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Special Report: Charitable Hospital Lawsuits

Trust and its perception: Hospitals and charitable lawsuits clash in the courts

Review your collections practices and EMTALA procedures now

Even if your hospital was not named in the recent wave of lawsuits against charitable providers, the alarm bell is ringing and you need take action now. The message from legal experts and health care analysts is clear: These lawsuits represent a significant new threat to all hospitals because they highlight business practices that may not withstand close scrutiny.

If your hospital is not included in the lawsuits, they say, count yourself lucky and seize the opportunity to correct any questionable practices before it's your facility's name on the court docket.

The lawsuits filed nationwide charge that nonprofit hospital systems and hospitals have failed to provide government-required charity care to uninsured patients. Thirty-nine lawsuits are under way in 20 states against defendants that control approximately 340 hospitals. **(For more on the lawsuits themselves, see article, p. 101.)**

The lawsuits should concern all risk managers, not just those currently facing lawsuits, says **Bryan Liang**, MD, PhD, JD, professor of law, medicine, and public policy, and executive director of the Institute for Health Law Studies at California Western School of Law in San Diego.

"Risk managers are going to be on the hot seat. This is going to be a major issue," he says. "Risk managers will be the ones who really have to deal with this issue because the CEOs and CFOs don't see these problems from a day-to-day perspective. But risk managers do."

One observer predicts there will be many more such suits filed in the near future, though not necessarily as part of the same effort currently under way. **Robert P. Charrow**, JD, a shareholder with the law firm of Greenberg Traurig in Washington, DC, notes that of about 4,100 hospitals in the country, 3,200 are nonprofit and could be targeted by such lawsuits.

"And there are potential implications for the for-profit hospitals from regulators," he says. "If the regulators think that these lawsuits highlight questionable practices, they will take action."

An attorney for one of the hospitals being sued, St. Thomas Hospital in Nashville, says the charges are "novel" and not supported by much previous case law. **Berry Holt**, JD, a Nashville attorney who serves as outside counsel for the hospital, says the charges against many of the hospitals are remarkably similar and speculates that some facilities seem to have been chosen just for the sake of including all geographic regions.

"We're being sued by a named plaintiff — who we don't have any reason to believe — paid us for any health care services," he says. "This is clearly an allegation to suggest that tax exemption carries an obligation to take care of the poor and uninsured, which St. Thomas certainly does, but to make it into a lawsuit is unprecedented. The country is debating how to pay for health care for the uninsured and with the lawsuits they're trying to decide that in the courts instead of in the legislature, where it ought to be."

Holt expects many of the claims to be dismissed. But he says the lawsuits may still have far-reaching implications for all health care providers because they have brought many policies and procedures into question.

A spokeswoman for the American Hospital Association in Washington, DC, which is being sued along with the hospitals, says the lawsuits are misdirected and divert focus away from the bigger issue of how to provide care for uninsured patients. **Alicia Mitchell** says the charges are "baseless, and the lawsuits will consume the already limited resources for caring for these patients."

Risk managers must take action

Liang says risk managers must be proactive in addressing some of the concerns raised by the lawsuits, and he says there are some legitimately troubling issues cited in the cases. Many of the hospitals are accused of excessively aggressive debt collection with poor patients, and he says that is a problem that might be found in many more health care organizations, both for-profit and nonprofit. The practice looks worse for nonprofits but certainly doesn't look good when it is revealed at for-profit facilities, Liang adds.

"At the very least, it's a marketing problem," he says. "There was a certain amount of arrogance among community hospitals when they said they didn't care what the local community thought of their business practices as long as they fulfilled the 501(c)(3) charity requirements. That was a big mistake."

Once the community learns that the charity hospital has been harassing poor people to pay debts — possibly at inflated charges many times more than that paid by insurers — the hospital's image takes a beating, Liang says.

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"The public is now hearing that the hospitals that promised to care for those who can't pay are going door-to-door, badgering people for money and making threats," he says. "That's the worst marketing in the world."

High charges also at issue

To make matters worse, the hospitals often charge uninsured patients far more for the same service than they would charge an insurance company. Some markup might be justified by the lack of volume discounts and individual billing costs, Liang says, but hospitals will find it hard to justify charging an uninsured patient 100% more.

The tightening of health care budgets in recent years and financial advisers who urged more aggressive collections prompted many of those practices. But he says the risk manager might have to be the person who says, "Enough." **(For more on how to review collection practices, see article, right.)**

The risk manager must make sure that the charges and collection practices are not only reasonable, but that they look reasonable to an outsider, Liang says. After these lawsuits shine a spotlight on these previously ignored practices, it won't be enough to merely meet the minimum requirements, he says, because critics will be eager to pounce on any perceived wrongdoing.

"You might have worked for years to build a trust relationship with your community and a positive public image," he says. "But all of that can be destroyed with one news report about how your collections agency was hassling some old grandmother for a few dollars."

Charrow suggests conducting an annual audit of charge structures and collections practices. An audit can help produce hard numbers on how much revenue those aggressive pricing structures actually bring in.

"It's not easy to go to your boss and tell them you want to lower those high charges for uninsured patients, but an audit might show you that you're only collecting pennies on the dollar from those people, anyway," he says. "And then you can weigh whether those pennies are worth all the grief and bad publicity from that pricing structure."

Can encourage lawsuits

The fallout from such negative publicity can have very real effects on the health care provider, Liang says. He compares the situation to a well-known fact in risk management: Patients are less likely to sue for malpractice when they trust the physician and believe he or she had the best intentions.

"When your image changes, and they see you as transferring charity dollars to for-profit enterprises and going after people aggressively, they're not going to give you the benefit of the doubt when something goes wrong," he says. "They'll take you right to the courthouse door."

Liang predicts that the lawsuits will prompt a significant increase in state scrutiny of financing and collections practices. That could lead to large settlements and fines if the hospitals are found to have abused public funds with their tax-exempt status, he says.

"The federal government also is going to get involved, looking at abuse of 501(c)(3) status and maybe revoking that status for some hospitals," he says. "Even without revocation, the hospitals could be looking at increased taxes, fines, and millions of dollars in legal fees." ■

Review collection practices critically, suggests lawyer

Do you know how your organization goes about collecting debts from past patients? Do you know *exactly* how? Would you mind if those practices were detailed on the evening news over a picture of your front entrance and logo?

The recent lawsuits filed against charitable hospitals has brought attention to the issue of collections practices in health care and made them a major risk, says **Scott Becker**, JD, a partner in McGuireWoods LLP's Chicago office and one of the co-chairs of the firm's health care practice. Some allegations in the lawsuits are not what you would like associated with your organization, but he warns that the very same thing could be happening down the hall unless you have taken steps to prevent abuse.

Charitable Hospital Lawsuits

A sample audit may be the best way to find out how poor patients are treated in your institution, he suggests. The audit should look at how those patients are treated from their intake — including whether you gather any information at that time about their financial status — and what efforts are made to collect payment.

Becker says he suspects many risk managers

would be surprised by what happens when their finance department hands a bill over to a collections agency. Reports of harassment, threats, arrests, and forced bankruptcy are not uncommon, Becker says.

Meet with collections

Becker suggests that risk managers should meet with the collections department or agency and go over exactly how the process works.

"It's a big mistake to say you don't know or don't care what happens after you send that bill to collections," he says. "Even if it's an outside agency, everything they do they're doing in your name and in the public's eye you are completely responsible. You need to know exactly how they handle collecting on that account, how far they go and what tactics they use, and you need to be comfortable with it."

The risk manager must exercise some control over the collections process, he says. For instance, you may want to develop a system in which the collections agency must come to you before pursuing legal action against debtors. If collections brings you 20 cases in which the next step is legal action, you might see that 18 are in poverty and decide to just write off the debts instead, he says.

"Whatever the system is, you need to understand it and agree to it up front," he says. "What is the nastiest thing they do in collecting these bills and are you OK with it? Can you live with seeing it on the front page of the local paper?"

Pricing structures also at issue

The same idea applies to the different charges for insured and uninsured patients. The risk manager should be familiar with the different pricing structures.

"Ask yourself if the only people you're charging full retail are the people who are least able to pay, the people who don't even realize that the usual and customary charge you're billing them is 10 times what everybody else is paying," he says. "Ask yourself if you're OK with that being detailed to the public."

Becker says the lawsuits also highlight the fact that many hospitals have not taken proper steps to identify indigent patients from the outset, instead treating all patients the same when it comes to collections. If that is your hospital's process, it's time to change, he says. **(See p. 102 for suggested guidelines.)**

"If someone is really poor and you're supposed to be a charity hospital, you need to have a system in your intake so that you know that and factor that in to how you go about bill collections," he says. "A lot of these problems could be solved by proper intake so that if you have someone who is truly in poverty, you start out by discounting their usual and customary charges." ■

Serious EMTALA violations charged in charity lawsuits

When it comes to EMTALA, you don't want to just toe the line, says **Bryan Liang**, PhD, a professor of law, medicine, and public policy at California Western School of Law in San Diego. You want to be so far away from the line that no one could even suggest you crossed it.

"You're not supposed to talk about insurance before the patient is seen, so any time they do that it is an EMTALA violation. I think that's a slam-dunk," he says. "There might be some exaggeration in the lawsuit about what actually happens in these hospitals, but there is usually a kernel of truth in the allegation somewhere. You don't want to get anywhere near that EMTALA violation line."

Charitable Hospital Lawsuits

Liang suggests that risk managers should review — again — how their emergency department staff discuss payment with patients. Be on the lookout for systems and procedures that might be technically acceptable but still come too close to a violation.

"If they wait until the examination is under way or just finished and then they bring in the paperwork and bring up the financial issue, that's not before stabilization, but it's so close that it can look like coercion. Any appearance of impropriety can invite a closer look and fines."

Liang recommends waiting until the patient is discharged, then inquiring with the patient about a payment plan or other options. That might not be the way to optimize collections, and it won't be recommended by the CFO. But he says it is the risk manager's job to contradict those optimal collections practices when they put the organization at risk.

"CFOs are not necessarily equipped to understand the intricacies of EMTALA or what the

community is thinking of you," Liang says. "CFOs have their own agenda and it's all about increasing revenue. It might be your job to say this is not the right thing for us to do, even if it costs us." ■

Lawsuit primer: Hospitals accused of profiteering

Here is what you need to know about the class action lawsuits filed against some of the largest nonprofit hospitals in the United States:

Charitable Hospital Lawsuits

The lawsuits were filed by Mississippi attorney **Richard Scruggs**, best known for heading the effort in recent years to sue tobacco manufacturers to recover money spent by state Medicaid programs on tobacco-related illnesses. Those tobacco lawsuits were settled and will bring more than $200 billion in payments to 46 states over the next 25 years.

The health care litigation seeks to stop nonprofit hospitals from "intentionally failing to fulfill their agreements with the United States Government, states, and local counties to provide charitable medical care to their uninsured patients in return for substantial tax exemptions," the lawsuits say. Named as a conspirator in the litigation is the American Hospital Association (AHA) in Washington, DC, which Scruggs says was included because it advises and provides substantial assistance to the defendants on all manners of hospital operation, including billing and collection practices concerning the uninsured.

Alleged failure to care for indigent

The lawsuits charge that the defendant nonprofit hospital systems and hospitals, working with the AHA, have failed to provide government required charity care to uninsured patients. A total of 39 litigations are under way in 20 states against defendants that control approximately 340 hospitals.

Scruggs and the plaintiffs allege that the named hospitals retain hundreds of millions of dollars annually as a result of their tax-exempt status, in exchange for which the hospitals should be providing charity care. Instead, he says, the hospitals charge the uninsured "sticker" prices for health care, an amount higher than any other patient group, and then, when the uninsured can't pay, the hospitals harass the uninsured through, among other tactics, aggressive collection efforts such as garnishment of wages and bank accounts, seizures of homes, and personal bankruptcies.

In addition to saving and amassing millions via unpaid taxes, the cases allege that the named hospitals benefit from income from their "for-profit" operations. These benefits often result in hospitals holding millions of dollars in offshore bank accounts located in havens which are known for secrecy, and where no taxes on these funds can be levied, the lawsuits charge.

The defendant nonprofit hospitals are charged with breaches of contract; breaches of good faith and fair dealing; breaches of charitable trust; consumer fraud and deceptive business practices; violations of EMTALA; unjust enrichment; civil conspiracy; conspiring with the AHA, and aiding and abetting with respect to the breaching of their tax exempt agreements.

The lawsuits allege that the defendants have operated free from federal and state taxes because they promised the government to operate as a charity provider of health care for the uninsured and that they would not engage in business "directly or indirectly, for the benefit of private interests."

"In reality, the defendants do just the opposite," Scruggs says. "The defendants violate the federal and state prohibition against profiteering by private interests through either board members and/or physicians whose for-profit businesses are favored and subsidized by the tax-free organization."

'Creative accounting' also charged

Private insurance companies and governmental third party payers also benefit from the tax-exempt hospitals' operations, each receiving large discounts off of the sticker price that only uninsured patients pay. The result, Scruggs says, is that only the uninsured, those who should be receiving charity care, pay the hospitals' highly inflated rates that bear no connection to the actual cost of providing the service.

The cases further assert that the defendants use "creative" accounting practices to grossly distort the small amount of charity care they provide to their uninsured patients, typically reporting the amount of charity care as the amount of gross charges — which are significantly inflated — rather than the cost of actually providing the service.

As if that weren't enough, the lawsuits also allege EMTALA violations in which hospitals require that before admission patients must sign a form contract promising to pay the defendants in full for unspecified and undocumented charges for medical care that are set by the defendant nonprofit hospital at its sole discretion. The defendants will not admit a patient into their emergency departments for emergency medical care unless and until that patient agrees to pay in full for such unspecified and undiscounted charges, a practice that clearly violates EMTALA, Scruggs says.

The cases seek monetary damages for the cost of medical care charged, injunctive relief and the imposition of constructive trusts to be imposed on the defendants and from these trusts medical care will be paid for to the plaintiffs and class in each case. ■

Guidelines cover five rules for charity care, collections

Responding to the lawsuits against charitable hospitals, the Hospital & Healthsystem Association of Pennsylvania (HAP) recently provided its member hospitals with a comprehensive set of guidelines addressing charity care, financial aid, and collection practices. The guidelines emphasize that compassionate patient care must always trump the need to be paid.

Charitable Hospital Lawsuits

HAP president and CEO **Carolyn F. Scanlan** explains that the guidelines incorporate key elements of Act 77 of 2001 (Tobacco Settlement Act) and Act 55 of 1997 (Institutions of Purely Public Charity Act), as well as federal tax exemption requirements.

"Hospital care and hospital financial practices are fraught with complexity," she says. "These charity care guidelines provide Pennsylvania hospitals with another tool to help them implement policies that are easily available to, and understood by, their patients and communities."

The charity care guidelines flow from five key principles articulated by HAP's CFO Advisory Group, Committee on Public Payor Policy, Trustee Leadership Steering Committee, and Board of Directors. Scanlan suggests that, for any hospital leaders worried about being accused of the same practices outlined in the recent lawsuits, adoption of these guidelines could be a good first step toward ensuring you're on track:

1. Concern over a hospital bill will never prevent any individual from receiving emergency health services. Hospitals will communicate this message clearly to prospective patients and to local community service agencies, and make it clear that essential services will be provided without regard to ability to pay.
2. Hospitals will assist patients in obtaining health insurance coverage from privately and publicly funded sources whenever appropriate.
3. Hospitals will have charity care and financial aid policies and practices that are consistent with their missions and values, and with federal and state law, and that take into account each individual's ability to contribute to the cost of his or her care, as well as the hospital's financial ability to provide the care.
4. Financial aid policies will be clear, understandable, and communicated in a manner that is dignified and in languages appropriate to the communities and patients served. These policies will be made readily available to prospective and current patients and to the community at large.
5. Debt-collection policies — by both hospital staff and external collection agencies — will reflect the mission and values of the hospital, and will be monitored carefully to avoid unintended consequences.

The complete guidelines also provide hospitals with tips for updating their financial aid policies; developing plans to communicate such policies to patients; identifying appropriate staff to administer the policies; and administering the policies fairly, respectfully, and consistently. The HAP document, Charity Care and Financial Aid Guidelines for Pennsylvania Hospitals, is available for download at www.haponline.org/public/charity_care. ■

Hospital investigated after improper photo is taken

A Denver hospital is facing strong criticism and threats of a lawsuit after emergency department (ED) staff photographed an unconscious patient's genitals and left the photo on the man's digital camera. The hospital already has weathered multiple investigations by the police and state regulators following the incident.

The 35-year-old man had been attacked outside a gay bar and was taken to Denver Health Medical Center with a cracked skull, says hospital spokeswoman **Bobbi Barrow**. While the man lay unconscious in the ED, two staff members found a digital camera among his personal belongings, Barrow explains. They first viewed the images stored on the camera, seeing that the patient had used the camera at the bar that night, she says.

They then pulled down a sheet to expose the man's genitals and took a photo before placing the camera with the rest of the man's belongings. The patient discovered the photo sometime after leaving the hospital.

Hospital admits misdeed

Barrow says the hospital does not deny the incident took place. It represents a breakdown of several fundamental hospital policies, she says.

"The digital camera was not immediately placed with his personal belongings, as policy required. There was a time lapse of an hour or more before the camera was put away," Barrow says. "In a very inappropriate and unprofessional action, someone shot a picture of him."

The staff members were a paramedic assigned to the ED, but not involved in transporting the patient to the hospital, and a health care technician.

The incident occurred at about 2:30 a.m. on Feb. 16, 2003, but was not reported to hospital leadership until July 17, 2003, she says. Hospital administrators immediately apologized to the patient in person and by telephone and launched an internal investigation.

Twelve days later, on July 29, the two employees involved with the incident were no longer employed at Denver Health. The hospital also reported the case to the Colorado Department of Public Health and initiated reminder training about patient privacy, management of personal belongings, and professional standards.

"The protocol for securing patient belongings was not adhered to," Barrow says. "Picking up something that belongs to a patient and using it is a major departure from anything expected in the emergency room. And the fact that we violated a patient's privacy was something we had to follow up on."

The internal investigations determined that all the proper policies already were in place, but that the staff needed reminders about respecting patients, Barrow says. She suggests that risk managers would be well advised to remind staff about patient respect and securing personal property. The other lesson is to respond promptly once such an incident is brought to your attention, Barrow adds. Denver Health leaders are confident that they did everything possible once they were informed, she says.

"The police investigation determined that there was a discussion around the emergency room that night about someone taking a picture, but it was a busy night," so the comments were not brought to the attention of administration at that time, Barrow says. When hospital leaders investigated, interviews suggested that three or four staff members knew about the incident. No one was disciplined for not reporting the incident, Barrow says.

The hospital cooperated with a state of Colorado investigation initiated on behalf of the Centers for Medicaid & Medicare Services, as well as cooperating with a local police investigation.

"The outcome was that we were not cited by the state and the police did not issue any charges," she says. "From our perspective, we took all the appropriate actions as soon as we knew. We behaved responsibly in response to what was clearly, clearly a violation not only of our policy but of the patient's privacy."

Patient threatens to sue

The incident did not become known publicly until the patient's attorney, Dan Caplis, JD, released a statement to the media. At that time, he also filed a notice of intent to sue, but Barrow says the hospital has not yet been sued. While Barrow admits that the incident was a clear violation of the patient's privacy, she relates her surprise that the patient's attorney released the photo in question to Denver television stations, at least one of which showed the photo during a newscast.

Barrow explains that the public disclosure of the incident came at the same time the hospital was already dealing with another scandal involving emergency staff. She says the two incidents are unrelated. On June 24, 2004, the hospital terminated five paramedics, placed three others on investigatory leave, and disciplined nine more.

"A former employee, after leaving, alleged actions of not only internal harassment of each other, but also some unprofessional treatment of patients by a small group of paramedics," Barrow explains. "We learned through our investigation that there was some substantiation of the allegations, so action was taken."

The internal harassment included anonymous, threatening letters and other issues that created a hostile work environment. Regarding patients, the paramedics were accused of callous and abusive behavior such as making a 96-year-old woman walk to the ambulance instead of carrying her, bullying patients, making vulgar and demeaning comments, and unnecessarily rough and demeaning treatment of patients.

"As a result, Denver Health is doing a review of the paramedic division, taking a closer look at various aspects of the organizational structure," Barrow says. "We have already changed the patient complaint system because we previously had a separate complaint system for the paramedics but sometimes those complaints never made it through to the hospital."

The hospital also now has a policy that requires rounding on patients admitted after transfer by paramedics, seeking feedback on how the paramedics treated them. The hospital also is reminding employees that they can report concerns anonymously through the employee hotline. ■

Newest JCAHO patient safety goals include falls

The newly released 2005 National Patient Safety Goals indicate that the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will put special emphasis on efforts to reduce patient falls, infections, and misidentification of patients.

Those are among several goals recently announced as part of JCAHO's efforts to steer health care risk managers toward the most pressing patient safety issues. The 2005 National Patient Safety Goals are specific to the various types of health care settings accredited and certified by JCAHO, including ambulatory care and surgery centers, office-based surgery, assisted living facilities, behavioral health care settings, critical access hospitals, disease-specific care program, home health care, hospitals, nursing homes, and laboratories.

The goals set forth succinct, evidence-based requirements regarding critical aspects of care, addressing for example, the accuracy of patient identification, effectiveness of communication among caregivers, safety in the use of infusion pumps, reduction of the risk of health care-associated infections, reconciliation of medications across the continuum of care, reduction of the risk of patients falls, and protection against pneumonia in older adults.

Announcing the new goals, JCAHO President **Dennis S. O'Leary**, MD, noted that the National Patient Safety Goals are reviewed and revised annually by the Sentinel Event Advisory Group. The goals are largely, but not exclusively, based on information from the JCAHO Sentinel Event Database. As part of the development process, candidate goals and requirements are sent to the field for review and comment before they are finalized.

Identification one goal for hospitals

The 2005 Patient Safety Goals for each type of health care provider are available on the JCAHO web site at www.jcaho.org/accredited+organizations/patient+safety/npsg.htm. Risk managers will find that some of the 2005 goals are a continuation of the current 2004 goals, while some are revised or completely new.

For hospitals, the first goal is the same as in 2004: Improve the accuracy of patient identification. JCAHO recommends using at least two patient identifiers (neither to be the patient's room number) whenever administering medications or blood products; taking blood samples and other specimens for clinical testing, or providing any other treatments or procedures.

The second goal — improve the effectiveness of communication among caregivers — also is a continuation from 2004 but with a new recommendation. JCAHO already had advised providers that for verbal or telephone orders or for telephonic reporting of critical test results, they should verify the complete order or test result by having the person receiving the order or test result read back the complete order or test result. JCAHO also recommended that you standardize a list of abbreviations, acronyms, and symbols that are not to be used throughout the organization.

The new recommendation for that goal is this: "Measure, assess and, if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values."

The third goal also is the same as in 2004: Improve the safety of using medications. The first two recommendations are also the same: Remove concentrated electrolytes (including, but not limited to, potassium chloride, potassium phosphate, sodium chloride > 0.9%) from patient care units;

and standardize and limit the number of drug concentrations available in the organization.

The third recommendation is new: Identify and, at a minimum, annually review a list of look-alike/sound-alike drugs used in the organization, and take action to prevent errors involving the interchange of these drugs.

As in 2004, the fourth and fifth recommendations involve improving the safety of infusion pumps and reducing the risk of health care-associated infections.

Reconcile medications, reduce falls

The sixth and seventh goals are new for 2005. Goal six is "Accurately and completely reconcile medications across the continuum of care." To achieve that goal, JCAHO offers this advice: "During 2005, for full implementation by January 2006, develop a process for obtaining and documenting a complete list of the patient's current medications upon the patient's admission to the organization and with the involvement of the patient. This process includes a comparison of the medications the organization provides to those on the list."

JCAHO's other recommendation is "a complete list of the patient's medications is communicated to the next provider of service when it refers or transfers a patient to another setting, service, practitioner, or level of care within or outside the organization."

Goal seven is "Reduce the risk of patient harm resulting from falls." The single recommendation for achieving that goal is "assess and periodically reassess each patient's risk for falling, including the potential risk associated with the patient's medication regimen, and take action to address any identified risks." ■

Infant deaths subject of new *Sentinel Event Alert*

Incidents of perinatal death of permanent disability have declined steadily in recent years, but the tragedy still occurs too often, reports the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO's most recent *Sentinel Event Alert* addresses this issue with recommendations for lowering the risk even further.

The entire *Sentinel Event Alert* is available on JCAHO's web site at www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea_30.htm. JCAHO notes that the rate of perinatal mortality in the United States has steadily declined to a rate of 6.9 deaths per 1,000 live births in 2001; but since the sentinel event reporting requirements began in 1996, a total of 71 cases of perinatal death or permanent disability have been reported.

Any perinatal death or major permanent loss of function "unrelated to a congenital condition in an infant having a birth weight greater than 2,500 g" must be reported as a sentinel event. Of the 71 reported cases, 61 resulted in infant deaths and 10 involved permanent disabilities. JCAHO reports that the mothers ranged in age from 13 to 41, with the average and median age being 27 years; and in just more than one-half of the cases, it was the first child. The average gestation was 39 weeks.

Contrary to what one might expect, a lack of prenatal care was an identified maternal risk factor in just 4% of cases. (The statistical analysis of the reports is based on only 47 of the 71 reported cases. JCAHO reports that it will release a complete statistical analysis soon.) Other identified maternal risk factors included age (13%), previous cesarean (11%), diabetes (4%), and substance abuse (4%).

Communication issues topped the list of identified root causes (72%), with more than one-half of the organizations (55%) citing organization culture as a barrier to effective communication and teamwork. Examples included hierarchy and intimidation, failure to function as a team, and failure to follow the chain of communication.

The reports also cited these root causes: staff competency (47%), orientation and training process (40%), inadequate fetal monitoring (34%), unavailable monitoring equipment and/or drugs (30%), credentialing/privileging/supervision issues for physicians and nurse midwives (30%), staffing issues (25%), physician unavailable or delayed (19%), and unavailability of prenatal information (11%). **(For advice on how to reduce infant deaths, see story, below.)** ■

JCAHO offers up advice for reducing infant deaths

Because the majority of perinatal death and injury cases reported root causes related to problems with organizational culture and with communication among caregivers, JCAHO offers these recommendations:

1. Conduct team training in perinatal areas to teach staff to work together and communicate more effectively.

2. For high-risk events, such as shoulder dystocia, emergency cesarean delivery, maternal hemorrhage and neonatal resuscitation, conduct clinical drills to help staff prepare for when such events actually occur, and conduct debriefings to evaluate team performance and identify areas for improvement.

3. Use a standardized maternal fetal record form for each admission.

4. Review and apply standards of care from professional organizations to facilitate these goals:

a. Develop clear guidelines for fetal monitoring of potential high-risk patients, including nursing protocols for the interpretation of fetal heart rate tracings.

b. Educate nurses, residents, nurse midwives, and physicians to use standardized terminology to communicate abnormal fetal heart rate tracings.

c. Review organizational policies regarding the availability of key personnel for emergency interventions.

d. Ensure that designated neonatal resuscitation areas are fully equipped and functioning.

e. Develop guidelines for the transfer of patients to a higher level of care when indicated, if essential services cannot be readily provided as required by professional guidelines. ■

Medical error rate may be higher than IOM estimate

The number of medical errors per year may be twice as high as previously estimated, according to a new report. An average of 195,000 people in the United States died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002, according to a new study of 37 million patient records released by HealthGrades, a health care quality company in Lakewood, CO.

The HealthGrades Patient Safety in American Hospitals study is the first to look at the mortality and economic impact of medical errors and injuries that occurred during Medicare hospital admissions nationwide from 2000 to 2002. The HealthGrades study finds nearly double the number of deaths from medical errors found by the Institute of Medicine's (IOM) 1999 report conclusion, which found that medical errors caused up to 98,000 deaths annually and should be considered a national epidemic.

The 1999 IOM report, *To Err is Human,* extrapolated national findings based on data from three states; whereas, HealthGrades looked at three years of Medicare data in all 50 states and Washington, DC. This Medicare population represented approximately 45% of all hospital admissions (excluding obstetric patients) in the United States from 2000 to 2002, explains **Samantha Collier**, MD, HealthGrades' vice president of medical affairs.

"The HealthGrades study shows that the IOM report may have underestimated the number of deaths due to medical errors and, moreover, that there is little evidence that patient safety has improved in the last five years," she says. "The equivalent of 390 jumbo jets full of people are dying each year due to likely preventable, in-hospital medical errors, making this one of the leading killers in the U.S."

HealthGrades examined 16 of the 20 patient-safety indicators defined by the Agency for Healthcare Research and Quality in Rockville, MD — from bedsores to postoperative sepsis — omitting four obstetrics-related incidents not represented in the Medicare data used in the study. Of these 16, the mortality associated with two, failure to rescue and death in low-risk hospital admissions, accounted for the majority of deaths that were associated with these patient safety incidents. These two categories of patients were not evaluated in the IOM analysis, accounting for the variation in the number of annual deaths attributable to medical errors, Collier notes.

"If we could focus our efforts on just four key areas — failure to rescue, bed sores, postoperative sepsis, and postoperative pulmonary embolism — and reduce these incidents by just 20%, we could save 39,000 people from dying every year," she says. ■

COMING IN FUTURE MONTHS

- *HRM's* plan for reducing slips and falls
- What JCAHO expects when you self-assess your program
- Mock emergencies: Making them realistic
- How much EMTALA education is enough?

Medical errors concern most of public, study says

Hospital-based medication, surgical and diagnostic errors are of concern to most Americans, according to the results of a new Harris Interactive poll of 2,847 U.S. adults.

Three in five Americans (63%) are "extremely concerned" (39%) or "very concerned" (24%) about hospital-based medication errors, such as receiving the wrong medication or the wrong dose, and 55% are concerned about hospital-based surgical errors that might include incorrect amputations or mistaken patient identities — 39% are "extremely concerned," and 16% are "very concerned."

The public is only moderately confident about the ability of U.S. hospitals to prevent these types of errors, explains **Katherine Binns**, senior vice president of health care at Harris Interactive in Rochester, NY. While one in three adults (33%) believe hospitals do an "excellent" or "very good" job preventing medication errors, nearly equal proportions (28%) believe hospitals do a "fair" or "poor" job. Likewise, one in three adults (30%) believe that hospitals do an "excellent" or "very good" job preventing diagnostic errors, but an equally large proportion believes they do a "fair" or "poor" job (29%).

The public is somewhat more confident about hospitals' abilities when it comes to preventing surgical errors; 42% believe they do an "excellent" or "very good" job. New procedures instituted in July to prevent surgical errors include double-checking patients' identities and using standardized procedures for marking patients' bodies in preparation for surgery. Most Americans think these new procedures will be effective — 15% "extremely effective," 43% "very effective," and 36% "somewhat effective" in preventing future errors.

"These findings suggest that efforts by the Institute of Medicine and others to increase public awareness of patient safety issues are hitting home with the American public," Binns says. "Public concern about medical, surgical and diagnostic errors is high; and many have doubts about the ability of our medical institutions to prevent these types of errors. On the bright side, most adults also are confident that initiatives like the recently enacted hospital standards to help prevent surgical errors will prove to be effective in advancing patient safety." ■

CE Questions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge.

To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this 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.

9. Regarding the charitable hospital lawsuits, what does Robert P. Charrow, JD, advise?
A. State and federal regulators may focus on some of the issues highlighted in the lawsuits.
B. State and federal regulators will not be interested or address any of the issues.
C. Only nonprofit hospitals have reason for concern.
D. The lawsuits will not have any significant implications for either nonprofit or for-profit hospitals.

10. Which of the following does Scott Becker, JD, recommend as a way to review your organization's billing and collections procedures?
A. Call patients at random to ask about their experiences.
B. Conduct a survey as patients are discharged.
C. Meet with the head of accounting in your organization.
D. Conduct a sample audit of how patients are treated throughout the entire process from admission to discharge and after.

11. In JCAHO's *Sentinel Event Alert* regarding infant deaths, what was the most commonly identified root cause?
A. Communication issues
B. Lack of prenatal care
C. Insufficient policies and procedures
D. Inadequate staffing

Answers: 9. A; 10. D; 11. A

Audio conference: Protect your tax-exempt status

Class action lawsuits on behalf of the uninsured have been filed against a number of nonprofit hospitals in multiple states. More suits are expected to follow as this issue draws increasing media and political attention.

If you're like many nonprofit hospitals, you're likely hanging by a financial thread. Do you know what actions you can take to protect your tax-exempt status? And does your staff know about the many alternative services available to help the needy?

Thomson American Health Consultants is offering an audio conference to help you learn where your hospital may be exposed, what policies and procedures you need to reform to preserve your tax-exempt status, and how to continue to provide necessary care for the uninsured.

Billing and Collections Practices Regarding the Uninsured: What You Need to Know to Preserve Your Hospital's Tax-Exempt Status, which will be held on Thursday, Sept. 6, 2004, from 2:30-3:30 p.m., EST, will be presented by **Jay Wolfson**, DrPH, JD.

Wolfson is a professor of public health and medicine at the University of South Florida Health Sciences Center in Tampa and is an expert in the field of health care law. He has done extensive research, written numerous books and articles, and given many talks on the subject.

Your facility fee of just $249 entitles you to invite as many participants to listen as you wish. You will receive presentation materials, additional reading, a 48-hour replay of the live conference, and a CD recording of the program upon request at no additional charge. And if you register by Aug. 26, you will qualify for the discounted facility fee of just $199 (a $50 discount off the regular price of $249). To register or to get more information, visit us at www.ahcpub.com, or contact customer service at (800) 688-2421 or by e-mail at customerservice@ahcpub.com.

When registering, please reference code **T04120-61822.** ■

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. ■

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

An obstructed airway causes permanent brain damage: $24 million verdict in Kentucky

By **Jan J. Gorrie**, Esq., and **Blake Delaney**, Summer Associate
Buchanan Ingersoll PC
Tampa, FL

News: A boy who broke his arm playing football was taken to an emergency department (ED). His broken bone was reset, and he was transferred to a recovery unit. The boy's airway became obstructed, which went unnoticed by his anesthesiologist, and he suffered a hypoxic-ischemic injury, resulting in permanent brain damage. The plaintiff brought suit against the hospital and the anesthesiologist, alleging negligence for failure to timely intervene, inadequate staffing in the recovery unit, and negligent removal of his translaryngeal endotracheal tube after the procedure. A jury found both defendants equally liable and awarded $24.2 million in damages. The hospital had settled with the plaintiff prior to trial, and the court assessed a $12.1 million judgment against the anesthesiologist.

Background: A 14-year-old boy broke his arm while playing football in November 1999, and his mother rushed him to a local ED. Instead of performing surgery to align the broken bone via an open reduction, medical personnel set the fracture using a closed reduction, eliminating the need to cut through the patient's skin. Because the boy had a full stomach, the orthopedist performed the reduction the next morning. The orthopedist, assisted by an anesthesiologist, took 20 minutes to perform the procedure, which was uneventful.

Afterward, medical personnel found the patient alert and transferred him to the post-anesthesia recovery unit. The anesthesiologist briefly evaluated the boy and observed his condition to be stable. She wiggled the boy's toe, received a response, and left to attend to another surgery. But the anesthesiologist failed to realize the boy had an airway obstruction. The boy sustained a hypoxic-ischemic injury, characterized by a reduction of oxygen in, and blood flow to, his tissue and major organ systems. Nurses tried to call a resuscitation code, but devastating damage already had occurred.

The boy is in a permanent state of minimal consciousness. He is aware of his surroundings, but unable to communicate, requiring 24-hour-care for the rest of his life, including daily removal and cleaning of a tracheal tube. The injury reduced the teen-age boy's life expectancy to fewer than 50 years.

The plaintiff filed suit, alleging negligence by the hospital and the anesthesiologist. He first argued that the standard of care required that the anesthesiologist wait until he was stable and connected to the proper monitors before leaving the recovery unit. The plaintiff pointed to the hospital medical record, which showed that the anesthesiologist failed to chart monitor readings until the next day. By ceasing direct observation too soon, the plaintiff alleged, she breached her duty. The boy also established causation by arguing that, had the defendants properly monitored him in the recovery unit, they would have detected his obstructed airway. Because the obstruction most likely occurred after the patient arrived at the recovery unit, the anesthesiologist's failure to timely intervene was

directly responsible for the patient's extensive, disabling damages.

The plaintiff also raised the possibility that an error while removing the translaryngeal endotracheal tube led directly to his damages and that inadequate staffing in the recovery unit led to the failure to timely detect his airway obstruction.

The hospital initially defended the suit, relying on numerous experts to argue that its conduct did not fall below the minimum standard of care. However, as the trial date loomed near, the hospital entered into a confidential settlement agreement with the plaintiff. The anesthesiologist, on the other hand, vigorously defended herself, arguing that her care was proper. She pointed out that, before leaving the recovery room, she had wiggled the boy's toe to confirm his alertness. The anesthesiologist also argued that the patient's injury was not the result of negligence.

At trial, even though the hospital already had settled with the patient, the judge instructed the jury to apportion responsibility between the hospital and the anesthesiologist, as Kentucky law requires an allocation of liability if more than one defendant is found responsible because defendants can be held liable for only their share of damages. The jury found both parties 50% liable. Its $24.2 million damages award represented the maximum requested for the plaintiff's past and future medical expenses, inability to earn a living, and future mental and physical suffering. The trial judge assessed damages of $12.1 million against the anesthesiologist and her employer.

What this means to you: This case exemplifies the importance of establishing and utilizing express, written policies and procedures.

"Had the direct care responsibilities attributable to both the anesthesiologist and the hospital been clearly outlined, this unfortunate injury possibly could have been avoided," says **Lynn Rosenblatt**, CRRN, LHRM, risk manager, HealthSouth Sea Pines Rehabilitation Hospital (Melbourne, FL).

As part of a typical anesthesiology procedure, the physician's duties probably would include monitoring the patient until the recovery room staff could establish mechanical monitoring. She suggests that hospitals should develop a checklist of vital indicators that the physician and the recovery room staff could utilize to assure that a patient has fully recovered from anesthesia. This checklist also should specify predetermined indicators to be met before the anesthesiologist relinquishes her responsibilities and leaves.

In this scenario, Rosenblatt points out uncertainty surrounding the indicators. Wiggling a toe seemingly has little to do with ensuring a fully patent airway; the patient's response may have been more reflexive than indicative of recovery. "Of course, it is also unclear whether the young boy exhibited any of these indicators because the anesthesiologist did not make her entries in the patient's medical chart until the next day," she says.

Also of concern is the apparent delay by recovery room staff in assessing the patient and connecting monitors. "In addition to ensuring that the basic safety net of mechanized monitoring was effectively in place before she departed, a prudent anesthesiologist would continue to monitor the patient manually until the nursing staff assured her that the patient was connected to the monitors. Again, a written procedure should establish the mechanism for relinquishing care to another provider," says Rosenblatt.

In addition to implementing effective written policies and procedures, a health care facility must ensure that the recovery unit is equipped with the necessary resources. Of prime importance is an efficient, properly trained nursing staff.

"A risk manager should investigate the nature of training provided in this recovery unit," says Rosenblatt. "A properly trained staff would never allow a patient's airway obstruction to go undetected. In fact, part of the very basic standard of care includes ensuring that all post-surgical patients have stable vital signs and effective oxygen concentration rates."

Another available resource is advanced life support, which Rosenblatt suggests should be the norm in all anesthesia recovery areas in conjunction with available physicians to assist the nursing staff at a moment's notice.

In the event that an injury occurs at a health care facility, a root cause analysis should be completed as part of the facility's investigation.

"In this scenario, an investigation by the medical staff oversight committee should look into the time intervals between procedures, the number of surgeries booked to the same anesthesiologist, the assessment responsibility of the recovery room staff, and with whom the ultimate responsibility for an injury of this type lies," Rosenblatt says.

"Other important questions involve whether the anesthesiologist had backup support that could assist the nursing staff immediately in a crisis and whether such assistance was provided for by means of the hospital's contract with the physician group or by means of whatever nursing staff happened to

be available at the time.

"In addition, the committee should scrutinize the individual conduct by the anesthesiologist. By investigating whether the anesthesiologist was fully qualified, whether she was recently credentialed, whether there had been previous problems with her intubations, and whether staff was aware of the symptoms of translaryngeal/tracheal edema, the committee should ultimately determine why the anesthesiologist left so quickly following the procedure. Certainly, her failure to chart at the time of completing the procedure contributed to her failure to properly assess the patient," notes Rosenblatt. "It indicates a sense of urgency on her part to move on to the next case, and it speaks to her failure to properly and adequately document her conduct, which is generally required at the time of completion of a procedure. In fact, had she remained to see through her full responsibilities, she would have been available to recognize and successfully deal with an airway obstruction."

Nevertheless, the anesthesiologist's negligence does not relieve the hospital from sharing in the blame in this situation. Also contributing to the injury was the hospital's failure to ensure the patient's medical stability before the anesthesiologist left, and the hospital's failure to adequately and appropriately provide staff that was able to recognize and handle any emergency that may arise.

"After all," concludes Rosenblatt, "the recovery room *is* critical care."

Reference

• Jefferson County (KY) Circuit Court, Case No. 00 CI 1471. ■

Failure to treat volvulus: $2.9 million settlement

News: A 5-year-old awoke in the middle of the night with intense stomach pains and was driven to an emergency department (ED). The ED physician's preliminary diagnosis was a probable bowel obstruction. The child was seen by his family practitioner and admitted to the hospital. A surgical consult was not requested until the next morning. Surgery was provided to address the obstruction. The boy died 14 months later from complications of having a shortened bowel. The boy's family settled with the hospital, nurses, and ED physician for $2.9 million. Trial is set for the case against the family doctor and the doctor's medical clinic.

Background: A 5-year-old child awoke screaming and holding his stomach. His father immediately drove him to an ED, and the child began vomiting bile. At the ED, the boy's blood pressure dropped sharply. The ED physician examined the child and ordered lab tests and X-rays in order to more completely assess his condition. In part based on the patient's vomiting of bile, the ED physician diagnosed the child as having "probable bowel obstruction." The physician phoned the child's family doctor, who came to the ED and examined the child at 2:15 a.m. The family doctor admitted the child to the hospital and went home.

At 2:55 a.m., the child was taken to a room in the hospital, and nurses took his vital signs. His temperature was 93.3° F and his blood pressure was 71/36. Concerned with the results, a nurse phoned the family practitioner at 4:30 a.m. and again at 6 a.m. At 6 a.m., the nurse also received two critical lab values for the patient: glucose and venous blood readings indicating the patient was acidotic. The family doctor cut the child's fluids and came to the hospital to order the child be moved to intensive care. When the next shift of nurses arrived at 7 a.m., the new nurse responsible for monitoring the boy saw the seriousness of his condition. She called the family physician, but he was performing a circumcision at another hospital. The nurse phoned the doctor again at 8:04 a.m. after discovering the child's blood pressure was 42/15 and his heart rate was 187.

The family doctor finally arrived at the hospital around 8:30 a.m. and immediately ordered a surgical consult. Surgery commenced at 9:50 a.m., more than nine hours after the child's arrival at the ED. As the ED physician had suspected, the boy had a bowel obstruction — volvulus of the colon. The family doctor had listed a generic bowel obstruction and a volvulus as two possible diagnoses on his differential diagnosis checklist, but he had believed the child might have been diabetic or was in diabetic ketoacidosis, even though lab results had ruled those conditions out.

Because of the delay in calling for a surgical consult and the subsequent surgery, most of the boy's small intestine and colon tissue had died. They were removed during the surgery. After surgery, the child was transferred to a children's hospital, where he spent 89 days of his remaining 14 months as an inpatient. He died from the complications of his shortened bowel.

The child's estate and his mother filed suit for negligence against the hospital, nurses, ED physician, family doctor, and the family doctor's medical clinic. The plaintiffs recognized that the ED doctor made the correct diagnosis of the decedent's bowel obstruction, but they pointed out that both the family physician and the ED doctor failed to promptly call for a surgical consultation.

The plaintiffs alleged that the ED nurse also failed to use the chain of command to obtain proper treatment after realizing that the child needed a surgical consult, and they argued that the night-shift floor nurse was too inexperienced to recognize the child's declining condition.

Using the decedent's medical records, the boy's mother outlined details of the extensive pain and suffering endured by her son over the last 14 months of his life. A $2.9 million settlement was reached with some of the defendants, including the hospital. The case remains set for trial against the family practitioner and his employer.

What this means to you: This case reinforces the basic notion that all health care providers have a responsibility to assure that their patients are receiving appropriate care in a timely manner.

"An examination by another physician or a transfer of care to another physician does not absolve the original physician of responsibility, nor does a change of shift relieve the first treating nurse of responsibility for the patient's initial care," says **Cheryl Whiteman**, clinical risk manager, BayCare Health System in Clearwater, FL.

Indeed, this case is a classic example of how individual negligent acts can compound due to an out-of-sight-out-of-mind mentality. Initially, the ED physician provided appropriate treatment when the boy was rushed into the hospital. He identified the urgency of the young patient's condition, diagnosed the boy's condition as a probable bowel obstruction, and phoned the child's family physician.

"However, as this condition is always of an urgent nature, the emergency room physician should not have accepted the primary care physician's plan to simply admit the child to the hospital. At the very least, the emergency room physician should have questioned the primary care physician as to why a surgical consult wasn't ordered," says Whiteman.

By allowing the child to be transferred to the intensive care unit, the ED physician may have missed his opportunity to intervene.

"It certainly would have behooved the emergency room physician to obtain the surgical consult while the child was still under the jurisdiction of the emergency room," Whiteman says.

Even if the ED physician felt that he could not order a surgical consult himself, he could have utilized the chain of command to make sure the boy received appropriate treatment.

"The emergency room physician could have contacted his medical director to obtain assistance in getting a surgical evaluation," Whiteman says.

In addition, the ED nurse also had the option of notifying a supervisor of the boy's urgent condition. "As plaintiffs' attorney pointed out, the emergency room nurse had a similar responsibility to enlist the supervisor's assistance in obtaining a surgical consult. At the very least had the supervisor been made aware of the situation, he or she could have assisted the floor nurse in monitoring the child's condition and seeking appropriate medical attention much earlier," says Whiteman.

In addition to the errors committed in the ED, the nurse caring for the child on the floor could have been more proactive. "The concern that prompted the two nighttime calls to the primary care physician should have escalated upon receiving lab values indicative of acidosis," she states.

Again, in the absence of immediate action from the primary care physician, this nurse could have activated the chain of command by notifying a supervisor. "The supervisor, in turn, could have taken the situation to an administrator and/or the family physician's section or department chair in order to obtain orders responsive to the condition, including a surgical consult," notes Whiteman.

Finally, the family practitioner would be hard-pressed to explain his lack of action considering that a young patient of his was facing a life-threatening situation. "From the beginning, a surgical consult should have been obtained at the time the differential diagnosis was established," says Whiteman. "He should have noticed that the lab results ruled out the differential diagnosis of diabetes, which in turn escalated the probable diagnosis to a surgical abdomen. Merely transferring this patient to a critical care unit instead of dealing with the cause of the symptoms would undoubtedly be found negligent in any court.

"To prevent similar breakdowns in the future, a risk manager should ensure that the facility has a strong chain of command policy," advises Whiteman.

Reference

- McHenry County (IL) Circuit Court, Case No. 00 L 187. ■