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SARS: Risk managers must concern themselves with details others miss

Virus could reappear next flu season; now is time to prepare

If you're unsure what your hospital is doing to prepare for SARS, now's the time to get involved. The worst may still be to come with severe acute respiratory syndrome (SARS), say federal health officials who warn that the deadly virus is likely to reappear and cause deaths in the United States during the next flu season. Risk managers have a key role to play in preparing their organizations for SARS cases, which can pose special liability risks unseen with most other infections.

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Hospitals must prepare for potential SARS cases even if they are in an area that has not seen any infections, said Health and Human Services (HHS) Secretary **Tommy Thompson**. More than 7,700 people have been infected with SARS worldwide and more than 640 people have died from the virus, the HHS reports. Almost all of those cases have been in Asia so far, but the virus has spread to Toronto and other locations. Federal health officials say there have been at least 65 cases reported in the United States, though none of those cases resulted in death. Thompson recently warned that U.S. health care providers should not take those numbers as reason to let their guard down.

"I do not think SARS is going to go away," he recently stated publicly while in Brussels, Belgium, to meet with European Union officials. Thompson's office confirmed statements made to the press there. "Even though it may level off now, it could come back in the fall, and then you can, I think, anticipate that you will have deaths in all the continents. The virus knows no borders whatsoever."

For risk managers, Thompson's statements should be seen as reason to move forward with SARS preparations and not think the crisis has been averted. SARS poses liability risks that must be addressed by the risk manager even as your organization's infectious disease specialists take measures

to detect and prevent the spread of the virus.

When a hospital prepares for possible SARS cases, most of the responsibility clearly falls on the infectious disease specialists, with the emergency department and perhaps employee health following close behind. But the risk manager should be on the front lines as well, says risk manager **Gina Pugliese**, RN, MS, vice president of the Premier Safety Institute in Chicago. She says SARS is similar to recent concerns about smallpox, anthrax, and other unusual infections that may show up at the hospital without warning.

"All of those issues are so complex and have so many dimensions that the risk managers must play a role," she says. "The hospital has to look at these issues from the perspectives of infection control, cost prevention, confidentiality, and liability. You can't look at any one of those things in isolation."

The hospital's approach to SARS preparation should be multidisciplinary and the risk manager should be a major player at the table, Pugliese says. She compares the SARS crisis to the way hospitals responded to the early years of the HIV epidemic. There are so many complex questions and so many issues involved that the hospital must pull experts from many areas. A top priority for the risk manager should be keeping up with the latest information on SARS, available at the federal Centers for Disease Control and Prevention's (CDC) web site, www.cdc.gov/ncidod/sars/. The CDC web site is updated frequently and has specific advice for SARS infection control and a link to the World Health Organization web site.

"The smaller the hospital, the more the risk manager needs to keep up with information like that. There are so many competing priorities for each professional in every area that is affected by SARS that the risk manager may have to be the one who makes sure nothing slips through," Pugliese says. "As new guidance comes out from the CDC, you have to look at it from a risk management perspective."

Infection control and epidemiology will look at SARS from their perspectives, focusing on details such as air exchanges and what masks to wear. But the risk manager has to look at topics that may not be of concern to anyone else. For instance, Pugliese suggests asking yourself these questions:

- What kind of warnings will you post on doors warning of a possible SARS patient? What will the signs say? On which doors will they be posted? Should you have the signs printed in advance?
- Should you post information in the emergency department so that everyone knows there is a potential SARS patient in the area?
- What is your hospital's potential liability for not following the CDC guidelines?
- What do you owe to your employees in terms of keeping them up to date about the symptoms of SARS to watch for?
- Do you have staff traveling outside the country in areas experiencing SARS infections?
- Do you have visitors or students from another country with SARS cases?

Those were some of the questions posed by **Susan Kinter**, RN, JD, director of claims litigation and risk management at the University of Maryland Medical System in Baltimore. Though her organization has not yet seen any SARS cases,

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Editor: **Greg Freeman**, (770) 998-8455.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).
Production Editor: **Nancy McCreary**.

Editorial Questions

For questions or comments, call **Greg Freeman**, (770) 998-8455.

Kinter and the others in her office have been directly involved in preparing a response to the virus.

"Our role is to make sure that there is an infection control plan out there, meaning that if we have a patient with confirmed SARS or suspected SARS, the staff have an isolation protocol that they can put in place immediately," she says. "A major concern for us is not infecting other patients and we also worry about health care workers becoming infected."

Kinter recently was involved with deciding what to do with two University of Maryland health care workers who could have been exposed to SARS. One was visiting relatives in China and the other was doing a rotation at a hospital in Toronto. Both were headed back to Maryland soon. Before they arrived, the health system put together a team to decide what to do with them. That team was made up of Kinter and representatives from infectious diseases and human resources.

The three perspectives yielded different recommendations, with human resources being the most conservative and recommending that the workers be barred from work for a period of time. The infectious disease professionals said there was no clinical reason to assume the workers were infected (at that time, Toronto had not had a new infection in more than 20 days) and recommended that they be allowed to return to work if an initial health checkup showed no symptoms of SARS.

"My department took a middle position and said that if their initial health check was OK, they could return to work and then be checked every other day," Kinter says. "That was what we went with in the end, and they never showed any signs of infection." **(See p. 77 for more on how a Toronto hospital enacted work quarantines. See p. 78 for more on the legal implications of some decisions to quarantine workers.)**

Potential for major liability if infection spreads

The prime risk management concern for Kinter is the virus spreading to other patients or health care workers within the hospital. Pugliese agrees, saying there is the potential for significant liability if SARS spreads within your hospital, as has happened at hospitals in Toronto and in China. A hospital always it at risk for a lawsuit when a patient acquires an infection while being treated, but SARS ups that risk because it can spread so effectively through a hospital, Kinter says.

"I think that's the exposure from a liability standpoint," she says. "You have a real liability exposure there. If the patient comes down with SARS, they're going to look to your hospital and ask why you let that happen."

Kinter believes the high profile of SARS changes how the public, or employees, will view infections that originate in your facility. A more routine infection acquired in the hospital may not be seen as evidence of malpractice, but SARS probably will just because of the hype and hysteria. And SARS is potentially deadly, which could lead to claims that the patient suffered emotionally as he or she contemplated death, a claim less likely to result from common nosocomial infections. "It's been built up into something really scary and it's on the news every day. That always means somebody will be more likely to sue, more so than some infection they've never heard of."

Early detection and a quick response is crucial to prevent the spread of SARS in your hospital, says **Thomas Terndrup**, MD, FACEP, professor and chair of the department of emergency medicine and director of the Center for Disaster Preparedness at the University of Alabama at Birmingham. **(See p. 76 for what to do if a suspected SARS case is reported at your facility.)** Until the SARS risk has passed, risk managers should make sure that the emergency department's policies and procedures include monitoring

for patients who may have SARS, such as a fever check by the triage nurse.

"You would not want a patient sitting in the waiting area for four or five hours before the condition is recognized and the patient is isolated," he says. "By then, the person would have exposed quite a number of people."

Terndrup also suggests that risk managers use SARS preparations as an opportunity to review the organization's abilities to respond to all sorts of infections.

"This is an opportunity to review your policies and procedures and to establish the relationships with some departments that might not be as close as you would like," he says. "This isn't just about SARS. Whether it's SARS, the West Nile virus, smallpox, or anthrax, all health care organizations ought to be vigilant about readiness. Don't look at this in terms of being ready for SARS this month, but rather that you should be ready any emerging infection."

Preparing for SARS may be different from many risk management concerns because you have to turn over so many responsibilities to others, Kinter and Pugliese say. Though the risk manager should be involved in all key decisions, you will have to rely on some other departments, such as infectious diseases, to work out the details and develop clinical strategies. But they say there are specific steps that the risk manager can take. Here are some suggestions:

• Confirm that other departments have proper protocols in place.

Though other departments must take steps to prepare for the detection, isolation, and treatment of SARS patients, the risk manager must ensure that those steps are indeed being taken. Meet with the directors of infectious diseases, infection control, and employee health to review their preparations, Kinter suggests. Watch for any signs of complacency and warn that SARS still poses a risk.

Kinter cautions that you may have to be careful not to step on the toes of others. SARS is a cross-departmental issue, and you may have to exercise some diplomacy when you check to see that others are doing their jobs. Explain that SARS involves issues that overlap your departments, and that there are risk management concerns you need to address. Acknowledge that you're not trying to tell the other department how to do their jobs, but that you do need to be aware of what they're doing.

If the other department is not addressing SARS, however, it is your role to explain why action is necessary.

• Emphasize that SARS poses more risk to employees than other infections.

Hospital employees are used to working around infectious agents and taking precautions to protect themselves and their patients, but they may not understand that SARS poses a larger risk to them than they are used to.

"Unlike some infections that really are a threat mainly to sick patients in the hospital, those who are compromised already, this is a disease that threatens the healthy health care worker just as much. It's different in that way from a lot of diseases they're familiar with trying to prevent in a health care setting," Kinter says. "So you have to reinforce the idea that these precautions are as much for your health as for the patients."

• Make sure media relations is in the loop.

If even one suspected SARS case shows up in your facility, the local media will descend on you in droves. How you manage that media attention may determine whether your health care organization looks like the problem or the solution, Kinter says. Risk management often oversees the media relations staff, so she says you must make sure they are directly involved in SARS preparations and kept informed of any suspected cases.

"It can be very damaging if your hospital is in the news every day with a SARS story," Kinter says. "Depending on how you're portrayed, some patients might not want to come for a while. Keep your media staff informed and encourage them get the facts out there, reassure the public that your facility is responding appropriately to make sure the story is not blown out of proportion." ■

What do you do if SARS shows up at your door?

SARS requires constant readiness, at least until health authorities determine that the virus is no longer spreading, says **Susan Kinter**, RN, JD, director of claims litigation and risk management at the University of Maryland Medical System in Baltimore. Recent comments by federal officials and guidance offered by the Centers for Disease Control and Prevention indicate that is not yet the case. For the near future, risk managers will have to ensure

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that the facility is ready to respond when a patient arrives with a suspected case of SARS.

Kinter suggests taking a walk through the emergency department — the most likely point of contact for a SARS patient — and asking staff how they would respond. Do they know what policies and procedures have been put in place for SARS? Do they have the necessary equipment, such as N95 masks and warning signs, as well as a room for isolating the patient? Do they know whom to call when they suspect SARS?

Make sure the policies and procedures include a call notifying the risk management department. That call may come straight from the emergency department, or perhaps infectious diseases will notify you when they find out. Either way, the protocol should ensure that you are notified immediately, Kinter says. And what will you do when you get that call about a suspected SARS case? Here are the five steps Kinter plans to follow:

1. Call the infectious disease department to discuss the case.

Confirm that the patient is being isolated and treated according to the pre-arranged protocols. Determine the specifics of the case and the likelihood that this is actually a SARS case.

2. Go to the unit where the suspected SARS patient is and verify the precautions.

Personally visit the unit and verify that the appropriate precautions are being taken. Ask the staff if they have any questions or concerns and if they have all the necessary equipment. Verify for yourself that there are warning signs and that no one can accidentally walk in on the patient without proper precautions.

3. Remind the unit's staff that they are at risk.

Though you should have told them already, remind the staff working on the unit that it is personally at risk from SARS more than they might be with other infections. Stress to them that their own health is at risk if they do not follow the precautions carefully.

4. Alert the media relations staff.

Word of your suspected SARS case will spread quickly, so make sure you inform your media contacts as soon as possible. Make sure they understand the facts clearly and determine what should be released to the media. If the clinicians only suspect SARS, have the media relations staff emphasize that the hospital is being cautious and erring on the side of safety until you can confirm whether the person actually has SARS. Stress that the hospital has prepared for this event and is taking all the necessary precautions.

5. Make arrangements to monitor the patient's condition and care.

Working with the infectious disease department and possibly employee health, work out a plan for how you can monitor the patient's condition and watch for any spread of the virus. One idea might be to have a short meeting or conference call each morning to update each other on the situation until SARS is ruled out. If SARS is confirmed, you might need to move to a more in-depth daily meeting to ensure that the virus is contained. ■

Toronto hospital enacts strict staff quarantine

The hospital at the center of Toronto's SARS outbreak has responded with extensive precautions that risk managers find useful when planning their own response. North York General Hospital closed most of its services, including its emergency department, and enacted strict staff quarantine.

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North York General Hospital implemented the changes in services on May 23 and initiated full-barrier protection, says spokeswoman **Kara Miel**. Employees and physicians were placed on work quarantine and the hospital closed all services at three of its sites.

North York General was in the geographic epicenter of Toronto's first outbreak of SARS but continued to provide essential services to the community. Then the hospital found out that a patient who had been discharged from its surgical ward apparently was the index case for a second outbreak. The hospital immediately responded with mandatory quarantines of staff and urged visitors and patients who were at the hospital between April 19 and May 12 to self-isolate if they had symptoms of SARS.

All hospital staff and physicians were placed under work quarantine immediately — generally meaning they could go to work but must isolate themselves at all other times — and then one week later, the Toronto Public Health revised the work quarantine policy to say that workers must be quarantined for 10 days from "the last day you

were present at any of the four Hospital sites without a mask. For example, if you were last at the Leslie site without a mask on Friday, May 23, 2003, your work quarantine ends on Monday, June 2, 2003." Staff and physicians must follow the quarantine instructions even they do not display symptoms of SARS.

The quarantine directives vary for different groups in the hospital. This is how the hospital instructed them to quarantine themselves:

- **You must go directly to work from home and directly home from work.** Do not stop in between your destinations. Do not take public transit. We are working setting up an account with a taxi company to provide transportation for those who are dependent on public transit.
- **Once you are at home, you may not go out unless you are going to work.** Ideally, please stay in a separate room from your family as much as possible. Wear a mask when you are in the same room with another member of your household unless they are also quarantined.
- **Change your mask twice a day.** Family members do not have to wear a mask. Do not share personal items, such as towels, drinking cups, or cutlery. Wash your hands frequently.
- **Do not have anyone visit you at home.** Family members do not have to be quarantined, unless a member of the household is diagnosed with SARS. Sleep in separate rooms.

Residents must remain in their current rotation until further notice. ■

Attorney cautions against improper SARS responses

Health care risk managers should exercise caution when implementing SARS-related work restrictions and other responses to the deadly virus, says **Kent Jonas**, JD, a labor and employment attorney with the firm of Thelen, Reid & Priest in San Francisco. Acting hastily might result in a lawsuit or charges of federal labor violations, he warns.

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The San Francisco area has a large population of Asian descent and many international companies, so many local employers are dealing with the legal implications of taking SARS precautions. Jonas advises following the guidelines from the Centers for Disease Control and Prevention (CDC), but he cautions that there still are gray areas.

"If you follow those guidelines I think you'll be safe but it's not an absolute defense against any and all claims," he says. "That's very good footing if you can say you did what the CDC told you to, but there are still areas where you can run afoul of the law."

Employers may feel pressured to take precautionary measures to protect the health and safety of their employees, he says, such as requiring them to undergo physical or medical examinations or requiring certain employees to stay home. For instance, many employers have closed their Asian offices and required employees returning from China to stay at home for periods of time. But Jonas says "employers should be aware that absent individual consent and specific employee authorization, precautionary actions can violate employment discrimination, confidentiality, and privacy laws. Employers should therefore be careful about mandating medical examinations, inquiring about an employee's physical condition, or taking other precautionary measures without first consulting their attorneys."

Requiring employees to stay at home when they are suspected of having SARS could be risky, Jonas says. "I'm not sure that's justified. If you can find justification for that in the CDC guidelines, that's one thing. But if you're just being very cautious and want to play it safe by having people stay home, that may not be a good idea. But it's usually with pay, so I don't think people will protest all that much."

Jonas notes that health care employers also can rely on the General Duty Clause enforced by the Occupational Safety and Health Administration (OSHA), which requires employers to provide a safe workplace. "If you have government advice that people in certain categories pose a danger to others in the workplace, there's at least a pretty argument that you have to send them home to comply with OSHA."

ADA and Title VII must be considered

Jonas lists these other areas of risk:

- **The Americans with Disabilities Act (ADA)**

The ADA, along with some state laws such as the California Fair Employment Housing Act, prohibit discrimination against employees with actual or perceived physical or mental disabilities.

President Bush added SARS to the list of communicable diseases for which quarantine may be used under section 361(b) of the Public Health Service Act, but Jonas says employees infected, or suspected of having been infected, may nonetheless qualify for protection under disability discrimination laws.

"SARS is a newly discovered disease, and therefore, it is still undetermined whether it qualifies as a disability protected under the ADA," he says. "Even if SARS is not a disability, the ADA still prohibits employers from requiring medical examinations of employees, unless such examinations are shown to be job-related and consistent with business necessity."

Temporary illnesses are not disabilities, so Jonas says SARS probably doesn't fall into the disability category. "But it's a very gray area. For instance, many cancers will make people disabled under these definitions. So I think the conservative view is to treat employees suspected of having SARS as if they are disabled and certainly not to stereotype people by treating them as having SARS or being dangerous just because they've been to China."

Courts have held that protecting the health and safety of employees or shielding them from significant risks of communicating infectious diseases may constitute a defense against alleged violations of these laws, so some SARS precautions may be exempt. Jonas says it would be reasonable to argue that the risk of SARS contagion endangers the health and safety of employees, and identification of infected employees may constitute a "business necessity."

But on the other hand, Jonas notes that the courts have held that mere fear and unsubstantiated suspicion of infectious disease will not suffice as a defense to a claim of ADA violations. He suggests you consult counsel before requiring diagnostic or other tests.

• Title VII of the Civil Rights Act of 1964

Title VII prohibits discrimination based on race, color, religion, sex or national origin. This law can become an issue with SARS because the disease is found mostly in Asian countries, and therefore you may find that staff with Asian backgrounds are most affected by your precautions.

Under Title VII of the Civil Rights Act of 1964, requiring an employee or a prospective employee to take or pass a physical examination may constitute an unlawful practice, unless it can be shown that physical requirements are job related. Potential Title VII claims may arise if mandatory physical examinations discriminate against certain classes of people because they disclose physical infirmities more prevalent in one race (or sex) than another, or because they affect only those employees of a certain race, national origin, or sex.

• Confidentiality of employee health records

The ADA requires that any information relating to the medical condition or history of an employee must be kept in medical files separate from general personnel information and must be treated as confidential.

"For example, if employees of Asian descent travel to countries affected by the SARS contagion more frequently than other employees, subjecting them to physical examinations could expose an employer to Title VII liability," Jonas says. "Employers should consider testing an employee only when there is an objective reason to believe that his or her presence in the workplace may cause a health hazard for others."

In addition to employment discrimination and confidentiality laws, employers should be aware of employees' privacy rights against mandatory examinations or inquiries about their physical or mental condition. In California, for example, individuals have a constitutional right to privacy against intrusions by both state *and* private actors. This is another reason employers should require medical tests only where there is a demonstrable business necessity for them and should consult counsel before acting. ■

Hospital settles EMTALA violation for $12.5 million

The parent company of Ravenswood Hospital Medical Center in Chicago has agreed to pay $12.5 million to settle a lawsuit brought by the family of a 15-year-old boy who died when he was shot just outside the hospital and medical staff refused to treat him because he was not on hospital grounds.

The settlement brings an end to the legal wrangling over the incident, but it does not end the confusion over how hospitals must respond to similar situations in the future.

Ravenswood was heavily criticized after the 1998 incident, which many observers saw as evidence of a callous staff, but risk managers at the time sympathized with the quandary over when and how staff should leave hospital property to

render aid. The hospital paid $40,000 to settle a federal complaint soon after the incident, according to an agreement signed by then hospital president John Blair. The hospital also agreed to place two quarter-page advertisements over the next year in the Sunday editions of the *Chicago Sun-Times*, reminding the community that the hospital will examine patients "without delay and regardless of their ability to pay."

The settlement was accepted by the federal Department of Health and Human Services, which had investigated the hospital for violations of the 1986 Emergency Medical Treatment and Labor Act (EMTALA), which requires all hospitals receiving Medicare payments to assess and stabilize emergency patients regardless of ability to pay. EMTALA violations carry a penalty of up to $50,000, so the settlement represented a savings of only $10,000 off the maximum fine. The Health Care Financing Administration (now the Centers for Medicare & Medicaid Services [CMS]) approved the hospital's revised policy on treating victims outside the hospital building after threatening to end its Medicare participation if the policy were not changed.

The hospital has since closed. The family of the gunshot victim recently announced the settlement with the hospital's parent company.

250-yard rule doesn't answer all questions

The story began when 15-year-old Christopher Sercye was shot less than a block away from the hospital. Emergency department staff refused to go outside and help him, consistent with hospital policy. Police eventually dragged the boy inside the hospital, but he soon died.

At first, Ravenswood defended the policy as a necessary precaution for the protection of hospital staff. Under fire from the public and regulators, the hospital then announced that the policy had been changed to allow staff to go outside and render aid. The new policy required hospital employees to call a special internal telephone number to report cases where they believe someone on or near the hospital campus needs immediate medical assistance. Then an emergency department nurse or physician would determine how best to treat the person, including the option of leaving hospital property.

The Ravenswood incident prompted risk managers across the country to question their staff's obligation to treat people who are near, but not in a treatment area such as the emergency department, says **Lowell Brown**, JD, a partner with the law firm of Foley and Lardner in Los Angeles and an expert in EMTALA interpretation. CMS offered an interpretation soon after the Ravenswood controversy, indicating that EMTALA obligations apply to an area 250 yards beyond the hospital's doors. That "250-yard rule" only muddied the water, Brown says, and risk managers are eagerly awaiting a clarification that is due soon.

"Right after Ravenswood, a lot of hospitals were asking themselves if that meant they had to send personnel out of the emergency department to get people, perhaps even putting them in danger," he says. "I think the legal answer to that is no, as least as far as EMTALA is concerned. But there is still some confusion. The rule's never been terribly clear."

Based on his readings of the CMS rules, Brown offers this advice: EMTALA applies when a person comes to your facility or within 250 yards in some circumstances. The regulation speaks of a patient being on your property, and your "property" means the whole campus — including parking lots, driveways, etc. But it also defines "campus" as the "physical area immediately adjacent to the provider's main building, and other areas that are not strictly contiguous to the main building but are within 250 yards of the main building, and other areas determined on an individual case-by-case basis by the CMS regional office to be part of the campus."

That leaves plenty of room for interpretation, Brown says. The safety of staff members is always a concern, he says, and CMS does not expect hospital staff to rush into situations they are unprepared to handle safely, especially off the hospital campus.

"People still struggle with it, because if you read the regulations literally, it could mean the Dairy Queen across the street from the campus," he says. "The proposed clarification narrows that down somewhat and just says it's the main campus, property that belongs to the hospital. Until we get that clarification, you'll still have to look at your particular situation and see what areas might qualify."

Some facilities may have well-defined surroundings that make the decision fairly simple, but Brown says many will see opportunities for confusion. A policy such as the one implemented at Ravenswood, requiring emergency department staff to quickly consult with the risk manager or another designated resource, can be one solution, he suggests. ■

Pharmacist meds review may reduce patient falls

It's common for health care providers to have a process in which they review patients for their risk of falling, but too often that review does not include a pharmacist. A pharmacist's review of the patient's medications can dramatically reduce the likelihood that a patient will fall and be injured, says one medication professional who organized such a system in his facility.

The pharmacist can assess the medications to look for those that increase the risk of falls, or combinations that increase the risk, says **Mark J. Haumschild**, MS, PharmD, cardiovascular/thrombosis scientific manager with Aventis Pharmaceuticals in Seminole, FL, and consultant pharmacist for Morton Plant Mease Health Care (MPMHC) in Clearwater, FL. Haumschild and colleagues recently implemented a systemic review process at MPMHC, a rehabilitation center, that resulted in 47% fewer falls in a one-year period. The reduction in falls saved approximately $308,000 in health care costs.

"Falls are a huge issue and a huge risk for elderly patients," he says. "We decided to develop a program where we looked at each resident's drug use more intensely. We wanted to make recommendations for discontinuing the drug, changing the dosage, or switching to a different drug for that particular patient, based on comorbidities."

The process was simple but effective. When a new resident was admitted, the staff at the rehab center faxed Haumschild a list of medications and dosages for him to review. In most cases, Haumschild reviewed the patient's medications within 24 hours of admission.

Save money

To study the effectiveness of the effort, called the fall-focused pharmaceutical intervention program (FFPIP), Haumschild randomly selected 200 patients from the pre-intervention and post-intervention periods. A data analysis found that the number of patient falls was reduced in the post-intervention group by 47%, resulting in a future savings of $7.74 per patient per day. The use of several classes of medication also decreased in the post-intervention period: cardiovascular agents were reduced by 10.7%; analgesics by 6.3%; psychoactive drugs by 18.2%; and sedatives and hypnotics by 13.9% (*Am J Health-Syst Pharm* 2003; 60:1,029-1,032).

The research also revealed a profile of the type of patient most at risk for falls. Haumschild found that the patients most likely to fall were male, greater than 76 years of age, and had a cardiovascular or orthopedic-related diagnosis. They also were taking analgesics, cardiovascular agents, and central nervous system agents.

Though the patients identified as most at risk were male, the intervention program had a more significant effect on female patients, Haumschild says. The reason is unknown.

"The process was based on us going over each patient's records and either reducing drug dosages or modifying their therapy in some way," he says. "That won't work unless you have the support of their physicians, but we found that physicians were very supportive. We probably had compliance of close to 99%."

Working with nurses at the rehab center, Haumschild also helped implement new recommendations for watching patients more closely, based partly on education about how a patient's blood pressure can be affected by a change in body position. A sudden drop in blood pressure can lead to falls. The educational efforts included almost all of the center's staff, not only nurses but also housekeeping, transportation, and therapists.

"Everyone became more aware of what patients were at risk and which ones to watch more carefully than average," Haumschild says. "Simply educating them about blood pressure changes and positioning made them much alert to risky situations. That was part of what led to the overall reduction in falls."

Haumschild says the rehab setting had no influence on the success of the intervention program and that it could be replicated in any health care setting. He notes that he is a consultant pharmacist and not involved in actively dispensing drugs, and that dispensing pharmacists may find it more difficult to incorporate medication reviews into their workloads. But you can suggest a system that would have the dispensing pharmacist review the patient's medications when drug prescriptions are filled. That may seem like less of a burden than having a list of medications sent for review while the pharmacist is trying to fill orders.

"The moment the drug is dispensed is a tremendous opportunity to make a difference because they can see that the patient is on certain drugs and make recommendations," he says. "They can affect the fall risk almost immediately."

The rehab center recently added pharmaceutical review as a routine part of its risk management committee meeting each month. The committee, made up of a risk manager and representatives from several departments, now includes Haumschild. The committee reviews a couple of injury cases each month, and falls are always a priority. Assessing the patient's medication regimen is a big part of figuring out whether the injury could have been prevented.

"The pharmacist is usually not involved enough in that effort, actually looking at patients in the fall evaluations," he says. "You usually have nurses and physicians involved in assessing fall risk at admission, but that's also where the pharmacist should get involved. I don't think that happens enough." ■

Jury awards millions for delay in C-section

A Hayward, CA, jury recently returned a $14.85 million verdict against John Carper, MD, an Alameda family practitioner, and Alameda (CA) Hospital for delay in performing a cesarean, resulting in brain damage and cerebral palsy.

The mother, Robin Page, became pregnant in 2000. She had a previous cesarean with twins but elected to attempt a vaginal birth, according to a case report provided by the law firm of Gwilliam Ivary in Oakland, CA, which represented the plaintiff. She was admitted on Jan. 19, 2001, for induction because of the baby's large estimated size. The nurse assigned to Page testified that despite the potential risk to mother and baby from uterine rupture, the labor was treated as routine. At 4 a.m. on Jan. 20, the fetal monitor strip began to show nonreassuring change in the baby's heart rate. At the same time, Page began experiencing severe unremitting pain, and the baby's head moved up in the birth canal rather than down.

A nurse called Carper but expressed no urgency or concern about the labor. Carper stayed in bed and went back to sleep. The nurse made a second call at 4:30 a.m., at Page's insistence. Carper eventually arrived at 4:50 a.m. Carper decided to wait and watch Mrs. Page for further progress in labor, despite a deteriorating fetal heart rate. The baby's heart rate continued to worsen.

At 5:23 a.m., Carper called for a cesarean when Collin's heart rate fell into the 60s (normal is 140-150 BPM). Carper did not have surgical privileges to do cesareans. A call was placed to the on-call obstetrician, who arrived after 5:28 a.m. This was the first notice to the obstetrician that Page was in labor. The anesthesiologist arrived at 5:44 a.m., the pediatrician arrived at 5:43 a.m., and the OR nurse arrived at 5:43 a.m. The baby suffered severe, irreversible brain damage.

At the trial, expert testimony indicated that the child would have been healthy and normal had he been delivered as late as 5:30 a.m. Collin has been diagnosed with cerebral palsy and has little voluntary control of his arms and legs. He always will be dependent on others for all his daily needs. The jury determined his life expectancy to be 32 years. ■

$250k cap could save 25% of malpractice payouts

A $250,000 cap on noneconomic damages in medical malpractice cases would have saved 25% of nearly $1.2 billion in malpractice settlements and awards paid in Florida in just three years, according to a new report by Floridians for Quality Affordable Healthcare.

Florida is one of several states considering such a cap as one strategy for addressing its medical malpractice crisis. The 29-page analysis of state records reveals that unless lawmakers limit noneconomic awards, referred to as pain and suffering, patients risk losing access to high-risk medical procedures and the physicians who are willing to perform them.

The cost of malpractice is eating up to one-third of some physicians' net revenues, leading scores of doctors to close their practices, retire early, or stop offering high-risk procedures.

Physicians are packing up and leaving Florida and states with similar legal environments such as Mississippi, Nevada, Pennsylvania, Texas, New Jersey and West Virginia; New York and Illinois are not far behind, says **David E. Berman**, principal investigator on the report and senior vice president of business development at iBX Group, a Deerfield, FL-based company that specializes in financial, administrative, and technology services for the health care industry. He says the results from the Florida study probably could be found in most other states battling a malpractice insurance crisis. ■

Court ruling triples verdict by counting inflation twice

A coalition of New York's leading health care providers and workers, representing close to 75 hospitals, is protesting a recent court ruling that they say has sent medical malpractice premiums spiraling out of control in New York State. Residents will lose critical medical services and thousands of health care jobs could be put at risk if the court ruling stands, they say.

As a result of the ruling, hospitals have been notified that insurance premiums will increase substantially, or coverage might not be available at all, says **Spencer Foreman**, MD, president and CEO of Montefiore Medical Center in New York City. Foreman is a member of the New York Healthcare Alliance, a coalition of health care providers and workers from approximately 75 hospitals throughout the state of New York. The coalition is calling on the New York State Legislature to avert the crisis by passing legislation to clarify the malpractice law.

"We are on the verge of a social and medical catastrophe that will force some of the finest hospitals in the world to stop providing service," Foreman says. "A technicality in the law will compel hospitals to stop delivering babies, shut down emergency response units, and lay off workers."

The debate was touched off recently when the New York State Court of Appeals upheld a lower court's interpretation of New York's structured judgment law (CPLR 50A). In the case, known as *Desiderio v. Ochs,* the trial court increased the jury award for future medical expenses from $40 million to $140 million by "averaging" and counting inflation twice, Foreman says. In rendering its unprecedented decision, the Court of Appeals implored the legislature to clarify the law, passed in 1986, which was designed to moderate the increases in medical malpractice premiums.

The ad hoc coalition of health care providers and workers has called upon both houses of the legislature to restore the original intent of the law and bring financial awards back in line with accepted norms and in proportion with the related injury. Such a change would remove the "averaging" and "double-inflation" features of the law, says **David P. Rosen**, president and CEO of Jamaica Hospital Medical Center, Brookdale University Hospital Medical Center, Flushing Hospital Medical Center and MediSys Health Network, all in New York.

"This law was originally written to ease the malpractice insurance burden on hospitals while ensuring that the jury awards to plaintiffs were fulfilled," Rosen explains. "But ambiguities in how the law was drafted has had unintended consequences and malpractice costs are about to threaten every hospital in New York."

Simply repealing the law will not solve the problem, says **Lisa Kramer**, president and CEO of FOJP Service Corp., an insurance program for hospitals in New York City. "That would bring back the malpractice insurance crisis of the 1980s that the law was intended to resolve," she says. "The structured judgment law attempts to control malpractice costs by making jury awards more equitable and by encouraging out-of-court settlements so that plaintiffs can decide for themselves how best to use the money. But the arithmetic prescribed by the statute needs to be fixed." ■

CE instructions

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 activity each semester, you must complete the evaluation form provided and return it in the reply envelope provided in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

COMING IN FUTURE MONTHS

- Computerized med entry reduces errors, but will docs cooperate?
- Universal consent form streamlines, but no panacea
- Strategies for minimizing nurse back injuries
- Crew resource management improves safety
- Reducing falls in long-term care settings

CE objectives

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

1. Describe legal, clinical, financial, and managerial issues pertinent to risk managers in health care.
2. Explain how these issues affect nurses, doctors, legal counsel, management, and patients.
3. Identify solutions for hospital personnel to use in overcoming challenges they encounter in daily practice. Challenges include HIPAA and EMTALA compliance, medical errors, malpractice suits, sentinel events, and bioterrorism.
4. Employ programs used by government agencies and other hospitals (such as EMTALA, HIPAA, and medical errors reporting systems) for use in solving day-to-day problems. ■

CE Questions

If you have any questions about the CE program, please contact customer service at (800) 688-2421.

1. Which statement accurately summarizes recent statements by Health and Human Services Secretary **Tommy Thompson** regarding SARS?
A. The SARS threat appears to have ended in the United States and will not return.
B. SARS could come back in the fall, and then there may likely will be deaths in all the continents.
C. SARS may resurface in Asian countries but will not be seen in the United States again.
D. North American SARS cases probably will be found only in Canada.

2. According to Thomas Terndrup, MD, FACEP, professor and chair of the department of emergency medicine, and director of the Center for Disaster Preparedness at the University of Alabama at Birmingham, which of the following statements is true?
A. There is no need to change emergency department procedures.
B. Emergency departments must ensure that no one waits for more than 30 minutes, to ensure the virus is not spread.
C. Emergency departments should screen incoming patients for SARS symptoms so that a patient with SARS does not wait for several hours in a common area, exposing others to the virus.
D. Emergency departments should treat every incoming patient or visitor as a SARS case until proven otherwise.

3. Which statement best represents the advice from Lowell Brown, JD, a partner with the law firm of Foley & Lardner in Los Angeles?
A. EMTALA does not require that hospital staff ever leave the property to render aid.
B. EMTALA requires that hospital staff render aid within 250 yards of the facility, no matter what the circumstances.
C. EMTALA requires that hospital staff render aid within 250 yards of the facility, but not if that means leaving hospital property.
D. EMTALA requirements are unclear but generally require that hospital staff render aid within 250 yards of the facility, even if that means leaving hospital property, and if the staff would not be endangered.

4. The pharmacist intervention program, developed by Mark J. Haumschild, MS, PharmD, cardiovascular/ thrombosis scientific manager with Aventis Pharmaceuticals, reduced falls by _____.
A. 12%
B. 33%
C. 47%
D. 63%

Answers: 1-B; 2-C; 3-D; 4-C.

HIPAA Regulatory Alert

Supplement to Healthcare Risk Management and Hospital Access Management

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Surveys gauge current state of HIPAA compliance

HIMSS, OIG release results of separate surveys

Now that two significant HIPAA compliance deadlines have passed — the April 14 deadline for health care industry compliance with the privacy rule and the April 16 deadline for health care business operations to begin testing transactions and code sets — it's time to take stock of how far along health care organizations really are when it comes to HIPAA compliance. To that end, both the Department of Health and Human Services' Office of Inspector General (OIG) and Healthcare Information Management Systems Society (HIMSS) have conducted surveys of health care providers.

HIMSS and Phoenix Health Systems conducted the HIMSS Spring 2003 HIPAA Survey. Among its findings are the following:

• 78% of providers, 68% of payers, and 47% of clearinghouses said they were compliant with the April 14 privacy deadline.

• Nearly 100% of providers who reported being privacy-compliant have implemented the most publicly visible elements of the privacy rule such as Notices of Privacy Practices and Patient Authorizations. However, significantly fewer have implemented requirements such as enabling patients to receive an accounting of health information disclosures, limiting staff access to protected health information on a minimum necessary basis, and completing agreements with business associates to ensure that they are protecting patient privacy.

• Among health care computer system vendors, only 39% had completed privacy remediation efforts.

• Cooperation among health care industry segments reportedly was less than satisfactory and again was ranked one of the top roadblocks to HIPAA compliance, along with "not enough time" and difficulty interpreting the HIPAA regulations.

• Management support for HIPAA compliance has significantly increased over measurements recorded in past surveys.

In-depth reports

Looking at privacy compliance in more depth, HIMSS reports that some 98% of reportedly compliant providers have implemented the most publicly visible requirements, such as the Notice of Privacy Practices, obtaining patient acknowledgement of receipt of the notice, and obtaining patient authorizations for use and disclosure of protected

health information. But only 88% have put in place other requirements, such as a process for providing an accounting of disclosures to patients, or setting minimum-necessary protected health information access restrictions on health care workers.

Forty percent of "compliant" providers indicated they had not yet finalized business associate agreements that will ensure that business partners with access to protected health information are protecting patient privacy. Twenty-nine percent have not implemented a working process for monitoring privacy compliance, and 18% do not yet have the privacy rule's required data security protections in place.

A more intense look at the transaction and code set compliance report suggested to HIMSS that on-time implementation of the highly visible privacy regulations may have dominated the focus of health care HIPAA compliance efforts in recent months. That emphasis may have delayed transactions and code sets compliance efforts in many health care enterprises, especially provider organizations.

In this survey, only one-half of all participants reported completing of transaction and code sets implementation activities, and just 53% had begun internal testing by the April 16 deadline. Still, a majority of organizations had completed transaction and code sets HIPAA awareness/education (78%), assessment (73%), and implementation project planning (67%). Further, almost 40% of respondents already had begun external testing with business partners.

Internal transaction testing was being conducted by 49% of all providers, 62% of payers, 55% of vendors, and 80% of clearinghouses as of the April 16 testing deadline. Only 39% of providers, 37% of payers, 39% of vendors, and 53% of clearinghouses were conducting external testing with their trading partners as of the testing deadline.

Spring 2003 survey results showed that 44% of respondents across the industry were using outside consultants to support HIPAA initiatives. As in the past, the biggest users of consultants were larger hospitals (46%) and payers (66%). Approximately 30% of respondents engaged consultants for assessment and implementation planning services, 22% for implementation support, and about 45% for HIPAA awareness and training support.

Hospital budgets for HIPAA compliance in 2003 generally are higher than 2002 HIPAA budgets. Also, payer budgets for 2003 are significantly higher than in 2002, especially for larger payer organizations.

Part A readiness

Meanwhile, OIG's report used a mail survey of Medicare Part A providers to assess level of readiness in four broad areas — assessment and awareness activities, impediments or current obstacles to achieving compliance, compliance strategies such as sequencing and testing plans, and contingency planning.

OIG says that almost all Part A providers have submitted a compliance extension form giving them until Oct. 16, 2003, to implement electronic standards and code sets. At the time of the OIG survey, 74% of providers were ready to implement the HIPAA electronic standards, and 96% indicated that they had a moderate to high level of satisfaction that they expected to meet the October deadline.

The 4% of providers not expecting to meet the compliance deadline said they were in the process

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Editor: **John G. Hope**, (717) 238-5990.
Managing Editor: **Russ Underwood**, (404) 262-5521.
Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).
Editorial Group Head: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcpub.com).
Production Editor: **Nancy McCreary.**

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Editorial Questions

For questions or comments, call **Russ Underwood** at (404) 262-5521.

of identifying the steps necessary to implement the standards.

While fewer than 30% of the providers had begun any testing, 90% will have a testing strategy. Most of the testing strategies include internal and external data interfaces. About 25% had begun to test transactions as of November 2002. However, only slightly more than 44% had received any notices from fiscal intermediaries or carriers regarding coordination of electronic transaction testing.

Strategies and barriers

When asked which strategy providers were using to implement the HIPAA standards, they most frequently identified these four: internal staff planning, developing, and implementing the standards; technical systems consultants working with staff and assisting in the process; technical systems consultants or vendors taking full responsibility for planning, developing, and implementing standards; and purchasing components of a new system or additions to current systems from a selected vendor to meet the standards.

Likewise, when asked to list as many as three barriers to compliance, 60% of the respondents listed one or more. The most common were: trading partners will not be ready; vendors will not be ready; inadequate staffing, training, and technical resources; and not enough time to implement.

One-third of those who listed any barriers identified their trading partners (specifically third-party payers, fiscal intermediaries, and/or the Centers for Medicare & Medicaid Services) as potential barriers to compliance. Providers who did not believe they would meet the compliance deadline expressed similar concerns. They cited their trading partners as a potential barrier, as well as inadequate resources.

More information is available from www.hipaadvisory.com. ■

Popular PC applications can cause security leaks

Is instant messaging compromising your PHI?

A report issued by Palisades Systems Inc. in Ames, IA, and Clive, IA-based HIPAA Academy, says that health care organizations that allow peer-to-peer (P2P) and instant messenger applications to run on their computer networks risk compromising patient health information and causing HIPAA privacy violations.

"P2P applications open up a health care organization's network to the outside world," says HIPAA Academy compliance manager **Mark Glowacki**. "Applications like P2P and instant messenger allow employees to communicate and share files covertly with outside parties. Because these applications can run without being detected by conventional security applications like firewalls, security violations are only discovered after the fact. With instant messaging, undocumented communications regarding a patient may occur without the health care organization's knowledge, leading to an unintentional breach of HIPAA's access requirements."

In addition to undetected file sharing, P2P and instant messenger can expose an organization to security threats targeted at these applications, such as worms, viruses, and spyware. Glowacki says that several P2P applications include spyware as a standard part of the installation, which may allow for unauthorized collection and distribution of confidential information. Free instant messaging applications can allow a hacker to take over the user's computer through security vulnerabilities that are not actively patched.

Police department passwords found

According to the report, in September 2002, Aspen, CO, city government officials received an e-mail indicating that someone had downloaded police department passwords and sensitive city information from its network through a file-sharing program. The user was searching for a movie and came across the entire contents of the network administrator's hard drive.

According to the report, although some cases of sharing confidential information are malicious, most involve users who are not savvy enough to restrict access only to appropriate files.

The authors say that instant messaging applications provide no control over the sharing of confidential materials. Employees using such applications related to patients open an institution to critical information leaks that can be a breach of HIPAA security requirements. "It would be easy for employees to illegally share

critical protected health information with outside parties, either unintentionally or maliciously, without the detection or knowledge of the health care organization," the report declares. In addition, hackers can leverage well-documented instant messenger security vulnerabilities to take over computers.

"No organization with P2P or uncontrolled instant messenger programs running on its network can be HIPAA-compliant," says Palisade Systems president **Doug Jacobson**. "The applications open up too many security holes, and companies discover them too late."

For more information, go to www.palisadesys.com or www.hippaacademy.net. ■

Interim rule on monetary penalties to be replaced

Final enforcement rule to take effect Sept. 16

The Department of Health and Human Services (HHS) says its interim final rule establishing rules of procedure for the imposition of civil monetary penalties on entities that violate standards adopted under the administrative simplification provisions of HIPAA will not be in effect after Sept. 16, 2003, because it will be replaced by a final enforcement rule.

HIPAA gives the HHS Secretary of Health and Human Services the authority to impose a penalty of not more than $100 for each violation of a provision of the administrative services sections up to a yearly maximum of $25,000 for all violations of an identical requirement or prohibition.

The law says the secretary cannot impose a civil monetary penalty if: 1) it's for any action that can be punished under the law's criminal penalty provisions; 2) it is established that the person liable for the penalty did not know that a provision was being violated; 3) the failure to comply was due to a reasonable cause and not willful neglect; and 4) payment of the civil monetary penalty would be excessive relative to the compliance failure involved.

The department notice says its approach to enforcement is to seek and promote voluntary compliance with HIPAA provisions. The agency is offering technical assistance to promote voluntary compliance. Enforcement activities will be primarily complaint-driven and will consist of progressive steps that give an opportunity to demonstrate compliance or submit a corrective action plan.

The interim final rule discusses all the procedures involved in imposition of civil monetary penalties.

To download the interim final rule, go to www.cms.gov/hipaa/hipaa2/enforcement/default.asp#penalties. ■

HIPAA affects ability to help law enforcement

Specific HIPAA provisions still must be followed

When two police officers arrived at a hospital emergency department asking to be informed if the facility had treated an elderly woman reported missing by her family, hospital staff contacted their outside legal counsel for advice because of wariness about HIPAA privacy regulations. And it's good they did.

Nixon, Peabody attorney **Claudia Hinrichsen**, who is leading the Garden City, NY, firm's HIPAA practice, says there are specific HIPAA provisions relating to release of information to law enforcement officials that must be followed, no matter how much staff may want to help the police do their job.

In the instance cited above, the woman had been treated at the hospital and specifically informed the hospital staff that she was planning to enter a particular nursing home but that her family was not to be informed of her location.

While the staff were eager to allay the family's fears and assist the police, they were faced with HIPAA restrictions on the information they could disclose. HIPAA describes the types of information that can be provided to law enforcement officials who are looking for a fugitive, a suspect, a material witness, or a missing person.

Competing restraints in state law

Complicating the issue in this instance was the fact that New York state has its own laws on cooperating with law enforcement, so that there were competing restraints. Generally in the past, it has taken a court order to free a hospital to disclose information.

Hinrichsen says she advised the hospital to

indicate that staff were not at liberty to disclose the woman's location. The most the hospital could have released, she said, was information such as name and address, Social Security number, and date of treatment at the hospital.

"My general guidance to facilities is to have a policy in place about disclosure of protected information to law enforcement officials," Hinrichsen says. "The policy should deal with the specific requirements in Section 164.512(f). It also should consider any more restrictive state laws for the particular state in question."

She tells of a hospital that traditionally notified the local police automatically whenever someone was treated for injuries resulting from a traffic accident. However, it was determined that there is no specific authorization for releasing such information and the hospital was advised to change its practice.

Hinrichsen says that hospital staff members accustomed to cooperating with the police may feel uncomfortable in saying that they cannot give out information any longer, but that still may be the only correct response and the one that should be used. She said they can always offer to pass the issue on to the hospital attorney or to an administrator to handle.

For more information, contact Hinrichsen at (516) 832-7532. ■

Company develops business associate agreement

Template created to fulfill HIPAA requirements

One of the nation's leading medical messaging services has taken the lead in developing a sound business associate agreement to present to its clients to fulfill HIPAA requirements.

Long Island, NY-based MEDFONE Inc., which works strictly for health care clients such as group practices, individual physicians, and insurance companies, offering them medical messaging services such as an answering service, telemarketing sales, and inbound and outbound call center activities, drew up a proposed business associate agreement template once president **Jay Moses** realized how much work would be involved in reviewing the wide variety of agreements being received from clients.

"We process 10,000 calls a day for more than 800 clients nationwide," Moses tells *HIPAA Regulatory Alert*. "Many of these calls deal with patient health information. We were already very security conscious, but we had to upgrade our technology platform to ensure that all calls are encrypted, safe, and password-protected. And we've trained all of our agents in what it means to be HIPAA-compliant."

Moses tells us that by the time he had received 200 business associate agreements from customers, he realized that HIPAA was going to be a huge undertaking for his organization, and also that many of his clients really did not have a good understanding of what HIPAA meant.

Template drafted

As a result, Moses turned to his company's outside law firm to draft a business associate agreement that he could send to clients on his own initiative. While it was a voluntary service he offered, many of the clients went ahead and used them, he says, freeing time for him and his law firm because he knows that when one of his agreements comes back, it will be acceptable without extensive review.

Moses says that MEDFONE, which recently won an award of excellence from *Customer Interactive Solutions* magazine, has never had a confidentiality problem in the 25 years in which it has been in business. "It's in the nature of our business that we already had many safeguards in place," he says. "But we still had to go to some very expensive changes to be sure that we would meet all requirements for our clients."

Moses says that because MEDFONE is required to store files for no less than six years, he had to upgrade storage devices, using a combination of on-site and off-site storage.

Asked his assessment of HIPAA readiness in health care covered entities based on contacts made with him, Moses expressed concern that HIPAA may still be an unknown entity for many organizations. "We still don't know what the repercussions will be if an issue arises," he says. "There are no HIPAA police out there and no legal precedents. Some people say HIPAA is like Y2K — lots of hype and not much else. We'll know more in October. We need to be able to handle the encryption keys that our clients need us to use. Because there's no standardization — and, really, standardization is almost contrary to what HIPAA is trying to accomplish — we're going to have to be able to deal with many different

encryption systems. It's important for our clients to know that they can work with us and we've done our due diligence. We don't want any of our clients or ourselves to be liable if an issue arises."

Moses says it's important that people realize HIPAA came about out of a desire for the financial savings for Medicare that can come from processing data in a consistent format. Health care organizations have to realize that there is a tremendous liability with penalties that can be severe, he says. He indicates that MEDFONE realizes that providers want to practice medicine and not worry excessively about administrative things, and that's why his company's role is to free clients as much as possible to concentrate on providing care.

For more information, contact Moses at (516) 679-7629. ■

WEDI seeks transaction and code set guidance

Concerns over the compliance of trading partners

The Workgroup for Electronic Data Interchange (WEDI) has asked Health and Human Services Secretary **Tommy Thompson** to provide guidance in light of the fact that a substantial number of covered entities will not be able to achieve compliance with HIPAA Transaction and Code Set (TCS) standards by Oct. 16, 2003, as required under the Administrative Simplification Compliance Act.

In a letter to Thompson, WEDI reported that a number of covered entities that will be compliant are worried about trading partners or transactions that will not be compliant. The covered entities are considering contingency plans to avoid unintended consequences and adverse impacts, including rejection of nonstandard electronic transactions; disruption of payment flows to providers under Medicare, Medicaid, and private-sector health plans; and reversion to paper transactions by covered entities that are capable of generating transactions in a nonstandard format.

WEDI said that much progress has been made and there is considerable industry support for HIPAA TCS standards and their successful implementation. "The issue at hand," the group said, "is how does the industry make the short-term transition from its current state to a successful implementation, given a substantial degree of noncompliance in October 2003, and thus avoid the so-called train wreck that will result from reversion to paper claims or stoppage of cash payment flows."

Potential solutions offered

Two potential solutions the group asked Thompson to consider were 1) permitting compliant entities to use HIPAA TCS standard transactions that may not contain all required data content elements, if these transactions can otherwise be processed to completion by the receiving entity, until such time as compliance is achieved or penalties are assessed; and 2) permitting compliant covered entities to establish a brief transition period to continue using their current electronic transactions in lieu of reversion to paper transactions.

WEDI said its experts believe that reversion to paper has the highest potential for unintended consequences and adverse impacts for the health care industry. It indicated that its two recommended courses of action would not have an adverse impact on compliant covered entities.

"Further," WEDI says, "they eliminate the need for covered entities that are in the process of achieving but will not achieve HIPAA TCS standards compliance by the deadline from diverting scarce resources to reverting to paper as a temporary fix to avoid noncompliance. The choice to accept a nonstandard electronic transaction would be at the discretion of the covered entity. Nothing would compel a covered entity to forego its rights or obligations, nor would it preclude a compliant covered entity from filing complaints with the Centers for Medicare & Medicaid (CMS). In fact, WEDI contends that CMS' complaint-based enforcement approach will be an incentive to hasten compliance with HIPAA TCS standards transactions, as will competition in the health care marketplace."

The group told Thompson that the health care industry believes that the goals underpinning a successful implementation of HIPAA TCS standards are to sustain cash flows from payers to providers, to minimize disruptions to business activities in the health care industry, and to allow sufficient time for covered entities that are making the effort to comply with HIPAA TCS standards transactions to make the transition to a successful implementation.

"For example," the letter says, "a large

clearinghouse that is now compliant with the HIPAA TCS standards indicates that it has completed testing with only about 10% of more than 1,000 payers, and that it will not be able to complete testing by Oct. 16, because it is having difficulty with its payers scheduling testing because of the payers' time constraints. Industry participants have indicated that a transition of approximately six months should be sufficient to achieve critical mass for a successful implementation."

For more information, visit www.wedi.org. ■

Software can ease authorization process

Electronic records keep facilities connected

As with many areas of health care, new approaches in technology have been sought to ease the way into compliance with HIPAA. One example is the HIPAA GUARD program from Monterey, CA-based Integritas Inc.

The program, which can be used either as a stand-alone or in concert with the STIX occupational health suite, was created in anticipation of the new HIPAA requirements, says **Mary Stroupe**, MA, MBA, vice president of sales for Integritas.

"We anticipated it would be needed," says Stroupe. "We were clear that HIPAA was going to apply to all our clients — both to freestanding occupational health and rehab organizations, and in the hospital-based environment, where we see an even greater need."

Authorization is the linchpin

While HIPAA GUARD addresses a number of concerns, including privacy notice acknowledgement and consents, authorizations, patient access requests, patient complaints, and accounting of disclosures, patient authorizations seemed to be an overriding concern for a number of clients. "Fundamentally, we saw that according to the law as we read it, the release of information to the employer for the purpose of a physical or a drug screening would require an authorization from the patient," Stroupe explains. "In a health system, if you go to three or four different places, should you have to be given three or four different privacy agreements? In the scheme of all issues, that's No. 1."

Evelyn S. Miller, CPA, executive vice president-finance for Medway Health Inc. in Dallas, agrees. "You don't want it to look to your clients like you don't know what you're doing," she notes. "If they come into your clinic and sign a privacy agreement, then get referred to the hospital, which is owned by the same company [and get asked to sign another], they think you are clueless."

Miller has just such a situation. "We have two freestanding locations, each with three distinct treatment departments," she says. "It's helpful for us to know whether a patient has already signed an authorization form; it not only eliminates paperwork, but we are perceived as being more professional." Miller says this is one of the primary reasons she decided to integrate HIPAA GUARD with her STIX software.

There are other reasons managing HIPAA compliance with software can be beneficial. "We anticipate that whether you are a freestanding facility or a hospital, because the occ-med department is the department that routinely releases information to the employer, this could potentially be a source of weakness in the whole system," notes Stroupe. "Plus, even though the law does not require authorization for purposes of workers' comp, it *does* require you to document and keep track of disclosures made for workers' comp. If you're a small operation, you can just pull out the chart and see it; but in a large one, where you have many disclosures in many different places, having no single place to keep track of all of them is a huge problem."

Miller sees other reasons for the electronic record keeping the software facilitates. "When we get audited, surveyors want to see your compliance with HIPAA and how you track it," she notes. "We are getting ready for our accreditation by CARF [the Commission on Accreditation of Rehabilitation Facilities], and they want to see how we are complying with HIPAA, as well as logs of where we have done the accounting, whether people are receiving proper notice, and so on."

Not a performance change

Both Stroupe and Miller agree that the new Privacy Standard may change the way certain processes are handled, but not the way care is given.

"The general thinking is that HIPAA allows health care providers to do things that in the past

they couldn't do, but that's just not true," Stroupe asserts. "It requires providers to tell people what is happening. What I anticipate is this: in the past, patients haven't asked to see their records; and in most cases, it probably never occurred to them to ask.

"Now they're being given a document that tells them there's a new law that says what their rights are," she continues. "Soon, a certain percentage of people will start to request their records just because they can. This can cause real headaches, because the law requires you to reply to these requests within a certain amount of time. The software keeps track of when this has been done, what is pending, and so on. Even in the absence of any breach this is important."

"I agree," says Miller. "We've not yet seen any increase in the number of requests for medical records. We already had a response system in place; this is just making it more standardized. Basically, for us, it's just creating more work to document what we already do."

[For more information, contact:

• ***Evelyn S. Miller**, CPA, Executive Vice President-Finance, Medway Health Inc., 2915 LBJ Freeway, Suite 102, Dallas, TX 75234. Telephone: (972) 241-9271. E-mail: evelynmiller@medwayhealth.com.*

• ***Mary Stroupe**, MA, MBA, Vice President-Sales, Integritas Inc., 2600 Garden Road, Suite 112, Monterey, CA 93940. Telephone: (800) 473-6309.* ■

Companies seek URAC security accreditation

Ten companies operating in more than 20 different sites across the nation are in the process of seeking accreditation under URAC's HIPAA Security Accreditation Program for Covered Entities and Business Associates. URAC president **Gary Carneal** says the commitment to security shown by those who are seeking accreditation "sets an excellent example for covered entities and business associates alike."

With a strong emphasis on the fundamentals of ongoing risk management, URAC's HIPAA Security Accreditation program enables health care organizations to validate their security compliance program and demonstrate to their customers and business partners that they have taken the necessary steps to safeguard protected health information as required by the HIPAA security rule.

The companies seeking accreditation include American Specialty Health Inc., and its affiliates, American Specialty Health Plans of California, American Specialty Health Networks, American Specialty Insurance Co., and Healthyroads; Health Ink & Vitality Communications; Imogen Systems; MedRisk Inc.; National Imaging Associates Inc.; and Wausau Benefits.

URAC HIPAA Security Accreditation is awarded for a two-year period, at the end of which an accredited organization must submit a reaccreditation application for URAC's review before accreditation is granted for an additional two-year periods.

More information on the program is available at www.urac.org. ▼

HIPAA.ICC.NET started to facilitate transmission

Internet Commerce Corp. says it has created a new service to address the need for health care payers and providers to exchange health care transactions that conform with HIPAA requirements. The new service, known as HIPAA.ICC.NET, incorporates software from eServices Corp. as well as that company's expertise in the new health care transaction requirements.

The company says that HIPAA.ICC.NET provides for seamless transmission of the HIPAA standard transactions between payers and providers.

"In today's health care environment, controlling costs is a major challenge," says ICC marketing vice president **Arnold Capstick**. "This new capability is aimed at providing a highly reliable, secure, accurate service at transaction prices that are more cost-effective than the current norm in the health care industry. HIPAA.ICC.NET allows users to comply with HIPAA regulations with a minimal investment of time and money." ■

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Attack in a psychiatric facility leads to $100,000 judgment

By **Edward J. Carbyne**, Esq., **Jan J. Gorrie**, Esq., and **Richard Oliver**, Esq.
Buchanan Ingersoll Professional Corp.
Tampa, FL

News: A 42-year-old woman was involuntarily transferred from a community hospital to psychiatric facility after her attempted suicide. At the receiving facility, she was placed in an all-male ward, where she said she was sexually assaulted. A jury returned a verdict of $150,000, that was offset by her contributory negligence.

Background: On Nov. 25, the plaintiff was admitted to the emergency department of a community hospital. The treating physician determined that she had intentionally overdosed on prescription medication. As provided in the jurisdiction, the patient was involuntarily transferred to a psychiatric facility for 72-hour psychiatric evaluation and treatment. Her admitting diagnosis at the psychiatric center was major depression, alcohol dependence, and status post-suicide attempt by an overdose.

At the receiving facility, she was placed in a private room on an all-male ward. She said she received inappropriate sexual comments, mostly from a male patient who, according to the facility's records, had been admonished several times for inappropriate sexual conduct.

She underwent detoxification and was checked every 15 minutes. After two days of hospitalization, she was taken off 15-minute checks, which was the normal routine and acceptable standard for patients. She was given a sedative to help her control her withdrawal symptoms. Later that day, the male patient who had verbally harassed her entered her room. She said he allegedly dragged her into the bathroom and sexually assaulted her.

She was discharged the next day.

The plaintiff provided evidence indicating multiple injuries that pointed to the viciousness of the attack, including vaginal infection, an anal tear, laceration of the anus, bite marks and dark red marks on a wrist, forearm, upper arm, and neck. She also claimed she suffered from post-traumatic stress disorder consistent with nonconsensual sexual activity.

The plaintiff's adult psychiatric medical expert testified that the defendant's facility failed to meet the requisite standard of care by not providing the mentally and emotionally impaired plaintiff with a safe environment and by allowing a male patient who had previously received staff warnings for inappropriate sexual conduct to enter the plaintiff's room and sexually assault her. The plaintiff claimed that this deviation of the standard of care was the direct and proximate cause of the rape.

The defendant said the incident was consensual. The facility also maintained that the harm claimed was the result of the negligence on the part of third parties.

The jury returned a verdict in favor of the

plaintiff and awarded $150,000 in gross damages. However, the jury found the plaintiff 40% negligent, so the judgment was reduced to $100,000.

What this means to you: This case is disturbing in the sense that one of our primary responsibilities as health care providers is the duty to provide, maintain, and enhance a safe environment for our patients. Several important questions are prompted by this scenario:

- Is the staff aware of the patient rights guaranteed under the Baker Act (which is the statute in the jurisdiction that called for at least 72 hours of observation)?
- Does the facility have a patient safety communication plan?
- What level of monitoring was appropriate for the male patient with reported incidents of inappropriate sexual conduct?
- Was there any observation by staff of the alleged injuries to the female patient prior to her discharge?

The protection and treatment of persons who have an intent or ideation to harm themselves or others may be prescribed by jurisdiction law, as in this case.

"Certainly those operating receiving facilities in those jurisdiction should be well versed in the prevailing rules and regulations. At a minimum, frontline staff should be familiar with the particular patient rights associated," says **Patricia Specian**, risk manager, of HCA Inc. in Lawnwood, FL.

At a minimum, a well-developed patient safety communication plan would have instructed staff on the need to be alert for potentially harmful situations such as this one.

"If there were no other alternative available other than to place this patient on an all-male ward, then the safety plan and basic education staff are required to receive should have triggered the necessity of implementing additional safe guards for this woman. Simple alternatives would include placing her in a room nearest the nursing station for easy observation and continuing the frequent observations as a means of ensuring her safety, even though the standard of care allowed for relaxing of the 15-minute checks," Specian says.

Although the scenario does not state whether the male patient was on frequent observations as a result of his noted inappropriate behavior, common sense would dictate that considering the presence of a female on the ward coupled with the sexual comments, the staff would have realized the need to monitor this patient more closely.

"With the potential for an escalating sexually charged environment, the prudent course of action would have been to attempt to transfer the female patient off of the unit. The scenario does not indicate whether or not this was an option but, at any rate, something should have been done by the staff in this situation to guarantee safety. The standard of care would require that this sort of assault be prevented. All psychiatric units have a measure of frequency by which they physically observe their patients and similarly as noted above the situation may have called for the male as well as female to be more routinely observed," states Specian.

This incident would also likely require a report to a state agency that has jurisdiction over the reporting of abuse. Further, the scenario does not suggest whether the woman was taken to the emergency department for an evaluation after the assault, which would be an ordinary precaution.

"An internal investigation would be required as well. The outcome would hopefully show a change in policy regarding placement of female patients on an all-male ward, education of staff on safety issues related to frequency monitoring, and the need to manipulate the environment to allow close observation of specific patients when warranted," concludes Specian. ■

Fall and fractures lead to a $240,000 settlement

News: After being admitted to a hospital for hip pain, a 69-year-old woman was allowed to walk about unassisted. Days later, X-rays showed she had a hip fracture, which was operated on. She was transferred to the nursing home next door to recuperate and be rehabilitated.

On the seventh day of her stay, she fell and re-fractured her hip. This time, the hip repair included a total replacement. The patient brought suit against the hospital, nursing home, and her attending physicians. The cases against the physicians were later dropped; the nursing home and hospital settled for $240,000.

Background: The 69-year-old woman, who had

a history of schizophrenia, was admitted to the hospital with hip pain. Radiological examination, including an MRI, failed to indicate a cause and the patient was allowed to walk without assistance. A few days later, she was walking and heard a crack. X-rays showed she had a fractured hip. She underwent open reduction and internal fixation for the fracture.

Following the surgery, she became extremely agitated. Her schizophrenia was no longer being controlled with psychotropic medications. It is not known if she was placed back on any medications. She was transferred to a nursing home adjacent to the hospital, and her transfer papers clearly detailed her high risk of falling with any ambulation.

Once admitted to the nursing home, the admitting nurse's chart note indicated that the patient was a high risk for falls, but the nurse failed to complete forms instructing the nursing assistants on how to monitor and care for the patient. No precautions for the avoidance of falls were taken. Seven days later, the patient tried to get out of her wheelchair and fell over, re-fracturing her hip. She was re-admitted to the hospital and told she needed a total hip replacement.

The doctor who performed the first surgery admitted that his repair work was obliterated and could not be more simply repaired due to the second fall.

The patient brought suit against the nursing home, hospital, and attending physicians. She argued that the nursing home should have provided a variety of safety devices to decrease the chance of falls, including nontipping devices that could have been easily added to her wheelchair. It was claimed that the nursing home should have lowered her bed to the floor and modified her toilet schedules so that she would have less need to get up.

The nursing home, as defendant, contended that the patient was an unreliable witness and unable to testify due to her schizophrenia and confusion. But this could just as easily have been used to show that the nursing home should have provided additional care to ensure her safety and security and address known medical conditions. The hospital contended that the injury occurred in the nursing home and that it bore no responsibility for what happened there.

Actions against the physicians were discontinued, with no payment by either. The nursing home and hospital eventually settled with the plaintiff for $240,000, with the nursing home picking up the bulk of the tab, $225,000, leaving the hospital responsible for $15,000.

What this means to you: This case certainly speaks to the necessity of accurate assessment of the patient both on admission and continuing over the length of stay, no matter if the patient is in the facility a short time or indefinitely. A patient's presentation on day one can be greatly different on day five or day 31.

A formal falls assessment that covers a multitude of indicators over time is the obvious first step in establishing a patient's baseline.

"A complete medical history goes a long way to provide a basis for the falls prevention program that should be individualized for that particular patient. Not only is the patient's past fall history significant, but an overview of his/her functional abilities and current state of health is essential. Family input at the time the patient is admitted is also highly desirable in developing an accurate profile of the risks pertinent to the patient," notes **Lynn Rosenblatt**, CRRN, LHRM, risk manager at HealthSouth Sea Pines Rehabilitation Hospital in Melbourne, FL.

Questions raised by this scenario includes: Does the patient suffer from hypertension, a seizure disorder, diabetes, hypoglycemia, or syncope? What type of medications does the patient take? Should any significant medical history be addressed? Does the patient present with dementia? Can the patient follow directions? Is the patient's memory intact? Is the patient's orientation consistent? What is the state of the patient's vision and hearing? Is the patient aware of limitations?

The admitting nurse should carefully assess the patient's mobility as a result of surgery or other previous disabling conditions. Are there any impairment to gait and mobility? Is the patient able to stand for transfers? How much assistance does the patient need? Is the patient fully continent? Can the patient be trusted in the bathroom alone? Can the patient ambulate and how far? What assistive devices are necessary?

"Assessing all of these facts, at the time of admission, provides a basis on which the nurse can formulate an individualized fall prevention plan for the patient. Had the nurse noted the patient's history of schizophrenia, she logically should have addressed the fact that the patient was not receiving medications usually indicated for a psychiatric condition. This information would have also alerted the nurse to possible changes in the patient's behavior over time," Rosenblatt says.

The patient's mobility status would have provided the nurse with reference points as to when the patient may be at highest risk for fall over the course of the day. The development of sound policies related to toileting patients, safe transfers, side rails and bed-height positioning, and use of assisted devices are paramount to a safe environment.

Once the nurse has formulated an accurate assessment of the patient's medical condition and the factors that contribute to falling, a prevention program for that particular patient can be implemented using existing policy and procedures.

"In this case, it appears that the nurse merely noted the patient to be at risk but did not address that risk appropriately. This highlights the value of a falls risk-flowsheet that not only identifies an individual patient's own risk factors, but provides a mechanism to develop a plan that avoids placing the patient in an increased-risk situation," says Rosenblatt.

"Then the plan must be communicated to the assigned caregivers. This speaks to communication tools used between the individual staff members across all shifts. Team rounds or posting the risk-prevention plan at the bedside provide a means to alert those caring for the patient to the particulars of the safety protocols for that patient. The credibility of the plan is lost if it does not allow for reassessment on a continuing basis. In this case, the patient's mental status was a factor codependent on the fact that she may not have been receiving her usual psychotropic medications. Over seven days, there may have been behavioral factors that were either overlooked, not documented, or both," adds Rosenblatt.

Obvious changes in cognitive status, unusual behaviors, and restlessness are all indicators of deterioration in mental acuity. They also place the patient at higher risk for falls. Agitated patients are particularly unpredictable in terms of safety concerns. The initial plan must be modified as often as necessary based on patient observation. It should be time sensitive as to day, evening, and night shifts.

Techniques for preventing falls may require modification as the patient's condition improves. Bed rails and bed height are preventative measures at bedtime or for the bed-bound patient. Greater mobility may equate to more opportunity for a fall. Wheelchair-bound patients are likely to attempt to stand particularly if they are unable to comprehend their full limitations.

"Seat alarms can be helpful if the patient's ognition is such that the sound provides a recognizable signal to the patient, but they are worthless if they only signal the staff that the patient is on the floor. Anti-tipper devices also have limitations. If a patient is prone to leaning forward or tipping back, than an anti-tipping device may provide some stabilization, but if the patient stands or is extremely heavy, the device will be of little reliability," Rosenblatt says.

"Patients using walkers and other gait aides are also at higher risks for falls. These facts demonstrate the need to accurately assess the patient together with the prevention plan that was developed, and not only to match that plan to the individual but to the environment on the unit and particular activities that are part of the normal day," add Rosenblatt.

"The admitting nurse failed to follow policy on completion of forms related to the patient's care and monitoring requirements. Since a mechanism did not exist for daily review of the patient's risk potential, the nursing assistants were unaware of their heightened responsibility toward this patient. They had no insight into her potential for falls or unpredictable behaviors as a result of her previous psychiatric history."

While the Health Insurance Portability and Accountability Act restricts the type of information that can be visibly displayed and widely communicated, the key factors in an individual patient-risk prevention plan is essential to maintenance of a safe care environment and oversight of the patient. Policy development and communication procedures that accomplish that end would have possibly prevented this suit.

"Insufficient information is provided to access any legal concerns related to the acute care admission. It would appear that the nursing home was operated by the hospital as a distinct entity. If that was not the case and the nursing home was in fact operated under the same governance as the hospital, the hospital would have shouldered the entire settlement. The payment of $15,000 in such a large verdict indicates more a 'nuisance level of settlement.' This is another area of concern for providers, as once a case is brought, it is frequently difficult to get out without some payment even in the absence of liability," opines Rosenblatt.

Reference

• Queens County (NY) Supreme Court, Index No. 12275/99. ■

Healthcare Risk Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Fill in the appropriate answer directly on this form. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses will be strictly confidential. Do not put your name or any other identifying information on this survey form.

1. What is your current title?

- ☐ A. risk manager
- ☐ B. risk management director
- ☐ C. vice president
- ☐ D. director/manager of quality
- ☐ E. medical director
- ☐ F. director of nursing
- ☐ G. other _____

2. Please indicate your highest degree.

- ☐ A. LPN
- ☐ B. diploma (3-year)
- ☐ C. BSN
- ☐ D. BA
- ☐ E. BSN
- ☐ F. MSN
- ☐ G. JD
- ☐ H. master's
- ☐ I. PhD
- ☐ J. other _____

3. Which certification best represents your position?

- ☐ A. ARM
- ☐ B. CHPA
- ☐ C. FASHRM
- ☐ D. MSM
- ☐ E. DFASHRM
- ☐ F. other_____

4. How long have you worked in risk management?

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

5. How long have you worked in health care?

- ☐ A. less than 1 year
- ☐ B. 1-3 years
- ☐ C. 4-6 years
- ☐ D. 7-9 years
- ☐ E. 10-12 years
- ☐ F. 13-15 years
- ☐ G. 16-18 years
- ☐ H. 19-21 years
- ☐ I. 22-24 years
- ☐ J. 25 or more years

6. What is your age?

- ☐ A. 20-25
- ☐ B. 26-30
- ☐ C. 31-35
- ☐ D. 36-40
- ☐ E. 41-45
- ☐ F. 46-50
- ☐ G. 51-55
- ☐ H. 56-60
- ☐ I. 61-65
- ☐ J. 66 or older

7. What is your sex?

- ☐ A. male
- ☐ B. female

8. What is your annual gross income from your primary health care position?

- ☐ A. Less than $30,000
- ☐ B. $30,000 to $39,999
- ☐ C. $40,000 to $49,999
- ☐ D. $50,000 to $59,999
- ☐ E. $60,000 to $69,999
- ☐ F. $70,000 to $79,999
- ☐ G. $80,000 to $89,999
- ☐ H. $90,000 to $99,999
- ☐ I. $100,000 to $129,999
- ☐ J. $130,000 or more

9. On average, how many hours a week do you work?

- ☐ A. less than 20
- ☐ B. 20-30
- ☐ C. 31-40
- ☐ D. 41-45
- ☐ E. 46-50
- ☐ F. 51-55
- ☐ G. 56-60
- ☐ H. 61-65
- ☐ I. more than 65

10. In the last year, how has your salary changed?

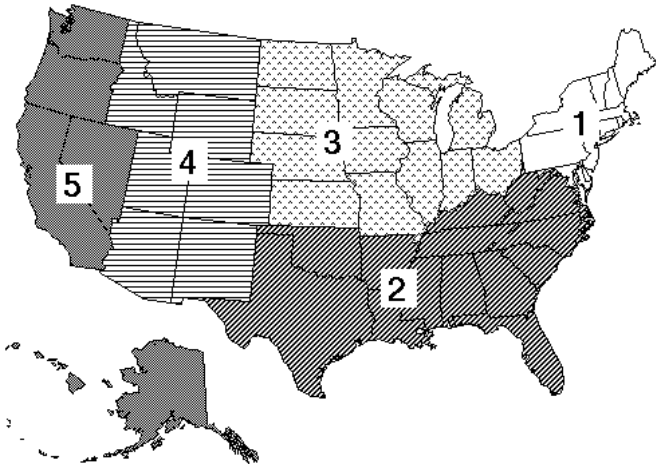
- ☐ A. salary decreased
- ☐ B. no change
- ☐ C. 1% to 3% increase
- ☐ D. 4% to 6% increase
- ☐ E. 7% to 10% increase
- ☐ F. 11% to 15% increase
- ☐ G. 16% to 20% increase
- ☐ H. 21% or more increase

11. Which of the following best describes the location of your work?

- ☐ A. urban
- ☐ B. suburban (outside large urban area)
- ☐ C. medium-sized community
- ☐ D. rural

12. Using the map (right), please indicate where your employer is located.

- ☐ A. region 1
- ☐ B. region 2
- ☐ C. region 3
- ☐ D. region 4
- ☐ E. region 5
- ☐ F. Canada
- ☐ G. other_____



13. Which best describes the ownership or control of your employer?

- ☐ A. college or university
- ☐ B. federal government
- ☐ C. state, county, or city government
- ☐ D. nonprofit
- ☐ E. for profit

14. Which of the following best categorizes the work environment of your employer?

- ☐ A. academic
- ☐ B. agency
- ☐ C. city or county health department
- ☐ D. clinic
- ☐ E. college health service
- ☐ F. consulting
- ☐ G. hospital
- ☐ H. private practice

15. If you work in a hospital, what is its size?

- ☐ A. <100 beds
- ☐ B. 100 to 200 beds
- ☐ C. 201 to 300 beds
- ☐ D. 301 to 400 beds
- ☐ E. 401 to 500 beds
- ☐ F. 501 to 600 beds
- ☐ G. 601 to 800 beds
- ☐ H. 801 to 1,000 beds
- ☐ I. >1,000 beds
- ☐ J. I don't work in a hospital

Deadline for responses: Sept. 1, 2003

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible. If the envelope is not available, mail the form to: Salary Survey, Thomson American Health Consultants, P.O. Box 740058, Atlanta, GA 30374.