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Changing state marijuana laws shake up drug policies at hospitals

Will you have to allow its use when legalized?

With more states legalizing or decriminalizing the use of marijuana, hospital risk managers are forced to consider the implications for their drug use policies and testing programs. Many questions remain unanswered as healthcare providers deal with this new development.

Will you have to accept the smell of marijuana drifting from the employee break room? Can you still test for marijuana use? Can you prohibit use of the drug on an employee's off hours?

Will you have to accept the smell of marijuana drifting from the employee break room?

Healthcare providers in the affected states are in uncharted territory, and others should watch their response, says **Cheryl D. Orr**, JD, a partner with the law firm of Drinker Biddle & Reath in San Francisco. Only two states — Washington and Colorado — have legalized marijuana, but Orr says the law is in flux and more states could follow. Also, several states have enacted laws that reduce criminal penalties or provide exceptions or defenses for medical marijuana use.

Regardless of the legal status of marijuana, hospitals still can regulate its use in the workplace, Orr says.

"In those jurisdictions where marijuana has been legalized, hospitals, like other employers, may have to tread more lightly when it comes to taking adverse actions against employees who are off-duty marijuana users," Orr says. "However, given that it can impair functioning, hospitals likely do not need to concern themselves with the effect of legalization on maintaining drug-free workplaces. Just as hospitals can prohibit on-duty alcohol use, they can prohibit on-duty marijuana use in the current legal landscape."

Colorado attorney **Thomas J. Overton**, JD, a partner with The Overton Law Firm in Denver, has been considering these issues since September 2013, when his state made recreational use of

INSIDE

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marijuana legal and allowed its retail sale. Overton says that legalization has prompted concern for all employers but healthcare providers in particular.

Orr notes that marijuana remains illegal under federal law. That fact means that in all jurisdictions where there is no state or municipal law regarding marijuana use, hospitals arguably are free to prohibit employees and contractors from using marijuana off duty, she says. Even medicinal marijuana can be prohibited, she says.

Overton underscores that point by noting that even aside from employment concerns, marijuana users can run into trouble with federal law enforcement even if the state says it doesn't mind.

"That's pretty important because it not only impacts the individual's outcome, but it can give the hospital administrator a basis for prohibiting its use," Overton says.

Some providers are establishing policies on marijuana use. MemorialCare Health System in Fountain Valley, CA, does not permit marijuana smoking on hospital property, even with a medicinal permit, says **John C. Metcalfe**, JD, FASHRM, vice president of risk management services. "Although marijuana has been legalized in California for medicinal use under a physician's supervision and prescription, its use is still illegal under federal law," Metcalfe says. "Therefore, a hospital allowing marijuana use even under a physician's supervision and prescription would be subject to search, seizure, and prosecution under federal law. That said, some physicians get creative and discharge their patients with a day pass so they can use their marijuana to help relieve what ails them."

Of the 22 jurisdictions that have enacted statutes permitting the medicinal use of marijuana, Orr says only six — Arizona, Connecticut, Rhode Island, Illinois, Delaware, and Maine — have placed limits on employers' ability to take adverse actions against employees based on their medical use of the drug. In addition, she says, supreme courts in California, Oregon, Washington, and Montana, and a Colorado court of appeals, all have held that employers are privileged to take adverse actions against employees who are medical marijuana users.

"Courts also have held that the federal prohibition on marijuana use

Executive Summary

Changing marijuana laws are raising questions about hospital policies on drug use. Risk managers are advised to assess their current policies, but you still can prohibit drug use.

- ✦ Legalization does not mean you have to allow marijuana use during work hours.
- ✦ In many cases, a hospital can prohibit off-duty use as well.
- ✦ Medicinal marijuana use might be protected more than recreational use.

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preempts any argument that an individual is protected from disability discrimination on the basis that they are a medical marijuana user," she says.

The issue can be trickier in some states — including California and Colorado — that have laws that prohibit employers from taking adverse actions against employees for "lawful" off-duty conduct. Terminated employees have argued that such laws protect them from adverse employment actions based on their medical marijuana use, Orr explains. The law has not been tested sufficiently to know with any certainty how courts will judge the issue, but a few courts have rejected such claims, Orr says. *(See the story on p. 40 for more on how case law affects these decisions.)*

"It appears that except where a statute provides to the contrary, in most states that have legalized medical marijuana use, it appears that courts will permit employers, including hospitals, to prohibit off-duty use," Orr says. "With those statutes in place, the employer is more constrained."

To further complicate the matter, Orr notes that the limits placed on employers can differ when the marijuana use is medicinal, rather than recreational. In the six states that have enacted explicit employment protections for medical marijuana use, employers may not prohibit off-duty medical use of marijuana.

"Of course, these enactments do not disallow hospitals from prohibiting the use of marijuana at work and maintaining a drug-free workplace. Likewise, employers in these states may prohibit off-duty recreational marijuana use by individuals who do not fall within the ambit of the relevant medical marijuana legislation," Orr says.

Hospitals that receive federal funding or are subject to federal drug-testing or drug-use restrictions — that would be most hospitals — are free to continue to prohibit use of marijuana when off duty, Orr says. "Any state enactments to the contrary likely would be considered preempted by a court, and the statutory employment protections in several states take this into account," she says. "For instance, the employment non-discrimination provisions in both Arizona and Delaware expressly carve out employers who would lose monetary- or licensing-related benefits under federal laws or regulations." *(See the story on p. 40 for more on assessing your drug policies.)*

The most important step for hospital risk managers, he says, is to notify employees of how the hospital will respond to marijuana use.

In addition, Orr notes, the Department of Transportation (DOT) regulates and provides drug testing requirements for certain safety-sensitive positions, so it is "unacceptable for any safety-sensitive employee subject to drug testing under the Department of Transportation's regulations to use marijuana." That federal position on safety-sensitive positions could be used to support a hospital's prohibition on all use of marijuana, she suggests. *(See the story on p. 40 for more on a hospital's right to prohibit marijuana use.)*

The DOT definition of marijuana impairment — 50 ng/ml of THC, the active ingredient in marijuana, in the blood — is a good threshold for hospitals to use, Overton suggests. The most important step for hospital risk managers, he says, is to notify employees of how the hospital will respond to marijuana use.

"It is only normal for employees to wonder how the changing drug laws will affect their employment, and I'm afraid the most likely conclusion is that it's legal so you can't be terminated for doing it on your off hours," Overton says. "That is not necessarily the case, but you can get into problems if you don't have a clear policy and follow it, and if you don't clarify the situation with employees."

State law can vary widely and could influence how hospitals address the situation, says **Kevin Troutman**, JD, an attorney with Fisher and Phillips in Houston. He notes that some hospitals prevent tobacco use by employees, even off duty, but some states prohibit that policy.

"If you are able to prevent marijuana use, you can expect some level of pushback from employees," Troutman says. "Your response should be that even with legal substances, you can establish a threshold at which you determine the usage affects job performance and amounts to a violation of your drug policy. The hospital is within its rights to set a low bar for the use of marijuana on the grounds that its use can affect performance and safety."

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Assess current drug policies in light of pot legalization

Risk managers in states in which marijuana laws are being relaxed should assess their current drug policies and testing requirements to determine if they should be revised, advises **Cheryl D. Orr**, JD, a partner with the law firm of Drinker Biddle & Reath in San Francisco.

Administrators in other states also should go ahead with an assessment, she says. Revisions might not be necessary immediately, but an early analysis can put you in a better position if your state follows the lead of others on marijuana laws.

Hospitals in Arizona, Connecticut, Rhode Island, Illinois, Delaware, and Maine should revise their policies to the extent that they prohibit off-duty medical marijuana use, Orr says.

A careful assessment is necessary because in those jurisdictions that have enacted employment protections for medical marijuana use, Orr says hospitals face potential liability related to any adverse employment actions they take against employees or applicants who are medical users.

"To avoid these risks, hospitals in such jurisdictions should carefully review their policies and practices to ensure that they are compliant with the applicable law," she says. "In addition, hospital risk managers in all jurisdictions should consider following developments in marijuana legalization in their respective jurisdictions and may wish to obtain qualified employment counsel to assist with compliance."

Orr suggests that employers in states that generally do not provide for employment protections still should consider whether their state has a "lawful activities" or "lawful products" statute or whether courts in their state might be more favorable to finding a clear public policy protecting medical marijuana users. Past cases suggest that courts in these states likely will find that their state law does not establish a clear public policy in favor of medical marijuana patients, she says.

Drug testing is another issue to consider. Employees are likely to contest positive test results for marijuana, particularly because marijuana metabolites remain in an individual's system for a long time. The employees are likely to argue that they were not impaired while working and the positive test was caused by past recreational use in a state in which it is legal. Hospitals in most states can stand firm on their complete prohibition on the drug, but you can count on more resistance from employees, Orr says. ✦

Case law provides some employer support

Although there are many unanswered questions about the civil protections afforded hospital employees who use marijuana, there is enough case law to suggest that the legal system will stand behind hospitals that do not want their employees using the drug, says **Cheryl D. Orr**, JD, a partner with the law firm of Drinker Biddle & Reath in San Francisco. She provides this summary of recent statutes and case law:

• Medical marijuana patients' civil protections are not clearly defined in the statutes of most of the states that have enacted a medical marijuana law, Orr says. Supreme courts in California, Oregon, Washington, and Montana have all upheld employer decisions to discharge employees that were medical marijuana patients, she notes. The courts have held that the medical marijuana statutes in their state only protect patients from criminal sanctions and do not create any civil remedies or protections, Orr explains.

• A plaintiff in Colorado recently argued that an employer's decision to discharge a medical marijuana user who fails a drug test violated the state's "lawful activities" statute. Colorado, like many states, prohibits employers from taking action against an employee for engaging in lawful activities or using lawful products outside of the workplace. The Court of Appeals of Colorado held that the state's "lawful activities" statute did not bar the employer from discharging an employee who tested positive for marijuana after a random drug test and who was also a licensed medicinal marijuana patient.

• In Connecticut, Maine, and Rhode Island, medical marijuana patients are given protected status and employers are prohibited from discriminating against an employee merely due to their status as a medical marijuana patient. Illinois is considering a bill with similar protections. ✦

Hospital has 'absolute right' to prevent drug use

Hospitals have an "absolute right" to prohibit drug use by employees, says **David Scher**, JD, principal with The Employment Law Group in Washington, DC. The legalization of easing of criminal statutes regarding marijuana does not preclude hospitals from forbidding the use of marijuana even when

off duty, he says.

The key fact is that marijuana use is still illegal under federal law, Scher says. Colorado and other states might declare that their law enforcement agencies will not prosecute the use of marijuana, but it is still a federal crime, and that designation gives hospitals leeway to prohibit it even on an employee's free time, he says.

"It's kind of like the gay marriage issue, where there is no definitive answer until it's addressed at a federal level," Scher explains. "The federal law preempts the state law, so hospital employees cannot get away with it, even if they do it off duty." ✦

System ordered to divest physician group or risk antitrust

In a first-of-its-kind ruling that should make risk managers worry, a federal district court judge has ordered a hospital to divest itself of a physician group practice because the judge says the deal created an unfair dominance in the market and violates antitrust laws.

The largest health system in Idaho, St. Luke's Health System based in Boise, had acquired the state's largest independent medical group, Saltzer Medical Group (SMG) in Nampa, as part of the system's efforts to create an accountable care organization (ACO). The plan might have worked too well, creating such a dominant force in the community that the court said no and ordered St. Luke's to unwind the deal. *(The full ruling can be found online at http://tinyurl.com/stlukesdeal.)*

The ruling sends a clear message that hospitals' acquisitions of physician group practices are not immune from antitrust scrutiny, says **Jason Greis**, JD, partner with the law firm of McGuireWoods in Chicago. As the trend toward hospital acquisition of physician practices continues, risk managers should carefully assess potential deals for antitrust violations, Greis suggests. *(See the story on p. 42 for more on the ruling.)*

Prior to this recent ruling, the Federal Trade Commission (FTC) had not challenged a hospital–physician group merger case in federal court, and so providers had no way to predict how courts would address such a challenge. This case suggests that the FTC staff are emboldened by recent victories in challenging hospital system mergers and now will be more likely to go after hospitals acquiring physician practices, Greis says.

Interestingly, the purchase price was not at issue in this case. St. Luke's paid about $28 million to acquire the physician practice. That amount is well below the $75.9 million threshold that requires a report to the FTC under the Hart-Scott-Rodino Antitrust Improvements Act. That purchase price might have led the administrators at St. Luke's to dismiss concerns about antitrust, Greis says.

... hospitals' acquisitions of physician group practices are not immune from antitrust scrutiny ...

"One of the lessons here is that antitrust can occur even with these smaller transactions, which physician practice acquisitions tend to be," he says. "Hospitals typically don't worry about the antitrust implications of their actions until they get to the Hart-Scott-Rodino threshold. This case says you also have to be cognizant of your market dominance in the geographic area."

St. Luke's cited the potential benefits to the community. Even the judge who ruled against the hospital applauded its efforts to improve the delivery of healthcare and agreed with the hospital that the acquisition would improve patient care. The FTC, the Idaho attorney general, and two of St. Luke's competitors argued that the transaction violated federal antitrust law and would increase healthcare costs to insurers and consumers. *(See the story on p. 42 for advice on avoiding such violations.)*

In siding with the plan's critics, the judge pointed out that the deal would include 80% of the primary care physicians in Nampa and the combined organization would be dominant in that market. The judge also concluded that, because the ACO would dominate the local market, the plan would lead to St. Luke's charging higher reimbursement rates from health insurance plans and increase the use of its ancillary services. The FTC cited St. Luke's previous acquisitions of hospitals and 30 phy-

Executive Summary

A hospital has been ordered to divest itself of a physician group practice it acquired. The federal district court judge says the practice acquisition violated antitrust laws.

- ✦ The acquisition was key to the hospital forming an accountable care organization.
- ✦ Antitrust violations can occur regardless of the purchase price.
- ✦ Risk managers should carefully scrutinize practice acquisitions.

sician group practices in the Magic Valley region of Idaho, which led to higher charges to insurers.

St. Luke's CEO **David C. Pate** issued a statement expressing disappointment in the ruling and suggested that ACOs and other facets of the Patient Protection and Affordable Care Act (PPACA) might be impossible to achieve if courts rule in this manner.

Greis notes that the antitrust risk is becoming more of a concern for hospitals and health systems because they are rapidly acquiring other providers in response to demand for ACOs and other healthcare reform initiatives. Such acquisitions typically promise increased referrals and revenue for the hospital or health system, and that benefit is fine up to a point, Greis says.

The tricky part is knowing how much you can benefit before crossing the line into antitrust, he explains. Greis suggests that a good rule of thumb is when 50% of the physicians in the community are employed or affiliated in some way with the hospital. At that threshold, you should look very carefully at the risk of antitrust.

"Hospital systems that are more successful in recruiting could see a problem if they are snapping up physician groups left, right, and center," Greis says. "If they have been the market dominance player and then they buy up all the dominant physician groups, their competitor could say that's just not fair. This ultimately comes down to issues of fairness for consumers and commercial payers."

SOURCE

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Court says deal would increase costs

The federal district court judge considering the antitrust allegations against St. Luke's Health System based in Boise and Saltzer Medical Group (SMG) in Nampa made clear in his opinion that he thought the community would be better served by allowing the merger, but he found the merged group would wield too much power in the market.

B. Lynn Winmill, JD, chief judge of the United States District Court also was asked by the plaintiffs to require St. Luke's to notify the Federal Trade Commission in advance of any future physician practice acquisitions, but he said that action was inappropriate. His opinion explains that the antitrust laws essentially require the court to predict whether the deal under scrutiny will have anticompetitive effects.

"The Court predicts that it will," he wrote. "Although possibly not the intended goal of the Acquisition, it appears highly likely that healthcare costs will rise as the combined entity obtains a dominant market position that will enable it to (1) negotiate higher reimbursement rates from health insurance plans that will be passed on to the consumer, and (2) raise rates for ancillary services (like X-rays) to the higher hospital-billing rates."

Winmill goes on to acknowledge that the acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes.

"The Court is convinced that it would have that effect if left intact, and St. Luke's is to be applauded for its efforts to improve the delivery of healthcare in the Treasure Valley," Winmill writes in the opinion. "But there are other ways to achieve the same effect that do not run afoul of the antitrust laws and do not run such a risk of increased costs. For all of these reasons, the Acquisition must be unwound." ✦

How to avoid antitrust when acquiring practices

Risk managers should take the St. Luke's ruling Idaho as a warning bell and carefully assess any plans for physician group acquisition, says **Jason Greis**, JD, partner with the law firm of McGuireWoods in Chicago.

He suggests risk managers pay attention to these lessons from the Idaho case:

• Don't think your lofty goals negate antitrust issues. Despite the push for better care coordination, patient outcomes, and efficiency, antitrust law still applies. In the Idaho case, the judge acknowledged that patients would be better off with the acquisition, but he still ruled that it violated the law.

• Analyze the impact on market share before acquiring physician groups. It might be up to the risk manager to put the brakes on a deal when everyone else is enthusiastic about it. Remind the C-suite executives that antitrust violations can be costly and so can unwinding a deal after it is made.

• The purchase price might not be as important as the effect on market competition. Your competitors in the market will raise a ruckus if the deal means they are effectively shut out of most of the healthcare business.

• Include "unwind" provisions in

the transaction documents. Greis suggests a statement such as, "In the event that we are required to unwind this transaction due an opinion from the Federal Trade Commission or the state attorney general regarding competitive concerns, the parties agree that the costs of the unwind will be borne by each party in the following way: ..." The division of costs is a negotiable item, and putting the provision in the documents reminds all parties that such an unwind is possible, which should encourage more scrutiny of the antitrust issue. ✦

Mental health parity act creates new, increased risks

Are you ready for an influx of mental health patients and the potential risks they bring? The Mental Health Parity and Addiction Equity Act (MHPAEA) requires many insurance plans to cover mental health or substance use disorders more than in the past, and that change will mean more mental health patients in your facility.

Historically, millions of Americans with disorders related to mental health and alcohol, drug and substance abuse have not had adequate insurance protection to afford the costs of treatment, notes **David H. Smith**, JD, partner at Garvey Schubert Barer in Seattle. The MHPAEA now makes it easier for those Americans to obtain the care they need by prohibiting certain discriminatory practices that limit insurance coverage for behavioral health treatment and services. The MHPAEA requires many insurance plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions, Smith explains.

That increase brings potential problems that healthcare risk managers should assess, suggests **Roger L. Hillman**, JD, an owner with Garvey Schubert Barer. A higher volume of mental health patients brings a potential increase in violence and self-harm, Hillman says.

"It's not just that there is a higher tendency to violence among these patients. The issue is also that the increased patient load could mean you are spending less time with patients or seeing them less frequently," explains Hillman, noting that he has defended providers against those claims recently.

The risk is dependent on state law regarding the duty that healthcare providers have to third parties, Smith notes. Case law in the states varies on the issue, with some assigning more responsibility for the provider to protect others from danger when the patient is known, or should have been known, to have a propensity for violence. *(See the story on p. 44 for more on mental health-related lawsuits.)*

With mental health issues, you can be responsible for what happens to a third party who is not even on your property.

"This is not a traditional medical negligence risk. Many states have statutes or common law that establishes a provider's duty to warn or protect third parties," Smith explains. "This is a different concern from most that a provider has to worry about, where the duty is to the patient. With mental health issues, you can be responsible for what happens to a third party who is not even on your property."

There are concerns as to whether the present mental health care system, both public and private organizations, can handle the anticipated increase of patients who can now receive treatment, Hillman says. This increase could have an adverse impact on the frequency and length of treatment, which might be perceived as impacting its effectiveness, he notes.

While there is awareness of the MHAPAEA among many mental health practitioners, the related legal issues and the overall impact on the healthcare infrastructure still are emerging, Hillman says. In addition to the risk of lawsuits alleging that a provider should have known a patient could harm a third party, there also is the risk of the provider being sued for not preventing a patient suicide, he says. Healthcare providers also should assess whether their team approach to mental health is adequate, to ensure that the patient doesn't fall through the cracks. *(See the story on p. 45 for more on the team approach.)*

Executive Summary

The Mental Health Parity and Addiction Equity Act (MHPAEA) will increase the volume of mental health patients, which could increase liability risks. Providers can be held accountable for acts of violence by a patient.

- ✦ An increased patient load might degrade the quality of care to mental health patients.
- ✦ State laws vary on the duty owed to third parties harmed by a patient.
- ✦ Predicting violence in mental health patients is difficult at best and sometimes impossible.

Predicting future violence among criminal offenders is difficult, but predicting violence among the general population, who are not criminals and who are simply receiving treatment for a wide range of mental health issues, is nearly impossible, says **Richard L. Packard**, PhD, clinical and forensic psychologist in Seattle, who performs psychological and forensic evaluations with legal cases. "We have no well-established, scientific methods to understand whether a mental health client coming in off the street would be violent," Packard says. "There is a huge gray area with people who have never been violent and how to predict whether they will be violent in the future."

Mental health professionals are aware of the MHPAEA but do not appreciate all of the details of the law yet, Packard says. "There are lawyers around me every day who specialize in mental health law, and we're having discussions about the MHPAEA," he says. "No one really knows what to say yet. It's important to seek legal counsel and to understand all of the details of the law."

Hillman notes that most providers do not consider the risks from dangerous mental health patients until they are sued. Even brief and inconsequential treatment of a patient can draw a provider into a lawsuit years later, he says.

"When somebody shoots up a movie theater, they will find out that he saw a psychiatrist in your hospital two times and three years ago, and suddenly you're a party in the lawsuit," Hillman says. "All your records become discoverable, and they will go over them with a microscope until they find something. They will be able to get someone to come in and say what you did with that patient was inadequate."

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Hospital's deep pockets will invite claims

When a mental health patient commits a violent act and harms another person, the provider will most likely be named as a defendant in subsequent lawsuits, says **Roger L. Hillman**, JD, an owner with the law firm of Garvey Schubert Barer in Seattle.

Hillman offers this hypothetical situation: A patient commits a violent act, and treatment records reflect that the frequency and length of sessions are either the same throughout treatment, regardless of situation, or have been adversely impacted by increased patient load. Victims might claim that either or both frequency and length of sessions violated the standard of care and lack of adequate treatment caused or contributed to the violent incident. How will the hospital defend itself?

In Washington state, there was recent litigation involving a school district and a number of mental health providers, who were named as parties to a lawsuit after a violent stabbing was committed by a mentally ill high school student who was undergoing treatment around the time she committed the crime. Plaintiffs' counsel attempted, unsuccessfully, to point to the frequency of treatment and duration of each session as establishing liability on the part of the mental health providers, Hillman explains.

> *In any assault by a mental health patient, the healthcare provider is likely to be named as a defendant.*

"Every time there is a mass shooting in a school or a mall, the first question people ask is whether the shooter was undergoing mental health treatment and whether the provider knew he could be a danger to others," Hillman says.

In any assault by a mental health patient, the healthcare provider is likely to be named as a defendant, says **David H. Smith**, JD, an owner with the Garvey Schubert Barer firm. Victims will go after the provider with deep pockets because the patient is unlikely to have resources to compensate them. "They're going to argue that the mental health provider should have seen this coming and had a duty to warn or protect the injured parties," Smith says. "The argument can be effective, particularly if you have to go before a jury."

Many healthcare providers do not recognize this risk because it is not the usual type of lawsuit they face, so they don't spend time and resources preparing for such a one-off problem, Hillman says. That situation must change now that the risk is growing, he says.

One step is to make mental health physicians aware of the

increased risk and particularly the connection to length and frequency of visits. Risk managers or department heads can monitor case loads and, if necessary, improving the staffing levels to accommodate the increased volume of patients.

"Physicians probably won't like to hear your advice on managing their caseload, but you can sit them down and show them the risks," Hillman says. "Show how they are seeing twice as many patients as before, spacing them out more, and spending less time with them. Walk them through how a plaintiff would use this against them, saying that if he had spent half an hour more with this person on the last visit, he would have known about the danger to others." ✦

Team approach can help, but only if adequate

The increased patient volume from the Mental Health Parity and Addiction Equity Act (MHPAEA) can put pressure on a hospital's team approach to patient care, notes **Roger L. Hillman**, JD, an owner with the law firm of Garvey Schubert Barer in Seattle.

It is common for mental health problems to be treated with a team approach in which a psychologist provides therapy and a psychiatrist prescribes medication, and the patient might see other healthcare professionals as needed. The coordination of those services often comes up in lawsuits alleging failure to adequately assess a patient's care and propensity for violence, Hillman says.

"The psychiatrist sees the patient once a month for 10 minutes, and the question from the plaintiff will be whether he took the time to read the notes from the whole month of therapy before prescribing," Hillman explains. "The answer from the doctor will be that he didn't have time to do that. That answer will not serve you well."

The liability from such a lawsuit can be enormous, Hillman notes.

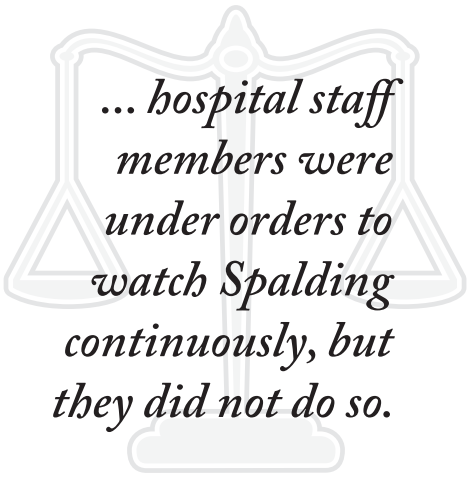
"If somebody shoots up a public place, you will be facing multiple claims for loss of life," he says. "Providers would prefer a medical malpractice case over that, I'm sure." ✦

Report finds hospital at fault in stairwell death

A state investigation into the death of a patient who was missing for 17 days before her body was found in a stairwell at San Francisco General Hospital has found the hospital and the nurses largely at fault for the death.

Hospital officials confirmed that 57-year-old Lynne Spalding disappeared on a busy fifth-floor corridor that passes a bank of elevators, a hallway to another unit, and numerous doors. Spalding had been admitted for complications related to an infection.

A report by the state health department, which investigated the incident on behalf of the Centers for Medicare and Medicaid Services (CMS), found that hospital staff members were under orders to watch Spalding continuously, but they did not do so. The *San Francisco Chronicle* obtained the state's report, which has not been released publicly. *(The full newspaper report is available online at http://tinyurl.com/stairwellreport. For more on the background of the case, see* Healthcare Risk Management*, December 2013, p. 142.)*



The report found that while it was clear Spalding needed 24-hour monitoring and a doctor had given written orders that she never be left unattended, nurses failed to record or fully heed that order, the newspaper reports.

Because Spalding had a frequent habit of getting out of bed, nurses disabled her bed alarm. She also was subject to periods of delirium, including an incident on Sept. 20, 2013, when she wandered to the nursing station and talked to them about working at an airport.

The next day, a doctor wrote an order that said "NEVER leave patient unattended."

A nurse on the unit told investigators that she "did not get a chance" to record the order for round-the-clock monitoring on Spalding's chart during a change of shifts. The patient disappeared two days later.

Without that order, nurses were instructed to keep Spalding under "close observation," checking on

her about every 15 minutes, the newspaper reports. When she disappeared from her room, the monitor assigned to her had been called away.

The report also cited the local sheriff's department for its failure to locate Spalding after she was reported missing. ✦

Imaging group to pay $15.5 million for false claims

Diagnostic Imaging Group (DIG) in Hicksville, NY, has agreed to pay $15.5 million to resolve allegations that its diagnostic testing facility falsely billed federal and state health care programs for tests that were not performed or not medically necessary and paid kickbacks to physicians.

DIG has agreed to pay $13.65 million to the federal government and an additional $1.85 million to New York and New Jersey.

The settlement resolves allegations that DIG submitted claims to Medicare, as well as the New Jersey and New York Medicaid Programs, for 3D reconstructions of CT scans that were never performed or interpreted.

Additionally, DIG allegedly bundled certain tests on its order forms so that physicians could not order other tests without ordering the additional bundled tests, which were not medically necessary. The settlement also resolves allegations that DIG paid kickbacks to physicians for the referral of diagnostic tests.

... the Justice Department has recovered a total of more than $19 billion through False Claims Act cases ...

According to the government, the kickbacks were in the form of payments that DIG made to physicians ostensibly to supervise patients who underwent nuclear stress testing. These payments allegedly exceeded fair market value and were, in fact, intended to reward physicians for their referrals.

The allegations resolved in the settlement were raised in three lawsuits filed under the *qui tam*, or whistleblower, provisions of the False Claims Act. The three whistleblowers, Mark Novick, MD, Rey Solano, and Richard Steinman, MD, will receive $1.5 million, $1.07 million and $209,250, respectively, as part of the settlement.

Since January 2009, the Justice Department has recovered a total of more than $19 billion through False Claims Act cases, with more than $13.4 billion of that amount recovered in cases involving fraud against federal healthcare programs. ✦

Health and Human Services addresses health IT safety plan with SAFER guides

The Department of Health and Human Services (HHS) is offering providers new tools to encourage safer use of electronic health records (EHRs).

A new set of guides and interactive tools to help healthcare providers more safely use electronic health information technology products, such as EHRs, is now available free of charge to healthcare providers.

The Office of the National Coordinator for Health Information Technology (ONC) at HHS released the Safety Assurance Factors for EHR Resilience (SAFER) Guides. These guides are a suite of tools that include checklists and recommended practices designed to help healthcare providers and the organizations that support them assess and optimize the safety and safe use of EHRs.

... all stakeholders have a shared responsibility to make sure that health IT is safely implemented ...

The release of the SAFER Guides is part of the implementation of the HHS Health IT Patient Safety Action and Surveillance Plan, which was issued in July 2013, explains **Jacob Reider**, MD, chief medical officer at ONC. "A basic premise of the Health IT Safety Plan is that all stakeholders have a shared responsibility to make sure that health IT is safely implemented and that it is used

to improve patient safety and care," Reider says. "The SAFER Guides combine the latest applied knowledge of health IT safety with practical tools that will help providers — working closely with EHR developers, diagnostic service providers, and others — effectively assess and optimize the safety and safe use of EHR technology within their organizations."

Each SAFER Guide addresses a critical area associated with the safe use of EHRs. Areas addressed include:

- high priority practices;
- organizational responsibilities;
- patient identification;
- computerized physician order entry (CPOE) with decision support;
- test results review and follow-up;
- clinician communication;
- contingency planning;
- system interfaces;
- system configuration.

Each SAFER Guide has extensive references and is available as a downloadable PDF and as an interactive Web-based tool. The SAFER Guides are available at http://www.HealthIT.gov/safer-guide. ✦

Risk managers meeting in Anaheim, CA, Oct. 26-29

Join the American Society for Healthcare Risk Management (ASHRM) at the 2014 Annual Conference & Exhibition, Oct. 26-29 in Anaheim, CA.

ASHRM leaders say attendees at the conference will enjoy these benefits:

- There will be more than 70 educational sessions designed to help you prepare for managing risk in the changing healthcare environment. There are programs in six specialized tracks — claims and litigation, enterprise risk management, legal and regulatory, patient safety, risk financing, and leadership development.
- Earn continuing education credits. This year's conference offers continuing education credit opportunities, helping attendees prepare for CPHRM certification and attain the association's FASHRM and DFASHRM designations.
- Connect face-to-face with peers during networking meals and receptions. More than 2,000 healthcare professionals will attend.
- Collaborate by sharing with your peers. Learn about successful risk management tools and strategies from healthcare professionals who implemented them firsthand.

For more information and to register, go to http://www.ashrm.org/ashrm/education/annual_conference2014. ✦

COMING IN FUTURE MONTHS

- ✦ How to handle whistleblower investigations
- ✦ Teaching compliance with EMTALA
- ✦ More HIPAA data breaches
- ✦ Huddles can improve safety

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

- describe the legal, clinical, financial and managerial issues pertinent to risk management;
- explain the impact of risk management issues on patients, physicians, nurses, legal counsel and management;
- identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

CNE INSTRUCTIONS

Nurses participate in this CNE program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Scan the QR code below, or log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you instantly. ✦

CNE QUESTIONS

1. According to Cheryl D. Orr, JD, a partner with the law firm of Drinker Biddle & Reath, how does the legalization of marijuana in a state affect the hospital's ability to regulate its use in the workplace?
   A. Regardless of the legal status of marijuana, hospitals still can regulate its use in the workplace.
   B. The hospital cannot regulate its use if the state legalizes recreational use.
   C. The hospital can regulate its use if the state allows medical marijuana but not if the state also legalizes recreational use.
   D. Regardless of the legal status of marijuana, hospitals cannot regulate its use in the workplace.

2. According to Orr, what does case law say about an employer's ability to prohibit marijuana use versus the person's protection under the Americans with Disabilities Act?
   A. Courts have held that a charge of disability discrimination supersedes the fact that marijuana is illegal on a federal level.
   B. Courts also have held that the federal prohibition on marijuana use preempts any argument that an individual is protected from disability discrimination on the basis that they are a medical marijuana user.
   C. There is not enough case law yet to determine any trend regarding discrimination claims and medicinal marijuana.
   D. Courts have held that state laws trump federal law regarding the legality of marijuana, so discrimination claims can be upheld.

3. In the antitrust case involving St. Luke's Health System and Saltzer Medical Group (SMG), why did a federal judge order the system to unwind the deal?
   A. The health system did not notify the Federal Trade Commission (FTC) before acquiring the physician group.
   B. The amount of money paid for the physician group was higher the amount allowed without involving the FTC in the transaction.
   C. The deal would result in the combined organization being too dominant in the geographic area it serves, and charges would increase for payers.
   D. The health system failed to disclose financial liabilities that could affect the revenue of the physician group.

4. Why will the Mental Health Parity and Addiction Equity Act (MHPAEA) result in increased liability risks for healthcare providers?
   A. It requires many insurance plans to cover mental health or substance use disorders more than in the past, and that change will mean more mental health patients receiving treatment.
   B. MHPAEA includes a provision that lowers the standard of proof in cases alleging negligence.
   C. It restricts some types of treatment that can be provided, but it provides no protection for a claim of malpractice.
   D. MHPAEA requires a level of treatment for mental illness that American healthcare providers can achieve.

Legal Review & Commentary

Expert analysis of recent lawsuits and their impact on healthcare risk management

Failure to recognize infection leads to sepsis and amputations, and $32 million settlement

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News: After complaining of a fever and inability to put weight on her right leg, an 11-year-old female was taken to the emergency department of a local hospital. The child had an internal infection that was quickly spreading. After waiting more than 24 hours for antibiotics, the child went into septic shock, then cardiac arrest, and ultimately organ failure. Tragically, the child's arms and legs had to be amputated to save her life. The child's mother brought suit against the hospital and five doctors responsible for the child's care shortly after the child was released from the hospital. Before going to trial, the hospital made the decision to settle the case for $32 million. However, pursuant to the terms of the settlement, the hospital did not admit fault.

Background: During the day at school, the child hit her knee while playing, but bounced back quickly. However, the following day, the child developed a fever and was not able to stand on her right leg. Because the child did not often complain about pain, the mother decided to take her to the local hospital for emergency treatment. Upon arrival, the triage nurse noted that the child was running a fever of 100 degrees Fahrenheit. The child remained under observation of the hospital, yet no medications were prescribed even after the fever jumped to 104 degrees. Despite worsening leg pain and an elevated white blood cell count, the physicians still had not started treatment with antibiotics or any other medication.

More than 24 hours after arriving at the hospital, the hospital staff finally began administering antibiotics.

More than 24 hours after arriving at the hospital, the hospital staff finally began administering antibiotics. However, the damage to the young girl's body already was irreversible. The child went into septic shock, which caused her blood pressure to decrease dramatically. Shortly thereafter, multiple organs were failing, and she was unable to breathe on her own. The child went into cardiac arrest but was stabilized.

During the following days, the young girl's limbs turned purple, as gangrene had developed in her arms and legs. The physicians made the difficult but necessary decision to amputate all four of the girl's limbs to keep her alive. For the next two weeks, the girl remained in a medically induced coma. Her mother was unsure whether she would survive. The young girl pulled through after spending two months in the hospital and then months in rehabilitation. Eventually the child learned how to walk around with her prosthetic legs and do basic tasks such as dressing

FINANCIAL DISCLOSURE: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Damian Capozzola**, **Jamie Terrence** and **Angelina Gratiano**, co-authors, have no relevant relationships to disclose.

herself.

Her mother brought suit against the hospital and the five treating physicians for medical malpractice and family damages after doing research on sepsis and realizing how crucial it was for the hospital to have acted quickly in treating her daughter. The mother claimed that the hospital failed to recognize that the child's vital signs and white blood cell count were consistent with sepsis and failed to provide the child with broad-spectrum antibiotic coverage within the first critical hours of the child's admission to the emergency department. Additionally, the hospital failed to admit the child to the pediatric intensive care unit for immediate care and treatment. The mother's complaint stated that as a proximate result of the hospital's multiple omissions, the child developed septic shock resulting in the amputation of her four limbs. Prior to commencing trial, the hospital agreed to settle the case for $32 million while denying culpability for the child's condition.

What this means to you: It is estimated that more than 750,000 people die each year from sepsis. Generally, the elderly population or persons with weakened or compromised immune systems are most vulnerable to sepsis. The quickly spreading infection is particularly dangerous because of how the body reacts to the infections. Chemicals are released into the bloodstream to fight the infection, which then causes systemic inflammation and eventually life-threatening damage to various organ systems. As sepsis worsens and further develops into septic shock, blood pressure significantly decreases, which often leads to the need for amputations, or death. It is always important to be alert for complications arising from sepsis.

Because the case did not proceed to trial, it remains to be seen what standards the hospital in question had regarding pediatric treatment for symptoms of sepsis. Many questions remain as to why the hospital chose to delay treatment for the broad-spectrum antibiotic treatment or even any standard course of antibiotic at all. What is most obvious is a repeated lack of action by the hospital staff to intervene.

The necessity for a standard triage protocol is crucial to the patient's outcome, and the hospital's ability to provide standard patient care cannot be overstated. A standard triage protocol is especially important for children, as their immune systems are more vulnerable and susceptible to infections. In this case, the plaintiff's medical experts alleged that child developed sepsis when she fell down at school prior to her hospitalization. Although there were no visible signs of damage or injury to the child's right leg, blood accumulated internally around the tissue damaged by the fall. While there were no external signs present when the child was admitted to the emergency department, the hospital staff should have followed some sort of procedure to determine if she had an infection and planned to treat it immediately. When the child entered the emergency department, she presented with a fever and an inability to put weight on her right leg. This presentation should have been enough for the hospital staff to immediately investigate an infection. Furthermore, despite laboratory results indicating an elevated white blood cell count, the hospital again neglected to provide the child with antibiotics to control the spreading infection. Had the hospital used an established pediatric triage protocol, and followed through with it, the child very well might have kept most, if not all, of her limbs.

Additionally, hospitals must be willing to forego diagnosing a patient based on one symptom in favor of a identifying and evaluating all the symptoms a patient presents with collectively and simultaneously. Too often medical professionals "follow the garden path" based on a primary symptom and overlook other symptoms or circumstances that might differentiate a given case from others with similar initial primary presentations. In this case, the child was admitted to the hospital with a low-grade fever, which likely did not warrant immediate treatment in and of itself. However, had the hospital staff considered the totality of the symptoms as presented, namely the fever, the recent fall, pain on ambulation, and an elevated white blood cell count, this should have raised serious concerns for the physician regarding sepsis. By neglecting to consider all the symptoms, physicians can misdiagnose a very serious condition that might lead to fatal results.

The Centers for Medicare and Medicaid Services as well as The Joint Commission expect that hospitals will comply with basic sepsis screening requirements for all patients coming in to their emergency departments. A screening tool is usually used to help emergency department staff quickly identify sepsis and severe sepsis. Elevated white blood cell counts accompanied by fever are two signs of sepsis that would trigger moving further along the tool's algorithm. A recent soft tissue injury must be considered as a source of infection, especially in the absence of upper respiratory symptoms, which is the most common source of sepsis in children. Even though the child's temperature was below 101 degrees Fahrenheit, which is usually the level indicative of sepsis, the recent knee injury should have been considered a significant part of the diagnostic screening. A simple CT scan of the child's knee would have shown the soft tissue swelling and fluid accumulation, the breeding ground for unwelcome bacteria. Intravenous antibiotics and fluids would have prevented the progression to severe sepsis and ultimately, septic shock that devastated this young child's frail body.

It is said that, in this case, laboratory results and scans were not ordered soon enough to determine the

source of the problem in an efficient and timely manner. Instead, laboratory results were ordered, and then the patient and mother waited hours. Then the physician reviewed the results. More time passed. Eventually more than 24 hours passed before a decision was made to provide the child with antibiotics. Had multiple possibilities been considered simultaneously, less time would have been wasted waiting prior to diagnosing the patient and administering treatment. All in all, although the settlement amount was substantial, by settling the hospital minimized the bad publicity surrounding the incident and avoided even greater potential liability.

Reference

Case No. 2013P005509(Cook County Circuit Court, Cook County, IL). Oct. 10, 2013. ✦

Negligent removal of tracheostomy tube results in $15 million verdict against hospital and doctor

News: Due to injuries suffered from a car accident, hospital staff inserted a tracheostomy tube to aid the breathing of a 17-year-old male. While still in the hospital one month after the tracheostomy, hospital staff removed the tracheostomy (trach) tube in anticipation of the patient's transfer to a rehabilitation hospital. However, upon removal the patient began experiencing difficulty breathing and tachycardia, and the tube was subsequently reinserted. Despite difficulty breathing without the trach tube, the patient was transferred to a rehabilitation hospital, where the tube once again was removed. Shortly thereafter, the patient went into respiratory distress and ultimately suffered anoxic brain injury. The boy's parents brought suit against the rehabilitation hospital and family practice physician who oversaw the removal of the trach tube, and they alleged negligence. The jury returned a verdict in favor of the plaintiff for $15.26 million after a month-long trial.

Background: Following a serious car accident, the 17-year-old male was admitted to a local hospital where a tracheostomy was performed. A tracheostomy is a surgical procedure in which a physician creates an airway by making an incision in the trachea. A tube is then inserted as an airway and to allow easy removal of secretions from the lungs.

Over the next few weeks of stabilization in the hospital, the boy's condition improved. The trach tube subsequently was removed. However, the boy experienced extreme difficulty breathing without the tube, so the tube was inserted again. Shortly thereafter, medical tests indicated that there was swelling in the patient's airway, but no treatment was provided to reduce the swelling. Capping off of a trach tube is standard practice before a patient's trach tube is removed. Generally, capping off trials are done to determine if a patient is able to tolerate the removal of the trach tube. If the patient does not respond well, the trach tube should not be removed at that time.

Eventually the patient was transferred to the rehabilitation hospital with direct orders that he return in two weeks to the hospital's surgical clinic for a checkup and to evaluate plans to downsize and cap off the trach tube. However, the appointment was not kept, and the boy was not evaluated by the hospital for removal of the trach tube. Instead, the rehabilitation personnel took initiative and starting capping off of the trach tube without advice or consent of the hospital's surgeon.

In this case, the boy experienced tachycardia and labored breathing after capping off of the trach tube. Despite this inability to tolerate the capping off trials, the family practice physician at the rehabilitation hospital decided to remove the trach tube. The boy continued to complain of difficulty breathing after removal of the trach tube, but the tube was not reinserted. The following morning, the boy complained that he felt as though something was stuck in his throat. No further tests were conducted. That same day the family practice physician administered a benzodiazepine to relax the patient and to allow for rest. Unfortunately, several hours later the patient went into respiratory distress. After waiting more than 20 minutes to call an ambulance, the patient was taken to the hospital; however, anoxic brain injury already had been sustained.

Additional testing showed that the boy had suffered subglottic stenosis. Subglottic stenosis occurs when there is a narrowing below the vocal chords and above the trachea. The underlying cause of the narrowing must be addressed to prevent any further complications. In this case, despite the boy's complaints that he felt like something was stuck in his throat, the rehabilitation facility made no attempts to treat or discover the cause of this feeling. Thus, it went untreated, which resulted in decreased ability to breathe.

The parents of the boy brought suit and alleged that the rehabilitation hospital and the family practice physician failed to replace the trach tube or otherwise act before it was too late to prevent the anoxic brain injury. On July 3, 2013, after five weeks of testi-

mony and 3-4 hours of deliberation, the jury found the physician and the rehab hospital negligent and awarded $15.26 million in damages.

What this means to you: This case highlights the need for communication. Had the staff members at the rehabilitation facility and the family practice physician maintained proper communication with each other, they might have been able to address the patient's concerns, specifically the patient's inability to tolerate the removal of the trach tube and narrowing of his airway.

A young person who has been breathing with the assistance of a tracheostomy tube should be able to be weaned off the tube fairly easily if there has been no local injury to the neck area. In this case, the fact that the patient developed respiratory distress following the first attempt at removal was significant. The noted swelling below the vocal chords might have been a reason to delay the transfer to the rehabilitation facility. However, if it was not treatable in the acute hospital, but a condition that would resolve itself in time, it should have been an indication to the receiving facility that the tracheostomy tube be left in place until the swelling had been assessed as resolved.

Before a patient from an acute hospital is transferred to a rehabilitation setting, typically a pre-admission assessment is done by staff in the receiving facility. This assessment includes a complete review of the patient's medical record and interviews with the patient and the patient's attending medical and nursing staff. The purpose is to ensure that the patient meets the qualifying requirements of the facility and can tolerate the rehabilitation program. Had this assessment been done as described, the receiving facility staff would have been aware of the patient's need to continue to breathe via the tube. Despite multiple complaints by the patient that he "felt something was wrong," the rehabilitation facility staff and the physician did not investigate further to find out if something was indeed wrong. Furthermore, because the rehabilitation facility staff and the physician were not communicating adequately with each other, they both failed to recognize changes in the boy's condition, namely the fact that he had been experiencing increased difficulty breathing during removal of the trach tube.

Another important point to be noted is that there must be adequate consultation with specialists anytime the patient's care requires knowledge outside of the physicians' scope of expertise and treatment capabilities. In this case, the rehabilitation facility failed to seek the assistance of additional specialists who would determine if there were any complications with the airway of the boy. Nor did the family practice physician ensure that the patient kept the appointment with the surgeon, as ordered to do so.

This tragic oversight could have been prevented had there been adequate communication by all medical staff. Here, the family care physician contended that she was not required to consult with a specialist prior to making the decision to remove the trach tube. The standard of care, however, is based on what a prudent medical professional would do under the circumstances. Physicians should request referrals and consultations from experts prior to making significant decisions related to a patient's care when the issues involved are not squarely within their areas of expertise. It is necessary to make it very clear that there is a professional medical standard of care that must be adhered to, and if current protocol does not appear to require it, perhaps that protocol should be reconsidered.

Lastly, and most importantly, it is crucial for orders from one medical facility to another be followed and implemented as ordered. In this case, orders from the hospital surgeon were not followed once the patient was transported to the rehabilitation facility. The orders were for the boy to attend a checkup two weeks after being transferred to the rehabilitation facility. Instead, the family practice physician made the decision to remove the trach tube without checking with the hospital's surgeon. The jury's verdict shows this decision fell below the required standard of care.

More generally, after transfer, admission orders usually are written by the receiving facility's physician based on the orders the patient had while in the acute hospital. What sometimes occurs is that the receiving nurse will transcribe orders from the medical records he or she receives from the sending hospital onto the order sheet used at the receiving facility. The new physician signs those orders as his or her own without a careful review of their relevance to the care of the patient. These orders seldom reflect the medical plan of care usually found in the physician's progress notes, which might or might not have even been sent with the transferring paperwork. This practice is not uncommon and is one that should be seriously reconsidered if happening in your facility.

When there are orders issued from one facility to another, a continuing and open line of communication also must be maintained to ensure that orders are followed exactly. Where there are differences in opinion as to those orders, medical facilities must ensure that physicians are required to consult and defer judgment to the appropriate specialist for that particular matter. Here, had the rehabilitation facility ensured that the hospital surgeon's orders were followed, costly mistakes would not have occurred without supervision by the appropriate specialist.

Reference

Case No. 4253(Weakley County Circuit Court, Weakley County, TN). July 3, 2013. ✦