, and still report the injury. Hospitals have come under fire recently for not protecting the privacy of celebrity patients, Kalish notes.

"Unfortunately, when faced with a celebrity patient, steps can be missed either intentionally or unintentionally," he says. "Especially in a facility in a location that may see celebrities, procedures should be in place to deal with this eventuality both to protect the privacy of the individual and to insure that the facility treats this individual in the same manner as any other patient with respect to all aspects of the law."

Kalish notes that the failure of a physician to comply with reporting obligations can result in discipline by the hospital, the state licensing board, and by the policing authorities. The results of these investigations could conceivably have various untoward effects on a physicians' ability to continue certain insurance contracts and perhaps continued participation in the Medicare and Medicaid programs.

"The failure of the hospital to comply with its reporting obligations could result in investigation and possible discipline by the state licensing authority and by the police," he says. "The adverse publicity generated will not be particularly helpful, and the expenses incurred in legal fees are rather wasteful when compliance would have been a lot simpler." ■

Steps for ensuring compliance with reporting

An incident such as the Plaxico Burress gunshot injury should prompt risk managers to review all relevant contracts, bylaws, and related policies related to the legal obligation to report gunshot wounds, says **Martin Kalish**, MD, JD, a partner with the law firm of Arnstein & Lehr in Miami.

Kalish says if the emergency department was outsourced, for instance, then the contract between the hospital and the provider of services would need to be reviewed and addressed, as well as any written employment agreement between the physician and the employer. If the physician were an independent contractor, any applicable agreement would need to be reviewed.

"In addition to reviewing any agreements, the medical staff bylaws should be reviewed to insure appropriate compliance when subjecting any applicable physician to corrective action including suspension," he says. "Failure to follow these procedures carefully can subject the hospital to legal difficulties [brought about] by the practitioner. Consequently, the hospital would want to insure that it was properly following all of its contractual obligations and its medical staff bylaws in suspending or terminating a physician."

Charles H. Cole, JD, chairman of the Public Policy Committee of DRI — the Voice of the Defense Bar, based in Chicago, cautions that it is not enough to have proper policies in place. You must make sure physicians and staff understand them.

"Policies and procedures may not be worth the paper on which they are written. Implementation and compliance can be difficult," he says. "Mere publication in writing of policy changes that affect the public may not be adequate. Use of video or web-based education seems more suitable to a modern-day work force. When issues of harassment came to the forefront many years ago, many in the workplace implemented sensitivity training to address these new liability exposures. The Burress case may bring such a need to light in matters involving the need to report."

Kalish offers these steps for helping avoid the same sort of problem encountered with the Burress case:

1. The risk manager should ensure that policies and procedures exist for all legal reporting requirements and determine which require input from the medical staff.

2. The risk manager should confirm that the responsible departments are aware of the policies and procedures that are applicable to them, and arrange for the appropriate inservice to be performed. Similarly, with regard to those policies and procedures that affect physician involvement, administration and the medical staff office should be advised so that the medical staff can be properly advised and updated.

3. Since EDs have many more requirements, specific attention should be paid to educating the hospital personnel and medical staff members who work in that environment and may have reporting obligations.

4. The risk manager should consider working with administration to develop a policy for dealing with the celebrity patient to ensure that things operate smoothly in the event such an individual should seek care at the facility.

5. Use the Plaxico Burress incident as a teaching opportunity. The risk manager should use news articles involving those incidents as an opportunity to insure that people at their facility know how to handle a similar situation. ■

ED workers fear radiological terrorism

Emergency department physicians and nurses are deeply concerned about the ability of the nation's hospitals to deal with the medical implications of a radioactive dirty bomb or other terrorist attacks involving radioactive materials, according to a new study. Experts say the findings should be a warning to risk managers that action is needed.

EXECUTIVE SUMMARY

A recent study indicates that emergency department physicians and nurses lack confidence in their hospitals' ability to respond to a "dirty bomb" attack involving radiological material. Experts say the ED professionals are right to be concerned.

- Many of those surveyed fear the hospital would be overwhelmed by such an attack.
- Doctors and nurses say they are unfamiliar with how to treat radiological injuries.
- The survey results should be a call to action for risk managers and ED managers.

The study was recently published in the American Medical Association's (AMA) *Disaster Medicine and Public Health Preparedness* journal. Researchers conducted a series of 10 focus groups with ED physicians and nurses in hospitals in three U.S. regions — Southeast, Northeast, and the West. Study participants discussed a hypothetical "dirty bomb" scenario and the treatment of patients affected by such an attack. Participants consistently expressed the view that medical professionals, EDs, and hospital facilities are not sufficiently prepared to respond effectively to a radiological attack.

Lead author **Steven M. Becker**, PhD, associate professor of public health and vice chair of the Department of Environmental Health Sciences at the University of Alabama at Birmingham, says the physicians and nurses were most concerned about the hospital being overwhelmed with patients, safety of loved ones, potential staff shortages, risks for hospital personnel, and a general lack of familiarity with radiation safety and treatment issues.

"Hospital emergency departments will play a crucial role in the response to any terrorist attack involving radioactive materials," he says. "In fact, it is no exaggeration to say that the actions of hospitals will be central to the success or failure of efforts to manage a radiological terrorism attack and its health consequences."

The study, which was funded by the Centers for Disease Control and Prevention (CDC) in Atlanta, provides new insights into physician and nurse concerns and viewpoints, and reveals major preparedness challenges. Those challenges must be addressed if hospitals and the nation are to successfully face current and future threats, Becker says.

"The study has clear implications for medical preparedness and response," he says. "There is a need for increased information and training on managing radiological events, protecting staff, and treating affected patients. Likewise, there is a need for increased access to informational resources, such as specialized professional hotlines, pocket guides, posters, and toolkits. In addition, physicians' and nurses' concerns for loved ones need to be better taken into account in preparedness planning to prevent a potential shortage of health care providers."

The study results are not surprising, says **Joshua Kugler**, MD, chief medical officer at South Nassau Communities Hospital in Oceanside, NY. He also is chairman of the Department of Emergency Medicine and spearheads South Nassau's emergency/disaster response preparations. Among all the possible disasters that a provider can prepare for, a radiologic event is the one with which hospitals

SOURCES

For more information about preparing for radiological events, contact:

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have the least experience.

"But hospitals have realized the threats posed by radiologic events, either terrorist events such as a dirty bomb or a type of exposure that may come from the use of radiologic material within the hospital," he says. "When we talk about the possibility of a dirty bomb, people are getting better prepared, but I'm not surprised to hear emergency department staff say they feel uncertain and unprepared. Much of that simply relates to the fact that we have not had to deal with that real-life scenario yet."

Jason M. Liu, MD, assistant professor of emergency medicine at the Medical College of Wisconsin in Milwaukee, agrees that much of the apprehension is related to inexperience with this particular type of emergency.

"There also is a concern about the lack of resources, the tight budgeting that is affecting every health care provider and every emergency department," he says. "No one feels like they really have adequate funding for all of their important projects, and I think we're hearing from the people in this study that they think funding and preparation for this type of event has been inadequate. This is an opportunity to persuade leaders about the importance of preparing for this event."

Kugler says the study points to particular concerns that risk managers may want to address. In particular, he notes, the respondents were concerned that they did not have the proper detection equipment for a radiologic event. Risk managers should push for adequate funding for this type of event, because the equipment will eventually be needed, he says.

"The U.S. intelligence agency issued a warning after the incident in Mumbai, India, that not only hard targets but soft targets like hospitals will be affected within the next four years," he says. "So, by 2013, there will be soft-target penetration. We all need to be prepared, whether it is biological, radiological, or nuclear. One of those events is going to take place on our soil." ■

Hospital uses RRTs to aid acutely ill in ED

A California hospital's efforts to improve the care of acutely ill patients who are in the emergency department or on medical-surgical floors rather than the intensive care unit has made it a 2008 recipient of the 12th annual Ernest Amory Codman Award, awarded by The Joint Commission.

Mission Hospital, in Mission Viejo, is one of three recipients of the award in the hospital category nationwide. Its program used a specialized nurse-driven rapid response team with the goal of reducing deaths associated with non-ICU cardiac/respiratory arrests by bringing to the patient's bedside the necessary staff to help the patient, says **Peter F. Bastone**, president and CEO of the hospital. The hospital uses a rapid response team (RRT) to render aid quickly.

Mission Hospital's program reduced cardiac or respiratory arrests outside the ICU from 36 to 16 during a one-year period. ■

CE objectives

After reading this issue of *Healthcare Risk Management*, the CE participant should be able to:

- **Describe** legal, clinical, financial, and managerial issues pertinent to risk management in health care.
- **Explain** how these issues affect nurses, doctors, legal counsel, management, and patients.
- **Identify** solutions, including programs used by government agencies and hospitals, for hospital personnel to use in overcoming risk management challenges they encounter in daily practice. ■

COMING IN FUTURE MONTHS

■ Kickbacks paid for recruiting homeless patients

■ Wake Forest creates model helicopter program

■ Preventing technology-related medical errors

■ Group effort yields safer surgery program

CNE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you.

5. The NTSB has investigated 65 fatal medical helicopter crashes since 1989. Those data revealed what about the helicopters involved?
A. Two-thirds of the helicopters began the mission at night and half in inclement weather or with reduced visibility.
B. Three-fourths of the helicopters were leased rather than owned by the hospital.
C. Forty percent of them were flown by a single pilot.
D. Slightly more than half carried too much weight.

6. What does Don Maciejewski, JD, say about the rate of medical helicopter crashes?
A. They always have had a lower accident rate than that of military or nonmedical civilian helicopters.
B. They always have had a higher accident rate than that of military or nonmedical civilian helicopters.
C. They always have had about the same accident rate as that of military or nonmedical civilian helicopters.
D. They had a much lower accident rate than that of military or nonmedical civilian helicopters until 2001, when the rate started to climb.

7. Regarding the failure of a New York Presbyterian Hospital employee to report the gunshot wound of NFL star Plaxico Burress, as required by law, what does Patrick J. Hurd, JD, say is the most likely cause?
A. While some staff may succumb to idol worship and refrain from contacting law enforcement, a more frequent problem is confusion over HIPAA provisions.
B. The employee did not know he or she was supposed to report the gunshot wound.
C. The employee probably tried to report the incident but was unable to for administrative reasons.
D. The employee probably was too busy with ED duties to report the incident.

8. What is the key finding of the study participants in a recent American Medical Association journal?
A. Participants said they felt they and their hospitals were adequately prepared for a radiological attack.
B. Participants consistently expressed the view that medical professionals and hospital facilities are not sufficiently prepared to respond effectively to a radiological attack.
C. Participants said they and their hospitals were not prepared for a biological terror attack.
D. Participants said they and their hospitals were not prepared for a terror attack of any sort.

Answers: 5. A; 6 B; 7. A; 8. B.

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Healthcare Risk Management's

Legal Review & Commentary™

A Monthly Supplement

Patient's halo slips off head, causing paralysis and incontinence: $1.195 million settlement in Michigan

By **Radha V. Bachman**, Esq.
Buchanan Ingersoll & Rooney PC
Tampa, Florida

News: A man injured his neck and back after diving into the bottom of a shallow lake. He was transported to the hospital, where physicians became concerned that the man's central spinal canal had been compromised. He was fitted with a halo to reduce the spine's interlocking facets, and the resident began applying manual pressure to increase the traction. The resident increased the pressure too much, though, causing the halo to rip off the man's skull and causing the his head to fall back. An MRI was conducted, and the man was taken to surgery to repair the fractures and separate the vertebrae. The man was able to return to work despite the permanent injuries he sustained. He sued the hospital, claiming that the attending physician, and not the resident physician, should have fitted the man for his halo. The hospital principally argued that the man's injury was the result of the original injury and not the slipped halo. A $1,195,000 settlement was reached with the hospital before a lawsuit was filed.

Background: A 47-year-old man felt pain between his shoulders and numbness in his upper arms and hands after diving into a shallow lake and lodging his head into the lake bottom. The man was lifted onto a back board and transported, via ambulance, to a local community hospital. Despite the fact that the man was able to move all of his extremities, the hospital's ED conducted a CT scan that showed a fracture of the C7 facets, full thickness anterior subluxation of C6 on C7, and bilateral interlocking facets. The results of the CT scan caused the ED personnel major concern that the man's central spinal canal had been compromised in the accident.

An orthopedic consult was performed by a third-year resident physician who noted tingling in the man's upper extremities and loss of grip strength in one hand. At no time did the resident or ED staff call an orthopedic surgeon or neurosurgeon in to consult on the man's injuries. The resident continued his examination and determined that a halo with tractions would be the most beneficial method for reducing the interlocking facets. Halo traction is a method of keeping a patient's head and neck still while the patient recovers following an accident or operation and is based on the attachment of the halo to a device worn around a patient's torso. The halo vest attaches through adjustable metal bars to a rigid vest that fits the patient's chest and provides continuous stability to the cervical spine while simultaneously allowing the patient to be mobile.

Traction was provided with weights that were steadily increased as the resident observed the vertebrae with a fluoroscope. When the weights reached 70 pounds, the resident began applying manual pressure to increase the traction. During this process, the man communicated to the resident that he felt the pins slipping. The resident

failed to heed the man's warnings, and the halo ripped off the man's skull, causing the man's head to fall back and the man to suffer shooting pains through the his extremities. According to studies, pin loosening is by far the most common of potential complications of halo use. Those studies have shown that pin loosening occurs in about 60% of patients over a three-month course and can result in severe pain at the pin sites. However, this situation is easily remedied by ensuring tightness of the pins.

Following the slipping of the halo, the resident conducted a neurological exam that showed no changes despite the fact that the man told the resident that he was losing motor function in his extremities. An MRI was conducted and the man was taken to surgery to repair the fractures and separate the vertebrae. Despite extensive rehabilitation following surgery, the man remains paralyzed and is incontinent of bowel and bladder. The man ultimately regained most function in his arms and was able to return to his profession as an engineer.

Malpractice cases in which halos are improperly fitted are quite common. For instance, in late 2007, Wake Forest University Baptist Medical Center was found liable when it was shown that halo screws were inserted too far into a patient's skull. In that case, an 11-year-old boy had been struck on the shoulder by a falling tree limb ripping out all five brachial plexus nerves from his spine. A week after the accident, orthopedic surgeons — concerned about long-term stability of the boy's spine — installed a halo device on the boy's head. During the procedure, the physicians screwed one of the four pins on the halo too far — 1.8 cm inside the skull or close to three-quarters of an inch. As the screw penetrated the skull, it caused extensive damage that led to bleeding inside the boy's head. The mistake was not discovered for six hours, during which a large epidural hematoma developed from the bleeding, causing a subfalcine herniation and midline shift of at least 9 mm. After discovering the hematoma, neurosurgeons performed emergency surgery, but the damage had been done. The boy was left with permanent brain injuries and neurocognitive deficits. After four weeks of trial, the jury returned a unanimous verdict in the amount of $10,437,093, which represented less than the past and projected future medical and other expenses.

In the case of the 47-year-old diver, the plaintiff claimed that manual pressure should not have been applied without the presence of the resident's attending physician and that the resident should have discontinued applying manual pressure when the plaintiff expressed his discomfort. Unlike the Wake Forest case in which the hospital had no strong defense, the hospital in the case at hand countered and claimed that the final injuries sustained by plaintiff were caused by the initial act of diving into the shallow lake and not the subsequent acts of the resident.

Damages for the plaintiff's future medical expenses were supported by a detailed life care plan. No specific claim for lost wages was made by the plaintiff since plaintiff was able to continue in his career as an engineer. The hospital and the plaintiff settled prior to suit in this case for $1,195,000.

What this means to you: "Until the time that this patient had the unfortunate luck of encountering a third-year resident who was not only overly confident, but also appeared totally unaware that he was way beyond his scope, the patient received appropriate treatment given his situation," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL. The emergency squad accurately assessed the man for a potential spinal injury and transported him using appropriate precautions such as a back board. While it was not explicitly mentioned, a stiff collar is typically utilized to prevent the injured individual from rotating the neck and causing additional trauma.

Once at the hospital, the patient received a CT scan that was certainly appropriate, given the facts surrounding his injury and his symptoms. In fact, at this point, a neurosurgeon should have been contacted. If such a specialty was not readily available at the receiving hospital, the patient should have been transferred to a facility with a higher level of care.

There was no discussion in the narrative regarding the scope of services available at the local community hospital to which the patient was initially transported. Given the absence of specific language, one may deduce that the community hospital did not have big-city trauma capabilities. In most cases, patients with that type of injury are triaged at the local community emergency department and transported, frequently by helicopter, to a designated trauma center. The hospital did not pursue that course of action and, having not done that, may have been guilty of its first act of negligence in this case.

A trauma center is equipped to provide

comprehensive emergency medical services to patients suffering traumatic injuries. Trauma centers were established because the medical establishment has come to realize that traumatic injuries often require complex and multidisciplinary treatment, including surgery, in order to provide the patient with the best possible opportunity for survival and recovery.

To qualify as a trauma center, a hospital must meet certain criteria as established by the American College of Surgeons (ACS). Trauma centers vary in their specific capabilities and are identified by "Level" designation: Level I (Level 1) being the highest, to Level IV (Level 4) being the lowest. Higher-level trauma centers will have trauma surgeons available, including those trained as neurosurgeons and orthopedic surgeons. Such centers have highly sophisticated medical diagnostic equipment and the technicians and physicians trained to use such equipment. Lower-level trauma centers may be able only to provide initial care and stabilization of a traumatic injury and arrange for transfer of the patient to a higher level of trauma care. Studies have confirmed that trauma centers save lives and that patients treated at trauma centers are more likely to survive their injury and be alive one year following the event which caused the trauma injury.

A Level I trauma center provides the highest level of surgical care to trauma patients. It has a full range of specialists and equipment available 24 hours a day and admits a minimum required annual volume of severely injured patients. Key elements include 24-hour in-house coverage by general surgeons and prompt availability of care in varying specialties such as orthopedic surgery, neurosurgery, anesthesiology, and emergency medicine.

A Level II trauma center works in collaboration with a Level I center. It provides comprehensive trauma care and supplements the clinical expertise of a Level I institution. It provides 24-hour availability of all essential specialties, personnel, and equipment. Minimum volume requirements may depend on local conditions. These institutions are not required to have an ongoing program of research or a surgical residency program.

A Level III trauma center does not have the full availability of specialists, but does have resources for emergency resuscitation, surgery, and intensive care of most trauma patients. A Level III center has transfer agreements with Level I or Level II trauma centers that provide backup resources for the care of exceptionally severe injuries.

As a community hospital, it is likely that the ED was designated at a minimum a Level III or possibly the lower Level IV designation. This level of care provides initial evaluation, stabilization, diagnostic capabilities, and transfer to a higher level of care. It also may provide limited surgery and critical care services as defined in the scope of services of trauma care, but such services are limited to availability of the specialty required given the nature of the injury. A trauma-trained nurse is immediately available, and physicians are available upon the patient's arrival to the ED. Transfer agreements exist with other trauma centers with higher levels when conditions warrant a transfer.

The narrative refers to an orthopedic consult, but the possibility also exists that the resident's specialty was emergency medicine — not orthopedics. Had he called his supervising physician, the senior physician would have transferred the patient rather than risk serious complications due to limited availability of services at the community hospital.

A fracture of the C7 facets, full thickness anterior subluxation of C6 on C7, and bilateral interlocking facets with the probably of central spinal canal compression is a neurologic emergency. In this case, a higher level of care was certainly warranted, and an existing transfer agreement would have mandated that the patient be transferred to a center with the immediate availability of a neurosurgeon. Even the average orthopedic surgeon may have been out of his or her element for that type of injury, given the severe consequences of improper intervention.

There was no description of the clinical specialty of the resident or his immediate supervisor. The narrative refers to an orthopedic consult, but the possibility also exists that the resident's specialty was emergency medicine — not orthopedics. Had he called his supervising physician, one must believe that given the facts presented, the senior physician would have transferred the patient rather than risk serious complications due to limited availability of services at the community hospital.

The extent of the patient's cord injury was not fully established. Direct injury, such as cuts, can occur to the spinal cord, particularly if the bones or the disks have been damaged. Fragments of bone (from fractured vertebrae, for example) or

fragments of metal (such as from a traffic accident) can cut or damage the spinal cord. Direct damage also can occur if the spinal cord is pulled, pressed sideways, or compressed. This may occur if the head, neck, or back are twisted abnormally during an accident or injury. Bleeding, fluid accumulation, and swelling can occur inside the spinal cord or outside the spinal cord (but within the spinal canal). The accumulation of blood or fluid can compress the spinal cord and damage it. None of those possibilities appeared to have been evaluated by the resident.

The next major error in judgment was the resident's decision to apply a halo device without consulting a neurosurgeon. A neurosurgeon would have had the greater expertise in determining the extent of injury and the proper course of treatment. A halo is an external fixation device for the spine. It provides traction in the manner described but requires specialized training and competency to safely initiate the application of the device as well as maintain it over a substantial wear period.

In most cases, the application of a halo device is done after a neurosurgeon has evaluated the patient and determined that there is no evidence of cord compression, and a surgical reduction and fixation is not necessary as an initial intervention. While a halo may be utilized after surgery, it is not common for that to occur. Rather, a hard plastic collar is utilized to maintain the surgically established alignment.

Halos are generally used when surgery is not necessary and the cord is not compromised or at risk of being damaged, but some sort of method is necessary to maintain anatomical alignment while the fracture heals. In this case, the patient had experienced a subluxation, and a compromise of the central cord was probable. The subluxation would need to be reduced into alignment without further compromise to the cord. Such a maneuver clearly would be a neurosurgical intervention.

The resident attempted a treatment for which he was either untrained or not fully competent. His failure to respond to the patient's warnings that he felt the pins slipping indicated a callous disregard for the patient's well-being and a serious lack of professional judgment. As a result, the man suffered an additional injury that has ensured a lifetime disability that may have been avoided had the patient been transferred to an appropriate level of care.

The resident's obvious bumbling in his attempt to stabilize the man's fracture may be indicative of the hospital's failure to properly credential and determine the practitioner's skill level at various tasks. The credentialing process not only verifies the practitioner's education, licensure, and certifications, but also assesses and verifies the competency of certain technical skills that would fall within the scope of the individual's specialty. In this case, the resident's specialty was unknown, and there is no indication as to where this procedure would fall within his training and scope of practice.

In a teaching environment, the liability is shared by the institution that is responsible for the resident staff and the hospital itself. The resident most likely was not fully competent in such a risky procedure and should not have attempted it without backup support. At the very least, his supervising physician should have been on site and overseeing the procedure, and a neurosurgeon should have been consulted prior to any attempt to apply the device.

Either the resident failed to follow the chain of command or the hospital failed to assert its policy in this regard. Either way, the hospital had liability and was smart to reach a settlement. The hospital had little evidence to substantiate its claim that the diving injury was responsible for the patient's sudden deterioration, and it would have been unusually difficult to find expert opinion that supported that contention.

Settling for slightly less than $2 million represents a serious loss but is hardly a fraction of what the cost may have been had the individual suffered full tetraplegia and could not return to gainful employment. The case provides a clear example of the amounts juries are willing to award in botched halo cases precisely because the consequences of negligence are extremely severe. The hospital must have fully considered the amount a jury may have awarded for what would have no doubt been portrayed as an act of premeditated negligence. Given the potential for lifelong injuries as a result of the improper fitting of halos, hospitals should be certain that halo fittings and maintenance are pursued only by physicians who have received proper training and experience with spinal cord injuries, and that a proper analysis is conducted as to whether the current hospital is the most appropriate setting for treating such injuries.

(Editor's note: This case had an anonymous plaintiff and defendant and was settled prior to trial. No case reference is available.) ■

HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

URAC unveils revisions to its health information standards

Risk assessment and training highlighted

Washington, DC-based URAC, an independent, nonprofit accreditation organization, has unveiled significant revisions to its health information technology standards. The changes affect health web site accreditation and URAC's HIPAA Privacy and Security standards.

For example, the HIPAA standards have been revised to emphasize the need for annual workforce training. They also clarify notice of privacy practices to consumers, including notice of material changes in privacy practices. (URAC was originally incorporated under the name "Utilization Review Accreditation Commission, " but the name was shortened to "URAC" in 1996.)

URAC-accredited organizations also are now required to conduct a risk assessment, which must include an analysis of the use of portable media such as USB drives and laptop computers.

Given how long it has been since HIPAA was passed, and the fact that URAC initiated HIPAA standards in 2000, why did the organization feel such revisions were necessary at this time? "As an accrediting body, we slowly develop and enhance our standards to raise awareness," explains **Christine Leyden**, vice president and chief accreditation officer at URAC. "For example, we made some revisions so that training would be a little more advanced, due to some of our more recent research findings. We found the need to strengthen the ability to ensure that whether handled in-house or with a contractor, staff training was a continuous process."

URAC's training expectations

In addition to requiring annual workforce training, who does URAC feel should be trained, and what should that training comprise? "You should have training for all employees, physicians that come out to the facility, as well as vendors who are on-site at the hospital that may have access to personal health information — like subcontractors on pharmacy staffs," says Leyden.

She adds that training should consist of a number of key elements, including the organization's privacy practices, what might be disclosed under whistle-blower protection, work force member crime victim exceptions, and the need for documentation of the training. "Most importantly, the staff should be aware of hospital sanctions that may occur if there is inappropriate release of PHI [personal health information] — be it termination, retraining, and so forth," notes Leyden.

Training program must-haves

The following is a more complete description of what a training program should consist of, according to URAC:

• The organization has a clearly defined organizational structure outlining direct and indirect oversight responsibility throughout the organization.

• The organization has an ongoing training program that includes:

(a) Initial orientation and/or training for all staff before assuming assigned roles and responsibilities;

(b) Ongoing training, at a minimum annually, to maintain professional competency;

(c) Training in current URAC standards as appropriate to job functions;

(d) Training in state and regulatory requirements as related to job functions;

(e) Conflict of interest;
(f) Confidentiality;
(g) Training on identification and prevention of fraud and abuse, as appropriate to job functions;
(h) Delegation oversight, if necessary;
(i) Documentation of all training provided for staff.

Documentation through risk assessment

One of the key standards that was enhanced, says Leyden, was documentation through risk assessment. "You can't have [HIPAA] compliance without it," she argues. "For example, if patients in your hospital enter through the ED, or through the admission process, does that [electronic] chart go with them? What are the areas of possible breaches? How are claims sent to insurance companies? How are they handled in your medical claims department? It is through risk assessment that you can try to mitigate any areas of breaches."

Karen Trudel, deputy director of the Centers for Medicare & Medicaid Services Office of e-Health Standards and Services, agrees. In a prepared statement that coincided with URAC's release of its new standards, she noted that risk assessment is a basic expectation of HIPAA compliance. "You cannot have a security plan unless you know where the risks are and where they will come from, the potential severity of them, and the likelihood that the risk will occur," she said. "That is absolutely critical and basic to developing a security plan."

There was an important security reason for adding portable media to the revised risk assessment plan, says Leyden. "We know of high-profile breaches that have occurred due to this type of media," she explains. "For example, many people now use hand-held devices; how do you secure them? Do they prohibit access to the Internet, so there is no risk of tapping into the mainframe or accessing medical records?"

Flash drives, USB drives, and laptops all have "high vulnerability," Leyden adds. "You've got to ask yourself if they're encrypted; there is encryption software available so that if something is stolen, after several attempts by the thief to log in, it will be wiped out." Some software, she adds, also enables the organization to wipe out confidential information if it is reported lost. "That's why training is so important," she emphasizes, "so the staff will know what to do when equipment is lost or stolen."

Quality structure critical

In order for HIPAA training to be successful, URAC maintains, a quality structure should be in place to educate the staff. "The quality structure is responsible for several different areas: how the organization will monitor any potential complaints from users or consumers; how changes in privacy practices are pushed out to the organization as well as to the consumer; and how the organization will react when a breach does occur," says Leyden. "For example, do they do an analysis and walk through the process, workflow it, and re-educate the staff?" This oversight body, often headed by the chief privacy officer, must monitor all these processes, she explains.

"You must understand that education is a continuous process; it's not even enough to require annual training," Leyden continues. "It's important to do spot checks of the system because problems can be caused inadvertently. For example, one department may decide a software change is desirable, but if they do not report this change to the privacy department, it can make them vulnerable."

[For more information, contact:
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Guidance assists providers' understanding of HIPAA

HIPAA flexibility can cause problems

Oftentimes HIPAA standards are not as straightforward as a hospital leader might hope or expect — but that's by design, says **Beth Hjort**, RHIA, CHPS, professional practice resource manager for the American Health Information Management Association (AHIMA).

Take, for example, the guidance issued this fall by HHS' Office for Civil Rights (OCR), titled "A Health Care Provider's Guide to the HIPAA Privacy Rule: Communicating with a Patient's Fam-

ily, Friends, or Others Involved in the Patient's Care," which was aimed at helping health care providers avoid unnecessarily withholding patient information from those who are permitted to have it. **(See "HHS guidance emphasizes what can be divulged," *HIPAA Regulatory Alert*, November 2008.)**

"HIPAA is written flexibly, and that's a good thing," says Hjort. "It's also necessary because there are different state laws that were in place before HIPAA was implemented."

However, she adds, in the quest to write the act reasonably and flexibly, specifics are often lacking — and this is one of those instances. "In the case of this particular standard of HIPAA, every organization needs to come up with its own approach," Hjort says. "It's likely to come out in many different ways depending on how someone interprets what they read."

Ironically, she notes, this interpretability is in part what led to the guidance. "We've had media reports of situations where valid family members have not been able to get the information they needed to support loved ones, so in 2008 OCR under HHS wrote this guidance to help."

Responding to the guidance

The guidance, Hjort observes, is divided into two broad categories. The first deals with the sharing of information when the patient is present and has the capacity to make health care decisions. The second deals with cases where a patient is not present or incapacitated.

"The high-level message is that the patient decides whenever possible, but there will be times when the patient is not there," notes Hjort. "Sometimes, the caregiver will default to past preferences; for example, if they know that in the past the patient has decided a certain way or always gave permission to the ex-husband or spouse." At all times, she adds, the ruling consideration should be what is in the best interests of the patient. "To do anything less would impede care," she asserts.

In fact, Hjort continues, providers are guided to have reasonable assurance that the patient formerly has included this person in their realm of openness. "We would pause a little longer, and take more precautions, when dealing with who does not fall in that category — such as an estranged relationship. Here, the caregiver must consider what they know and use their best professional judgment," Hjort asserts.

Taking the extra step

In cases where a standard — or even a guidance — is intentionally broad, Hjort says many hospitals will err on the side of caution. For example, this guidance refers to people claiming to be family members requesting information over the phone. "This can be sticky, because you have no idea who is calling," Hjort notes. "While HIPAA does say it is not the organization's responsibility to validate the truth, it does say that if the person on the phone does not state they are a family member or friend, special precaution should be taken."

What some organizations are doing, she says, is putting in place a system whereby the patient is in greater control — and that, she notes, "is at the base of the privacy rule." Such a system works like this: The patient is given a code number — say the last three digits of his or her hospital account number. "This way, access to information is controlled because the code is only given out to people the patient is comfortable sharing information with," Hjort explains. In addition to code numbers, a birth date or password might also be used, she says.

What about documentation?

Another area where the guidance is not proscriptive is that of documentation. HIPAA does not require the provider to document the decision to share information — but doesn't that create the potential for liability exposure?

This is a judgment call, says Hjort. "I think, in a normal patient care setting where activity is significant and communication needs to move swiftly, many organizations would not find documenting every decision to be practical," she concedes. "However, if there was a circumstance that seemed unusual and documentation would serve as a 'memory,' I would err on the side of documenting those circumstances. By doing what is in the patient's best interest and keeping things moving along, that is the most practical way for the organization to deal with this element; that's one of the reasons it was written so flexibly."

Hjort strongly recommends that those who work in privacy and leadership roles stay up to date with any changes or additional guidance provided about HIPAA. "With the privacy and security rule, online guidance regularly comes out," she notes. "Once that information is

known, the privacy program should call for updates, reminders, and keeping staff current in whatever manner you teach the staff. You might do it as an inservice at the department level, through online training, and you may update your policies and procedures so the changes are communicated throughout the work force. This can both help you clarify your policies and teach your staff at a more granular level, so they become more aware of how they might deal with these questions."

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What if HIPAA conflicts with your state's law?

Disclosure isn't always prohibited

According to **Jill M. Steinberg**, a health care attorney with Baker Donelson in Memphis, TN, the Health Insurance Portability and Accountability Act (HIPAA) would prevent an ED physician from discussing a patient's HIV status with any other person, even if that person could be potentially exposed to an infectious disease.

Instead, the ED physician should do what he or she can to obtain permission from the patient to disclose the information and/or make a strong recommendation to the patient to disclose his or her HIV status. "The physician should also document in the patient's record that he was counseled to avoid unprotected intercourse, stop using drugs, and warn all of his sex partners of their potential exposure," she says.

It is unlikely that a successful lawsuit could be maintained against the emergency physician for failure to tell a patient's girlfriend of his HIV status even if she becomes infected, since HIPAA prevents the disclosure, says Steinberg. "Without permission or a health care power of attorney, there are very few, if any, scenarios, wherein an ED physician or nurse would be legally able to divulge patient information unless the patient is incompetent or comatose," says Steinberg.

There appears to be no private right of action for a HIPAA violation. Patients complaining of violations are required to file their grievance with the Office of Civil Rights. However, suits may be filed by patients alleging a breach of confidentiality based upon state law rights of privacy.

There may be situations in which state law and federal law are in conflict, such as states that require the physician to notify a sexual partner or local health organization of the patient's status as HIV-positive. "Failure to notify may put the physician in violation of state law. But notifying a nonpatient of the patient's status would be in violation of federal law," says Steinberg.

However, ED physicians likely will not violate HIPAA by complying with a state statute that permits or requires reporting known contacts of an HIV-positive individual to a public health agency. "Such reporting probably would fall under the HIPAA exception for public health activities, so those state laws would not be contrary to HIPAA," says **Erin McAlpin Eiselein**, a health care attorney with Davis Graham in Denver.

Eiselein adds that there is a "good argument" that an ED physician notifying a contact or a local health agency about a possible HIV infection would not violate HIPAA for the reason that there is an exception for disclosures to avert a serious threat to health or safety. Steinberg points to a Wisconsin case that found that an emergency medical technician invaded the privacy of an overdose patient when she told the patient's coworker about the overdose.[1] In a Michigan case involving a pharmacy employee who loudly blurted out a patient's HIV status in a crowded waiting room, the court of appeals upheld a jury verdict of $100,000 for slander, invasion of privacy, intentional infliction of emotional distress, and violation of a Michigan statute that protects the confidentiality of HIV results.[2]

Before HIPAA, physicians had been sued for failure to disclose to third parties in limited instances, notes Steinberg. A physician was successfully sued in a case involving the failure to warn family members of the possibility that they also had been exposed to Rocky Mountain spotted fever when a relative had died of the disease.[3] "With HIPAA now in effect, these lawsuits probably not be successful if filed today," says Steinberg.

References

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2. *Doe v. American Medical Pharmacies Inc.* (unpublished), 2002 WL 857766 (Mich. App.).
3. *Bradshaw v. Daniel*, 854 S.W.2d 865 (Tenn. 1993). ■