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IN THIS ISSUE

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Condition H phone line provides last chance to prevent serious errors

Family or patient can make emergency call if no one will listen

The idea of a Code Blue is well ingrained in hospitals. When the designated team hears that page for cardiac arrest, they drop everything and go running to help. Now one hospital has adopted a similar system for patients and family who fear something is seriously wrong but can't get any staff around them to help.

Called "Condition H" for help, the system at the University of Pittsburgh Medical Center (UPMC) Shadyside is designed to avoid or mitigate medical errors, says **Tamra Merryman**, RN, MSN, FACHE, vice president of the Center for Quality Improvement and Innovation for the UPMC Health System.

The system works this way: Patients and family members are taught on admission that if they ever feel that the situation is desperate and they can't get anyone around to listen to their concerns, they can pick up any phone in the hospital and dial 3-3131. When the operator picks up, the caller requests a "Condition H" and then that page is sent through the hospital's public address system. Several designated team members respond immediately, usually within a few minutes, and address the caller's concerns. The system works 24 hours a day, seven days a week.

EXECUTIVE SUMMARY

A Condition H protocol can give patients and family a way to obtain help when they think no one is listening to their concerns. The program is intended to help avoid medical errors or lessen the damage once an error has occurred.

- Condition H works much like a Code Blue call.
- Patients and family must be educated about how the program works.
- Fears that patients and family would abuse the system have been dispelled.

The Condition H program was prompted by the death of Josie King, an 18-month-old girl at Johns Hopkins Hospital in Baltimore in 2001. The girl's mother, **Sorrel King**, has become a prominent advocate for patient safety and says the option to call a Condition H would have saved her daughter's life. **(For more on the medical errors involving Josie King, see p. 17.)** The phone system is also known as "The Josie King Call Line."

At the most recent meeting of the American Society for Healthcare Risk Management (ASHRM), Sorrel King told her story and explained that she knew something was wrong with her child but that her concerns were dismissed by the staff and physicians. The errors that killed her daughter were easily correctable, but there was no system for Sorrel King to take her pleas to the next level.

"I know Condition H would have saved Josie's life," she says. "There is no doubt about it."

Rapid response team needed

Merryman heard King tell her story at a patient safety conference and realized that the bereaved mother had revealed a major flaw in the way hospitals operate. People have become accustomed to being able to pick up the phone and call 911 for immediate help everywhere except in a hospital. When you or your loved one is hospitalized, you are dependent on those around you to respond, and if they don't, you usually have no recourse.

She realized that families should be able to call a rapid response team when they are concerned and contacted Sorrel King last April to devise a plan that soon evolved into Condition H. Merryman found out quickly, however, that the idea was a radical one in the health care community. When she first approached her vice president for medical affairs, "he looked at me like I had lost my mind," she recalls.

Like many people hearing the idea for the first time, he feared that patients would abuse the system to complain about cold meals and grumpy nurses. That was a legitimate fear, Merryman says, because the Condition H system would be useless if it was overused and staff didn't take the calls seriously.

Merryman and Sorrel King worked with **Richard Kidwell**, JD, who had just recently joined UPMC Shadyside as director of risk management and associate counsel, coming from Johns Hopkins. At Johns Hopkins, Kidwell had worked with Sorrel King after the death of her daughter. Together, they created the Condition H program and piloted it on a medical/surgical unit at UPMC Shadyside. They introduced the idea to patients and family by explaining that they can call the rapid response team not for everyday, minor complaints but rather for two dire situations:

- If the patient is deteriorating clinically and no one is listening to their concerns.
- There is a communication failure and you don't know where to go with your concerns.

The pilot program was launched in May with good results, and Condition H was introduced throughout the hospital last July. By the end of the year, there had been six Condition H calls in the hospital, roughly one per month. **(See p. 16**

(Continued on page 16)

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Condition H

Shadyside Hospital is building the hospital of the future with the help of patients and families we care for. We believe in teamwork and ask that you be a part of our team when visiting your loved ones.

Dial # 3-3131

UPMC Shadyside

Part of UPMC Presbyterian Shadyside

5230 Centre Avenue
Pittsburgh, PA 15232

The Condition H Brochure is provided by the Josie King Foundation.

Condition H

(Condition Help)

The Josie King Call Line

A HELP line *for Families*

Dial # 3-3131

The Josie King Story

Josie King, an 18 month old little girl, died in 2001 from medical errors at one of the best hospitals in the country. Josie was the sister of Jack, Relly, and Eva and beloved daughter of Tony and Sorrel. She died as a result of a series of hospital errors and poor communication.

Listening to Sorrel King tell her tragic story left a lasting impression with me – 'if I would have been able to call a Rapid Response Team, I can't help but think Josie would be here today.' – providing the highest quality care for patients and their families is UPMC Shadyside's history. I knew that we had to bring a family life line (Condition H) to our patients.

Tami Merryman
Vice President
Patient Care Services

Condition H

At UPMC Shadyside, we are leading the national focus on eliminating system problems that affect delivery of care. As a response to providing the best care to our patients, we created a Josie King Call Line – Condition H. Josie's mother, Sorrel King, worked with UPMC Shadyside to design how this valuable resource will work in health care.)

UPMC is dedicated to making the hospital a safe place for patient care to happen.

Condition H was created to address the needs of the patient in case of an emergency or when the patient is unable to get the attention of a healthcare provider. This call will provide our patients and families a resource to call for immediate help when they feel they are not receiving adequate medical attention.

When to Call

1. If a noticeable medical change in the patient occurs and the health care team is not recognizing the concern.

2. If there is a breakdown in how care is being given and/or confusion over what needs to be done for the patient.

To access Condition H, please call 3-3131. The operator will ask for caller identification, room number, patient name and patient concern. The operator will immediately activate a "Condition H" where a team of medical professionals are alerted and will arrive in the room to assess the situation. Additional clinical supports will be called in as needed.

In offering our families the Condition H option, we want you to know that you are our partners in care. If you have any questions, please discuss them with one of our healthcare providers.

To access Condition H, please call # 3-3131

Source: University of Pittsburgh Medical Center (UPMC) Shadyside.

for more on those calls.)

To educate patients about the Condition H program, all patients receive a brochure at admission. The front of the brochure has a picture of Josie King. **(See p. 15 for excerpts from the brochure.)** The hospital also uses signage in patient rooms, stickers on the telephones, and it is introducing a video message hosted by Sorrel King on the hospital's in-house television system.

Good patient education is key to making the program work and avoiding false calls, Merryman says. "If people misuse the system, that means we haven't done our job in educating them about why the system is here and how to use it," she points out.

Speaking from the family's perspective, Sorrel King says she is certain that patients and family will not abuse the Condition H system. "When they see that it is named for a little girl who died because people wouldn't listen, they're not going to complain about bad hospital food," she says. "At the same time, though, the nurses, staff, and physicians know they have to listen or it could go to a Condition H."

Not seen as a negative

Management at UPMC Shadyside encourages unit directors not to see Condition H as a failing by the staff and respond negatively when one happens. Instead, unit directors are encouraged to see a Condition H as a learning experience.

"You don't want staff thinking you're going to snap their heads off if the family calls a Condition H," Kidwell says. "It's true that a Condition H means things weren't going as well as they should have in some respect, but that doesn't mean that it's time to blame the nurses on that unit."

Each Condition H call is analyzed by Merryman and her colleagues to see what can be learned from the experience, Merryman says. In one call, for instance, residents learned about how important it is to go over the pros and cons of medical procedures without glossing over the patient's concerns. The patient had felt that the doctor did not adequately consider her fears and called a Condition H, so the hospital used that as an opportunity to teach medical residents about how a patient's particular background with medical care can create unique concerns that must be addressed.

Kidwell says the Condition H program should reduce the risk of liability from adverse medical events, but he stresses that reducing lawsuits should not be the real motivation. Empowering patients and family this way will improve patient safety by adding another chance to step in before a tragedy, he says. "It does help the staff ramp up their game a notch with a little extra communication and paying attention to the family." ■

SOURCES

For more information on Condition H, contact:

- **Richard Kidwell**, Director, Risk Management and Associate Counsel, and **Tamra Merryman**, Vice President, Center for Quality Improvement and Innovation, University of Pittsburgh Medical Center Health System, 5230 Centre Ave., Pittsburgh, PA 15232-1381. Telephone: (412) 623-2121.
- **Sorrel King.** E-mail: sking6137@comcast.net.

Response team always on call for Condition H

This description of the Condition H system comes from **Tamra Merryman**, RN, MSN, FACHE, vice president of the Center for Quality Improvement and Innovation for the University of Pittsburgh Medical Center (UPMC) Health System:

Condition H is activated by calling the same number — 3-3131 — that anyone would use to activate a code call. (In the case of UPMC, a code call would be a Condition A or Condition C. Like many hospitals, UPMC uses Condition A for cardiac arrest and Condition C for a critical medical crisis, rather than Code Blue.) The operators have been trained to respond not only when a caller asks for a Condition H, but also when the caller seems to need a Condition H but just doesn't know the proper term. The operator also can tell what room the call comes from. At that point, the operator sends a Condition H page to the pagers of the rapid response team and also makes the call over the public address system throughout the facility. The initial response team is three people: a house physician, the nursing supervisor, and a patient relations representative.

"The makeup of the team can be different for other organizations," she says. "The important thing is that it's a different group of people who are objective, responsive, and listening."

The patient's floor nurses also must respond because they have the most current information about the patient. The key person in the rapid response team is the house physician, Merryman says, because even though most of the first Condition H calls have not been a matter of immediate life or death, any call could be. "They respond just like to any other emergency," she says. "They come running."

Once they arrive, the team listens to the patient or family's concerns and responds appropriately with medical care or further investigation. Response time is usually three to five minutes, and Merryman says team members are chosen partly for their ability to show up with a smile on their face. The whole effort can be sabotaged if someone on the response team shows up and says, "This had better be good, because I was busy . . ." ■

Death of young girl prompts Condition H program

Condition H was prompted by the experience of **Sorrel King**, whose daughter Josie died in 2001 at Johns Hopkins Hospital in Baltimore due to medical errors.

Josie was admitted to Johns Hopkins after suffering first and second degree burns from climbing into a hot bath. She healed well and within weeks was scheduled for release. Two days before she was to return home, she died of severe dehydration and misused narcotics.

Sorrel King spent 10 days in the pediatric intensive care unit with her daughter, by her side every day and night. She says she paid attention to every minute detail of the doctors' and nurses' care, and she asked plenty of questions. She was then sent down to the intermediate care floor with expectations of being sent home in a few days.

The following week her central line was taken out, but no one realized that she had been receiving hydration through that line, as well as medications. Sorrel King began noticing that every time her daughter saw a drink she would scream for it, and she thought that was strange. However, the physicians and nurses told her not to let the girl drink. While being bathed, the girl sucked furiously on a washcloth. As Sorrel King put her to bed that night, she noticed that the girl's eyes were rolling back in her head.

She asked the nurse to call the doctor but was reassured that children often did that and that her vital signs were fine.

"I told her Josie had never done this and perhaps another nurse could look at her," Sorrel King says. "After yet another reassurance from another nurse that everything was fine, I was told that it was OK for me to sleep at home. I called to check in two times during the night and returned to the hospital at 5:30 a.m. I took one look at Josie and demanded that a doctor come at once. She was not fine."

When a medical team arrived and administered two shots of Narcan (Endo Pharmaceuticals, Chadds Ford, PA), Sorrel King asked if the girl could have something to drink. The request was approved, and Josie gulped down nearly a liter of juice. Verbal orders were issued for there to be no narcotics given.

As she sat with Josie, Sorrel King thought the nurse on morning duty was acting strangely. She seemed nervous, overly demonstrative, and in a hurry. Other nurses assured her that the woman was an experienced nurse, but she still mentioned her concerns to a doctor, who agreed with her but did not intervene. Meanwhile, Josie was perking up after receiving the liquids. Then the nurse who had concerned Sorrel King came over with a syringe of methadone.

The mother explained that there was a verbal order for no narcotics, but the nurse told her that had been changed and administered the drug. The order had not been changed.

Josie's heart stopped as her mother was rubbing her feet. Her eyes were fixed, and Sorrel King screamed for help. Two days later, Josie King was taken off life support and died in her parents' arms, the victim of a series of medical errors in a hospital having a reputation as one of the best medical facilities in the world. ■

Level of harm not factor when deciding to punish

(Editor's note: This month's Healthcare Risk Management *includes the second of a three-part series on the "just-culture" approach to improving patient safety. Last month's issue included stories on how the just culture approach works and some potential problems with implementing it. This month,* HRM *include a discussion of the types of behavior that can result in*

EXECUTIVE SUMMARY

Determining when discipline is appropriate can be a difficult part of implementing a "just-culture" model. The criteria for determining when to punish an employee must be considered carefully to avoid discouraging the reporting of errors.

- The level of harm to the patient is not a factor in whether an employee should be punished.
- Timeliness of reporting is a key factor.
- Any false reporting can prompt discipline.

discipline, tips for implementing a just culture, and the criteria for deciding when to punish an employee. The following issue will include a report on one hospital's experience in adopting a just culture.)

Adopting a just culture instead of a nonpunitive or blame-free culture means you have to be ready to discipline employees for some behavior that can threaten patient safety, but how do you know when punishment is appropriate?

For starters, it doesn't depend on the patient's outcome or the level of harm done to the patient, says **Geri Amori**, PhD, ARM, FASHRM, a consultant with The Risk Management & Patient Safety Institute (RM&PSI) in Lansing, MI, and past president of the American Society for Healthcare Risk Management (ASHRM). She spoke on this topic at the most recent annual meeting of ASHRM with **Margaret Curtin**, CPH, also a consultant with the institute.

They say the just culture approach avoids the old "blame-and-shame" management style that can drive errors underground, but it also allows for the discipline of employees who recklessly disregard safety rules. Instead of promising that you won't punish employees as long as they report errors, a just culture tries to distinguish between an honest mistake or systemic problem and a more willful act of disobedience, Curtin explains.

Timeliness is important in reporting patient safety issues under a just culture, Amori says. You should require a report prior to the end of the shift when the event or near miss was discovered, she says. Failure to do so can increase the likelihood that punishment is the appropriate action to take.

These other factors can lead to discipline under a just-culture approach:

- The employee repeatedly fails to participate in the detection and reporting of events and near misses.
- The employee is directly involved in sabotage, malicious behavior, chemical impairment, or criminal activity.
- The employee fails to respond to educational efforts and/or fails to participate in the education process or other preventative plans and activities.
- False information is provided in the reporting, documenting, or follow-up of an event.
- There is a reason to believe that a violation of a state or federal regulation or law may be involved.

In general, she says, an employee's behavior can be categorized as human error, at-risk, or reckless behavior, and the last category may justify punishment. **(See article, below, on those categories.)**

"Accountability" is the key word in a just culture, Amori says. When discussing problem situations with an employee, the focus should be on keeping the agreements that the employee and the employer made regarding patient safety. Blaming someone for a problem can elicit an emotional reaction, but the accountability perspective helps the employee look at the systemwide problem analysis and what role he or she can play.

Accountability is about responsibility, Amori says. "It focuses attention on the problem and how to improve performance," she says. "Blame is more likely to focus on the person and punishment." ■

3 types of misbehavior determine when to punish

Under a just culture, employee misbehavior can be categorized in these three general ways, says **Geri Amori**, PhD, ARM, FASHRM, a consultant with The Risk Management & Patient Safety Institute (RM&PSI) in Lansing, MI:

- **Human error.** This misbehavior is a mistake, plain and simple. The employee meant well and did not realize he or she was doing anything wrong. The response to this kind of error might be improvements in processes and procedures, more training, better design, or changes in the work environment.
- **At-risk behavior.** This behavior is habits developed over time that lead to unintentional risk taking. An example would the staff member who skips double-checking high-risk medications so

SOURCES

For more information on adopting a just-culture approach to patient safety improvement, contact:
- **Geri Amori** and **Margaret Curtin**, The Risk Management and Patient Safety Institute, 6215 W. Saint Joseph Highway, Lansing, MI 48917. Telephone: (517) 703-8464.

much that he doesn't even realize he is skipping that safety step anymore. Not double-checking becomes his norm (normalization of deviance).

The appropriate response to at-risk behavior includes removing incentives such as the employee being overworked or without proper tools. The manager might also create incentives for healthy behaviors.

• **Reckless behavior.** This behavior occurs when an employee takes intentional risks by overriding safety mechanisms or ignoring standards and knows the outcome can be dangerous. It is not a simple mistake because the employee consciously knows he or she is taking a risk.

This behavior justifies disciplinary behavior under a just culture. In addition to examining factors such as illness or medication use by the employee, it also may be appropriate to consider other factors such as whether the person already received retraining on this issue, lied about the event or tried to cover it up, lacks remorse, or does not appear willing to learn from the error. The employee's previous involvement with errors, or lack thereof, also should be considered. ■

Recruit staff from all over to keep you informed

Every risk manager thinks the job is too big for one person, especially as health systems keep heaping on more and more responsibility, so maybe you shouldn't try to do it alone. A better strategy is to recruit unofficial risk managers throughout the hospital, from all departments, to be your eyes and ears and to reinforce your risk management strategies when you can't be there to do it in person.

That's the advice from **Denise C. Myers**, RN, MS, CNAA, CPHRM, director of risk management at Monongalia Health System in Morgantown, WV, where she has employed that strategy to great effect. She reports that the program has increased incident reporting by 400% in five years.

Myers began the effort in 1998 when she joined Monongalia. At that time she received only about 30 incident reports a month, and she knew there was more going on than that.

"So I went to staff meetings and started telling people that we wanted to hear about everything, not just the one time something really bad happened," she says. "I had to let them know that we wanted them to talk to us, that we were eager to hear from them, and that's where this all started."

Recruiting others to help with risk management offers several benefits, Myers says. First, there is strength in numbers. More people means you can do more work. Plus, they are the ones who are in the trenches at your hospital and know what's going on.

Having people from other departments on your team also lowers the mystique, and the fear, that sometimes surrounds risk management, she says. You also will see increased ownership in the process and more buy-in for corrective actions.

The effort pays off, reports **Susan S. Brewer**, JD, an attorney with the law firm Steptoe & Johnson in Morgantown, and the health system's general counsel. She says there has been a significant reduction in litigation against the hospital since Myers began her campaign. In previous years, there usually were nine or 10 lawsuits against the hospital open at any time, but currently there are only two.

"You get real results when you include people from the very top to the very bottom of the pay scales and everyone in between," Brewer explains. "The input you get from some of the staff in housekeeping and food service, for instance, can be extremely revealing because these are people who are out on the floors all the time, doing their jobs

EXECUTIVE SUMMARY

Including staff from all levels of your organization in risk management activities can help reduce liability and improve incident reporting. Creative educational strategies will help involve frontline staff.
- One hospital system quadrupled incident reports in five years.
- Staff from other departments often are eager to participate.
- Rewards for risk management tips can encourage participation.

SOURCES

For more information on recruiting assistant risk managers, contact:

- **Susan S. Brewer**, Steptoe & Johnson, 1085 Van Voorhis Road, Suite 400, P.O. Box 1616, Morgantown, WV 26507-1616. Telephone: (304) 598-8103.
- **Denise C. Myers**, Director, Risk Management, Monongalia Health System, 1200 J.D. Anderson Drive, Morgantown, WV 26505. Telephone: (304) 598-1404.

and seeing everything as it really is on a daily basis, not just when a manager walks down the hall."

Myers and Brewer say frontline staff often already have an interest in patient safety and risk management issues, so you only have to give them a voice. In many cases, you don't have to convince them that they can contribute. You only have to convince them that they are welcome on the risk management team and that their contributions are valued.

"I spent a lot of time out and about, convincing people that I wanted to talk to them, that I wanted to be approached," Myers says. "It takes some work to change that impression that risk management is a department you want to avoid because it means you messed up and there might be a lawsuit."

So what does it mean to recruit risk managers from other departments? It can mean different things for different staff.

For administration, it might mean encouraging top-level executives — your chief executive officer, chief financial officer, vice president of patient care, director of nursing, vice president of medical affairs, and general counsel — to participate directly in risk management activities. For instance, Myers recommends having vice presidents sign off on incident reports so they are aware of what is happening and how you are managing those incidents. They also can participate on the sentinel event response team and the risk management committee.

Myers also recruits members of the health system's board of directors to sit on the risk management committee, and she makes risk management a standard agenda item for the board. She also recruits physicians to participate, both those employed by the health system and those privileged to practice there.

One of the keys to success, however, is to recruit all the way down the line, Myers says. Include staff who aren't usually seen as key players. Look for candidates in transport, housekeeping, dietary, the business office, and maintenance. When educating them about risk management issues, you should be sure to present the material at a level commensurate with their education and ability to understand, Brewer says.

"A lot of what you are educating these people about is basic information anyway," Brewer notes. "You don't have to get into complicated risk management strategies and policies." Sometimes it's as simple as reminding them to wear their name tags so people can see them and to check identification bracelets on patients, she says. "It sounds basic to us, but they don't hear it nearly as much as we do," Brewer says. ■

Use variety of ways to educate staff on issues

When educating front line staff members, it is best to use a combination of methods, says **Denise C. Myers**, RN, MS, CNAA, CPHRM, director of risk management at Monongalia Health System in Morgantown, WV.

She uses presentations, positive and negative feedback, computer communications, informational brochures, and a lot of person-to-person contact. The in-person contact happens during patient safety rounds, orientation sessions, and visits with the staff. Myers also stresses that her open door policy is crucial to encouraging communication with all staff. Any staff member from any department is welcome to walk into her office and discuss risk management concerns.

She uses a combination of mandatory teaching sessions and less formal interaction with staff. She conducts a risk management lecture at least once a year and requires key staff members to attend, and she has created a videotape library of herself and others speaking on risk management issues.

She also provides staff with educational brochures on risk management issues, as well as posters, an internal newsletter, and a "cheat sheet" for preparing for surveys by the Joint Commission on Accreditation of Healthcare Organizations. The cheat sheet is a handy way for staff to keep track of key issues that will be important in the survey, such as that year's patient safety goals. For the 2005 goals, Myers used the acronym "SPECIAL," reminding staff that because patients are special,

everyone must focus on:

- **S**topping falls;
- ensuring the safety of infusion **P**umps;
- removing concentrated **E**lectrolytes from patient care units;
- improving **C**ommunication among caregivers;
- verifying **I**dentification of patients;
- standardizing a list of do-not-use **A**bbreviations for medications;
- **L**istening carefully as others "read back" verbal orders.

The cheat sheet is folded into thirds so that it can be carried and accessed easily when staff are questioned as part of survey preparation.

"We wanted them to have something handy they could pull out of their pocket if someone walks up to them and asks them to name one of this year's patient safety goals," she says. "It keeps it on their mind and lets them know we'll do what we can to help them learn these things." ■

'Risk management hero' award prompts staff

Staff respond best to positive feedback and to seeing that their participation results in a meaningful change in the workplace, says **Denise C. Myers**, RN, MS, CNAA, CPHRM, director of risk management at Monongalia Health System in Morgantown, WV.

Staff at Monongalia can be designated a "risk management hero" if they make a significant contribution. They receive a special certificate that recognizes them for "being an active member of the risk management department by being proactive in preventing/reducing risk. This official document may be shown to one and all as proof of their contribution to Monongalia's goal of actively managing patient and employee safety and satisfaction."

Risk management heroes also receive a coupon for a free meal in the cafeteria and recognition in the hospital newsletter. The first two recipients of the Risk Management Hero award were employees of the laboratory services department who developed a special label to use when sending lab results while the hospital's pneumatic tube system is down. The label clearly identifies that the envelope contains confidential laboratory results, and the envelope is blue instead of the usual tan color.

The bar is purposefully set low for being deemed a risk management hero so that staff are encouraged to report themselves or another person and a lot of people can be rewarded for their effort, Myers says.

"It's part of becoming more of a proactive organization," Myers says. "We want to encourage people to report everything they even think might be a risk management concern, so we don't mind sending out an 'attaboy!' every time someone reports a loose railing in the stairway or a leaky pipe that could cause someone to slip and fall." ■

To manage aggression, give staff right skills

Most aggressive behavior in a health care setting can be controlled before it turns violent if you know the right strategies to use, says **Steve Wilder**, CHSP, EMT-P, a security consultant with Sorenson, Wilder & Associates, a security consulting firm in Bradley, IL.

Wilder teaches health care safety with a continuum that trains the health care professional to recognize the six behavioral changes a person goes through between "calm and "physically violent," as well as ways to defuse the aggressive behavior at each level. In addition, the program covers basic do's and don'ts for dealing with aggressive behavior, as well as steps the health care professional can take to lessen the chances of injury. He presented an overview of his recommended strategies at the most recent meeting of the American Society for Healthcare Risk Management (ASHRM).

Workplace violence is common in many industries, but the health care workplace poses

EXECUTIVE SUMMARY

Managing aggression in the workplace requires training staff at all levels in how to respond to potential violence. Many of the skills involve de-escalation and practical tips for survival.

- There are six steps that take people from calm to violent behavior: calm, verbally agitated, verbally hostile, verbally threatening, physically threatening, and physically violent.
- Early intervention can prevent violent incidents.
- Nonverbal clues such as glancing around for possible weapons can signal when a person may become violent.

special risks, Wilder notes. In addition to the catalysts that can prompt violence in any workplace — disgruntled employees, domestic disputes, unhappy customers — the health care facility also has to deal with people who may be mentally unstable, on illegal drugs, or emotional overwrought over health issues. The good news, he says, is that many violent incidents can be avoided if staff members know how to respond when people show the first signs of aggression.

"The risk manager's role is to assess the training that has been done in various departments and to provide more training whenever necessary," Wilder says. "This is not something that comes naturally to people."

He also cautions against providing training only in the most obvious departments such as the emergency department and the mental health department. While those staff certainly need training, so do employees in many other areas. Obstetrics and pediatrics are good candidates, for instance, because people become involved in custody disputes that can turn violent.

"And sadly, we see violence in oncology departments," Wilder says. The stress level is high, and often it is the family members who are involved in violent incidents in the waiting room, he says. "You're dealing with death and dying, and the stress can lead to domestic problems in your facility," he explains.

He recommends training staff to limit physical interventions, and he says all employees should be trained using role playing, sample situations, and mock drills. Much of the training should consist of teaching people how to recognize when someone may become violent.

"We hear a lot of people say they didn't see it coming," Wilder says. "They say the person was calm one minute and then he just started swinging and caught them off guard."

That shouldn't happen if staff members are trained properly, he says. Few people actually go from totally calm to violent that quickly. The signs of impending trouble are there if you know what to look for. **(See p. 23 for tips on how to spot a person who is close to violence.)**

Wilder teaches health care staff that they can profile people to spot potential trouble. Eighty percent of people who get violent in a health care setting are male, 75% are white, and 90% are of working age, he says. There also is a 90% chance that the person will have at least one of the these characteristics: history of violence, evidence of erotomania (a rare disorder in which a person holds a delusional belief that another person, usually of a higher social status, is in love with him or her), alcohol dependence, history of pathological blaming, elevated frustration levels, history of personality disorder, evidence of psychosis, chemical dependence, history of depression, impaired neurological function, or an interest in weapons.

Training on how to avoid and handle violence is a necessity for health care workers, says **Robert Chicarello**, CPP, acting director of security and parking at Brigham and Women's Hospital in Boston. The hospital offers a variety of training programs, including classes on managing aggression in the workplace and rape and aggression defense for women. He makes a point of ensuring that all the emergency department nurses are well trained because they are the most at risk, but he also encourages training for all nurses and other staff.

"We offer two classes, a three-hour course and a six-hour course that comes with certification from the particular course materials we use," Chicarello reports. Brigham and Women's uses the Management of Aggressive Behavior (MOAB) program, provided by MOAB Training

SOURCES/RESOURCE

For more information on controlling aggressive behavior, contact:

- **Robert Chicarello**, Acting Director, Security and Parking, Brigham and Women's Hospital, 75 Francis St., Boston, MA 02115. Telephone: (617) 732-5500.
- **Steve Wilder**, Sorensen, Wilder & Associates, 111 N. Michigan Ave., Bradley, IL 60915. Telephone: (800) 568-2931.

For more information on the Management of Aggressive Behavior (MOAB) program, contact:

- **MOAB Training International**, P.O. Box 460, Kulpsville, PA 19443. Telephone: (215) 723-2533. Web: www.moabtraining.com. The company offers a varied pricing structure depending on the length of training and the number of students. A three-hour introductory program, for instance, costs $1,695 for up to 24 attendees, and then an additional $50 for each additional attendee. The company also offers "train the trainer" programs in which one person can be trained to provide MOAB instruction to others in your organization. Other options also are available.

International in Kulpsville, PA. **(See resource box, p. 22, for more information on MOAB training.)**

Chicarello and Wilder emphasize that training in aggression management is no substitute for having an adequate and properly training security staff. The goal is to have the front line staff trained well enough that they can see the potential for violent behavior and possibly de-escalate the situation. The training also should enable them to protect themselves better once violence breaks out.

Once the security staff are on scene, they are responsible for controlling the situation, Chicarello says. "We don't want people thinking that they can wrestle someone to the ground because we trained them in aggression management, but so much of the benefit comes from being able to recognize the situation you're in and talk to the person appropriately," he says. "Sometimes the right words can prevent the violence from ever happening." ■

6 steps from calm to violent behavior

Risk managers should encourage health care staff to think of a six-step aggression continuum, suggests **Steve Wilder**, CHSP, EMT-P, a security consultant with Sorenson, Wilder & Associates in Bradley, IL. The closer the person gets to Step 6, the more likely he or she will turn violent.

In Step 1, the person is calm and nonthreatening, though he or she may be unhappy about an issue.

In Step 2, the person is verbally agitated but the anger is not directed any specific person or object. At this step, the health care staff should listen to the person and try to save his or her self-esteem. Do not give orders.

In Step 3, the person is verbally hostile, ramping up his or her comments and agitated, oblivious to efforts to calm him or her. At this stage, the staff should maintain a nonthreatening body posture and respect the person's personal space. Allow him or her to vent his or her anger, and keep your instructions to a minimum.

As the person moves to Step 4, he or she becomes verbally threatening, focusing his or her anger on specific people and making demands for action. He or she may threaten consequences if his demands are not met. Staff should maintain eye contact but avoid cornering this person. Give him or her options and anticipate that violence could erupt at any moment.

Step 5 is when the person becomes physically threatening. He or she takes a stance that suggests violence and may scan the area for potential weapons. He or she may make aggressive moves against particular people. Staff must know that this is the critical point when violence may be prevented or its effects mitigated. They should assume a defensive posture at this point and be prepared for a physical attack.

Step 6 is when the person becomes physically violent.

"Knowing those steps can help people gauge where they are with this person and adjust their behavior accordingly," Wilder says. "If you don't have some reference points, you're just waiting to see what happens." ■

CE objectives

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

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

COMING IN FUTURE MONTHS

- Joint Commission 'hot buttons' for risk managers
- Responding to charges of sexual misconduct
- Shallow cause analysis vs. root cause
- Make sure OBs get credit for proper care

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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.

5. When is the Condition H phone line available at the University of Pittsburgh Medical Center (UPMC) Shadyside?
A. Weekdays from 9 a.m. to 5 p.m. only.
B. Only when the patient is on an intensive care unit
C. Seven days a week, but not between 5 p.m. and 9 a.m.
D. Twenty-four hours a day, seven days a week.

6. Which of the following is true of a Condition H call at UPMC Shadyside?
A. Nurses from the unit respond to the call because they have the most current information about the patient.
B. Nurses from the unit are barred from the room while the rapid response team investigates.
C. Nurses from the unit may choose whether to participate in the Condition H response.
D. Nurses from the unit must confirm the need for a Condition H before the rapid response team will come to the room.

7. Under a just-culture philosophy, which of the following is not an indicator that discipline may be appropriate for the employee after an adverse event or violation of policy?
A. The employee repeatedly fails to participate in the detection and reporting of events and near misses.
B. The employee is directly involved in sabotage, malicious behavior, chemical impairment, or criminal activity.
C. The employee fails to respond to educational efforts and/or fails to participate in the education process or other preventative plans and activities.
D. The patient was seriously harmed.

8. According to Denise C. Myers, RN, MS, CNAA, CPHRM, who should you recruit as unofficial risk managers in your organization?
A. Only top administrators
B. All departments except top administrators
C. Only department heads
D. Any staff member from any department

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

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

Refusal to administer epidural anesthesia leads to $200,000 CA settlement

By **Blake Delaney**
Buchanan Ingersoll PC
Tampa, FL

News: A pregnant woman in labor was admitted to the hospital. In agony due to the large size of the baby, the patient asked for epidural anesthesia. However, because the woman could not pay for the cost of the epidural in cash in advance, the hospital refused to comply with her request. The woman eventually delivered her baby, who was born with mild Erb's palsy. After filing a lawsuit for negligence based on the nursing staff's refusal to administer an epidural, the parties settled for $200,000.

Background: In December 1998, a 30-year-old woman in labor was admitted to her local hospital. The woman, experiencing tremendous pain, asked for epidural anesthesia, a local anesthetic medication that relaxes pelvic muscles and causes an insensitivity to pain. However, the hospital and the anesthesiology group had a policy of not providing epidural anesthesia to uninsured women or women on Medi-Cal, California's Medicaid program, unless the patient paid $400 cash in advance. Because the patient was on Medi-Cal and did not have the cash, the medical staff refused to comply with the woman's request, even though she offered to write them a check.

The woman continued to ask for an epidural as she suffered in agony prior to delivering her nearly 10-pound baby. During the birth, the obstetrician encountered shoulder dystocia, a rare problem in which the fetal head had been delivered, but the baby's shoulders were "stuck" and could not be delivered. After the obstetrician maneuvered the baby to deliver the shoulders, the girl was born with mild Erb's palsy, a weakness in her arm caused by an injury to the nerves controlling her arm during the birth process.

The mother filed a lawsuit against the hospital, the treating obstetrician, and the on-call obstetrician who delivered the baby. The plaintiff sought damages for emotional distress relating to the hospital's refusal to administer epidural anesthesia. The plaintiff also sought damages for her daughter's lost future earnings, which she alleged to be the direct result of the hospital's negligent conduct. The woman claimed that the delivery was made more difficult because her extreme pain prevented her from being able to cooperate during the delivery.

In her defense, the on-call obstetrician testified in deposition that she would have ordered an epidural if the nurses had informed her of the patient's request for one. The court eventually dismissed both obstetricians from the case.

The hospital, alleged to be vicariously liable through its nursing staff, denied that the woman requested an epidural. It also argued that because the woman's medical chart did not contain a physician's order for an epidural, it would have been improper to administer one. Lastly, the hospital contended that even if the mother had requested an epidural and even if her medical chart had reflected a physician's order to administer one, the anesthesia would not have taken effect before the

delivery because the woman delivered so quickly. Consequently, the hospital maintained, its conduct did not cause any injuries to the mother or daughter. Nevertheless, the hospital settled with the plaintiff for $200,000 prior to trial.

What this means to you: This case demonstrates the need for every health care facility's risk management department to develop policies concerning payment for services rendered and communication among staff members. The first aspect of developing a policy governing payment for services rendered is determining who is responsible for billing the patient. "Billing policies should be determined up front and discussed in the contract terms and conditions," says **Beth Huntington**, BSN, MSN, JD, director of risk management at Baylor Health Care System in Dallas. Although it is not clear from the case study who was in charge of determining payment policies for anesthesia services, most hospitals do not employ anesthesia groups. Instead, an anesthesia group usually will contract with a hospital to provide its services. Consequently, because the anesthesia group provides the service, it (not the hospital) will determine the billing policies, she notes.

A second aspect of a payment policy concerns the manner or methods by which patients must remit payment to the health care provider. "Although it is unclear from the case study whether the patient had prenatal care prior to presenting to the hospital in labor, if she did, the payment expectations should have been discussed and documented in her prenatal record," advises Huntington.

The failure to establish payment protocols with the patient in advance of the patient presenting for treatment is troubling because patients should be made aware of how they will be expected to pay for services rendered as early as possible. Especially considering that the patient in this case was in the middle of labor when the dispute over how she would pay for the epidural anesthesia arose, requiring her to comply with a payment procedure that she may not have been informed of ahead of time is bad practice. Furthermore, Huntington cautions against the hospital's policy of discriminating against Medi-Cal patients. Having different policies for prepayment of out-of-pocket costs with Medi-Cal patients than with private pay or other payer groups may be problematic.

This case also demonstrates the importance of communication among staff members at a health care facility. Huntington attributes much of the liability exposure in this case to poor communication between the nurses and obstetricians. The medical record contained inconsistent information: "The patient must have requested an epidural to *someone*, or else the issue of her payment would not have come up," says Huntington. If the nurses and doctors had communicated with each other and had documented such conversations in the patient's chart, the hospital's liability would have been reduced.

Finally, the hospital's argument that an epidural would not have taken effect before the delivery even if the patient had requested one is questionable. "Generally, epidural analgesia takes effect immediately," notes Huntington.

Despite the several problem areas emphasized by this case, the hospital's liability was not clear-cut. "I'm not convinced that there was negligence here. But this case had all the potential to be a gross negligence case because it appears that the care offered to a woman in labor was driven by her ability to pay and not her medical condition," says Huntington. Clearly, the suggestion that the hospital conditioned the provision of medical care on the patient's financial profile is troubling. Huntington concludes, "Likely, the hospital agreed to settle in order to save the hospital from a public relations embarrassment — apparent discriminatory treatment due to a patient's ability to pay." ■

Traction during birth causes partial paralysis

$900,000 verdict issued in Ohio

News: An obstetrician encountered difficulty in delivering a baby because the baby's shoulders had become stuck. After attempting several maneuvers to disimpact the shoulders, the obstetrician finally delivered the newborn girl, but not before the infant had suffered a nerve injury, resulting in partial paralysis. The mother filed suit against the obstetrician and alleged that the doctor applied excessive downward traction to the baby's head during delivery. The jury returned a verdict in favor of the plaintiff in the amount of $900,000.

Background: A pregnant woman went into labor and was taken to the hospital's delivery room, accompanied by her birthing coach. During the delivery, the obstetrician delivered the fetal head, but then encountered shoulder dystocia, whereby the newborn's shoulders had become stuck. The doctor attempted several ancillary maneuvers to disimpact the baby's shoulders. She first attempted the McRobert's maneuver, in which she sought to rotate the mother's symphysis pubis cephalad by hyperflexing the woman's legs and straightening the maternal sacrum relative to the lumbar spine. The technique, if successful, would have enabled the baby's shoulders to pass over the woman's sacrum and through her pelvic inlet, which would be positioned so as to maximize the amount of expulsive force during birth.

Although the McRobert's maneuver failed, it enlarged the woman's episiotomy so as to allow more room for subsequent maneuvers. The obstetrician then applied suprapubic pressure to displace the baby's impacted shoulders into the mother's oblique diameter. After some time, the obstetrician was able to successfully deliver the newborn girl. During the birth, however, the infant suffered an injury to her right brachial plexus, a network of nerves conducting signals from her spine to her shoulder, arm, and hand, resulting in paralysis of her right arm.

The mother filed a lawsuit on behalf of her daughter and alleged negligence by the obstetrician and her clinic. At trial, the plaintiff claimed that the doctor applied excessive downward traction to the baby's head before attempting the McRobert's maneuver and applying suprapubic pressure. The mother's birthing coach, who also was a labor and delivery nurse, testified that the obstetrician pulled down on the baby's head so hard that it looked like she could not pull any harder.

The witness concluded that it was this application of excessive downward traction, before any suprapubic pressure was applied, that harmed the infant during delivery. Plaintiff's counsel also relied on the testimony of two expert witnesses, one in obstetrics and gynecology and one in neurology, which cost in excess of $100,000.

The obstetrician, who stopped practicing some time after the incident to become the hospital's vice president of medical affairs, denied she acted negligently. She had no clear memory of the delivery, which had occurred 14 years earlier, although she had written in her delivery note: "Mild shoulder dystocia relieved by suprapubic pressure." She argued that the baby's injury was caused by a combination of uterine contractions, the mother's expulsive forces during labor, and a normal amount of traction necessary to deliver the baby.

After trial, the jury returned a verdict in favor of the plaintiff in the amount of $900,000, $118,000 of which was for economic damages. The mother said she was planning on using the balance of the award to pay for specialty items, including cookware and doorknobs, to make her daughter's life easier.

What this means to you: Although this case presents similar facts to the prior case, it highlights different risk management concerns in the context of childbirth.

"Although no information is given in this case study regarding prenatal care, one wonders whether fetal size should have suggested the potential for delivery problems," says **Beth Huntington**, BSN, MSN, JD, director of risk management at Baylor Health Care System in

Dallas. A fetus who is large for its gestational age (LGA) weighs more than the usual amount for the number of weeks of pregnancy, often resulting in a birth weight greater than the 90th percentile for its gestational age. A baby's birth weight can be estimated during prenatal consultations by measuring the height of the mother's fundus from her pubic bone or by conducting an ultrasound. Although LGA can be caused by genetics or excessive weight gain by the mother during pregnancy, the most common cause is maternal diabetes. Because LGA babies are so big, delivery can be difficult and result in prolonged vaginal delivery time and increase in cesarean delivery. Delivering mothers can be affected by postpartum hemorrhage, rectovaginal fistula, symphyseal separation or diathesis (with or without transient femoral neuropathy), third- or fourth-degree episiotomy, and uterine rupture. The fetus also is at risk for brachial plexus palsy, clavicle fracture, fetal hypoxia (with or without permanent neurologic damage), fracture of the humerus, and, in some cases, fetal death. A diagnosis of LGA may lead to a recommendation of early delivery via induction of labor before the baby grows bigger or a planned cesarean delivery to prevent the injuries potentially associated with a vaginal delivery.

Huntington recognizes the implications of the $900,000 verdict in this case. "The fact that a baby experiences shoulder dystocia and injury is not in and of itself sufficient for a finding of negligence," she says.

Because not all of the facts from this case study are known, it is unclear whether the obstetrician handled the situation appropriately. An occurrence of shoulder dystocia becomes obvious when the fetal head emerges and then retracts against the perineum. Once encountered, the situation must not be exacerbated by applying fundal pressure or excessive force to the fetal head or neck. Instead, an obstetrician should seek to increase the functional size of the pelvis, decrease the breadth of the fetal shoulders, or change the relationship of the fetal shoulders within the mother's pelvis. Some techniques used to accomplish these goals in the treatment of shoulder dystocia include evaluating for episiotomy, performing the McRobert's maneuver, applying suprapubic pressure, attempting internal rotation maneuvers, removing the fetal posterior arm from the birth canal, and rolling the patient to an all-fours position in an attempt to dislodge the impaction. If none of these techniques is successful, some "last-resort" maneuvers may aid in the ultimate delivery of the fetus, including a deliberate fracture of the fetal clavicle, the Zavanelli maneuver (rotating the fetal head into a direct occiput anterior position and then pushing the top of the head back into the birth canal while holding continuous upward pressure until cesarean delivery is accomplished), providing halothane or some other general anesthetic, rotating the infant transabdominally through a hysterortomy incision, and a symphysiotomy, whereby the fibrous cartilage of the symphysis pubis is intentionally divided.

Although the defendant-obstetrician testified at trial that she attempted at least two of the commonly used techniques — the McRobert's maneuver and the application of suprapubic pressure — the jury apparently did not find her testimony credible. Instead, the jury believed the account of the birthing coach, who testified that the obstetrician's application of excessive downward traction, before any suprapubic pressure was applied, harmed the infant during delivery.

Because an award of nearly 1 million dollars, including a proportionately larger amount awarded for noneconomic damages, is rather large for this type of case, Huntington surmises that the jury must have been motivated by something that occurred at trial. Specifically, Huntington wonders whether the jury got angry with the obstetrician. If so, this case highlights the importance of sufficient documentation in the patient's medical record.

Many cases whose outcomes rely on differing eyewitness accounts do not go to trial until several years have passed. Because human memories can fade, Huntington advises that the best eyewitness is a well-documented medical chart. In this case, the notations in the patient's record were not consistent with the birthing coach's eyewitness testimony regarding the difficulty of delivery.

"If the physician had carefully and in detail noted the techniques and maneuvers used to deliver the infant, the record would have been a more credible defense witness than the birthing coach, who was also relying on memory of events that occurred 14 years previously," Huntington notes. Of course, no doubt the plaintiff's investment of $100,000 in expert witnesses helped the jury see that the obstetrician was indeed responsible for the damages suffered in this case.

Reference

• Marion County (OH) Court of Common Pleas, Case No. 00 CV 0278. ■

HIPAA Regulatory Alert

Supplement to Healthcare Risk Management and Hospital Access Management

Survey: Americans worried about health info privacy

Most have favorable view of health information technology

A survey from the California Health Care Foundation finds that despite new federal protection, 67% of Americans still are concerned about the privacy of their personal health information and are largely unaware of their rights. Survey results also indicate many Americans may be putting their health at risk by doing things such as avoiding their regular physician or forgoing needed medical tests. And the survey found that a majority of consumers are concerned that employers will use their medical information to limit job opportunities.

Despite their concerns, consumers generally have a favorable view of health information technology and are willing to share their personal health data when those offer a benefit, such as improving coordination or safety of care.

"These findings will help inform and guide efforts to build a nationwide health information network," said foundation program officer **Sam Karp** at a news conference announcing the survey results. "Americans' privacy concerns pose potential barriers to realizing the significant benefits of health IT to improve health care quality, reduce medical errors, and lower health care costs. Without better education about their rights, strong privacy safeguards, and vigorous enforcement, the public's support for health IT may be in jeopardy."

The 2005 survey follows a groundbreaking 1999 study on medical privacy. Since the initial survey, national privacy protections have been implemented under HIPAA. The latest survey found that Americans continue to show high levels of concern about personal health information privacy. Ethnic and racial minorities (73%) and chronically ill populations (67%) show the most concern. The survey also found that 25% of consumers are aware of recent privacy breaches reported in the media. And of those who are aware of those incidents, 42% say the reports increased their concern about their own medical privacy.

While a majority of consumers (67%) have some level of awareness of federal laws that protect the privacy and confidentiality of personal health information, awareness of privacy rights varies with education and race, with ethnic and racial minorities the least likely to acknowledge or recall receiving notification of their privacy rights (60%).

More worried about what employers will do

The survey found that concerns about employer use of medical claims information has increased dramatically from 36% in 1999 to 51% in 2005. Ethnic and racial minorities (61%), the chronically ill (55%), older workers (51%), and people with less education (53%) were significantly more concerned that an employer would use medical information to limit their job opportunities.

"Although employers work to ensure that their health plans or third-party administrators always keep all medical claims data private and confidential, in line with federal and state laws as well as professional ethics, this survey suggests that we need to work harder and communicate more effectively to reassure employees and their dependents," said **Helen Darling**, president of the National Business Group on Health. "We need to demonstrate through frequent communications that trustworthy systems with many safeguards are in place to ensure that their records are safe and can never be used in ways they haven't authorized."

The survey found that one in eight consumers engage in behaviors intended to protect their

privacy, including asking their physician not to record a health problem, going to another physician to avoid telling their regular physician about a health condition, and avoiding some medical tests. The chronically ill are more likely to risk their health over privacy concerns. Privacy protective behaviors also have increased for people with diseases such as cancer, diabetes, and depression.

"People should not have to sacrifice their health in order to shield themselves from job discrimination and loss of health benefits," Health Privacy Project director **Janlori Goldman** said at the news conference. "The large rise in people fearful that their medical information will be used against them on the job makes it imperative to expand the scope of health privacy law to cover employers."

Despite increased concerns about health care privacy, the survey found that most Americans (59%) are willing to share their personal health information when it is beneficial to their care or could result in better coordination of medical treatment.

The largest motivating factors for consumers to share their medical data are better treatment coordination (60%), enhanced coverage benefits (59%), and access to experimental treatments (58%). Consumers are most willing to share medical information with their regular physician (98%) or other physicians involved in their care (92%), but less willing to share with drug companies (27%) or government agencies (20%).

Download an executive summary and detailed survey findings from www.chcf.org. ■

AHA wants contingency period for attachment rule

AHA warns standard should have strict limits

The American Hospital Association (AHA) has told the Centers for Medicare & Medicaid Services (CMS) that hospitals should have a contingency period of at least three years after a final rule on standards for electronic health care claims attachments is issued to allow hospitals adequate time to prepare budgets, train staff, and conduct testing with their trading partners.

In comments on a proposed rule for the standards, the AHA said it welcomed many of the proposal's recommendations, but emphasized the importance of having an attachment standard that also imposes specific limitations on its use. "Without strict limits," the AHA said, "we will see inappropriate use of the attachment standard. The practice of requesting an attachment should be rare and never become a routine item that would accompany all claims for a specific type of service. Health plans and others that require routine reporting of a particular piece of data have opportunities to present their requests to the appropriate data content committees. Misuse of the attachment standard will increase not only the administrative burden and costs for providers, but more importantly, the potential for privacy violations."

The AHA cautioned the proposed standards introduce several elements not widely used in the current billing process, thus requiring new methods for capturing and handling clinical information at significant cost to providers. "We believe the attachment standards will yield a zero net return on investment for hospitals," the association said. "Moreover, the attachment standards will be far costlier to implement than the previous HIPAA claims standards."

One area of significant concern to providers not directly mentioned in the proposed rule involves establishment of a formal communication process between providers and health plans, the AHA said. "Today, many claims are delayed pending additional information from the provider," the AHA said. "However, hospitals are often unaware that the health plan has submitted a request for additional information and are left wondering about the status of their claims. The health plan's request is often lost as it moves from the health plan to the clearinghouse and sometimes even to an unspecified location within the provider's operation. The communication flow is unpredictable. Clearinghouses usually do not know how to handle such requests, and consequently they are unable to direct the request to the responsible person at the provider's operation.

"We would welcome a set of comprehensive business rules that would improve how covered entities would formally communicate with one another to handle such requests on a timely basis. While the request transaction standard includes specific contact information about the contact at the health plan, there is no comparable segment for the provider to indicate the contact person within its operations. It is unfortunate that the claim standard does not have a similar segment

that would allow providers to designate contact persons within their organizations to handle specific types of attachment requests. We recommend CMS establish a technical group to explore options for creating better communications between providers and plans."

Finally, AHA recommended that CMS issue rules for ICD-10 adoption before finalizing the rule for claim attachments, since ICD-10 provides greater clinical specificity and has the ability to reduce or eliminate reliance on claim attachments. ■

Court rejects privacy suit related to HIPAA

Decision reinforces status quo

A federal appeals court has rejected a challenge by patient advocacy groups to a rule promulgated under HIPAA that eased a prior regulation to permit health care entities to use and disclose individually identifiable health information for routine uses without obtaining prior consent. The advocacy groups had argued the more permissive rule violated their substantive due process rights, the First Amendment, the Administrative Procedure Act, and HIPAA itself. But the Third Circuit Court of Appeals rejected these arguments, saying that HIPAA may be implemented in a manner that places reasonable limits on the privacy protections available under that law. The court expressly said the objective of protecting patients' privacy must be balanced against the statute's other legitimate goals.

In an analysis for Sidley Austin LLP, attorney **Alan Raul** said that while the advocacy groups argued that elimination of the consent requirement for routine uses violated their privacy rights in violation of the Fifth Amendment's due process clause, the court found that the alleged privacy violations were attributable to private entities and not to the federal government. Raul said the court reasoned that the groups were not challenging the protection of health information by the government itself, but rather were concerned about use and disclosure of their health information by third parties such as pharmacies and private health care entities.

The court also was not persuaded by evidence that some covered entities had relied on the amended rule to change their privacy policies, Raul said. In the court's view, "the fact that a private party changed its behavior in response to a law does not give the law the coercive quality upon which the state action inquiry depends unless the law itself suddenly authorized something that was previously prohibited."

Since Citizens for Health and the other plaintiffs were not able to demonstrate that pre-HIPAA law prohibited covered entities from using or disclosing information for routine uses without consent, the court concluded that the amended rule neither authorized previously prohibited conduct nor enhanced the ability of these entities to engage in the challenged conduct.

The court's reasoning in rejecting a First Amendment argument was similar in that it found that any potential chilling effect on communications between patients and health care practitioners could be attributed not to any government action but rather to decisions by private entities regarding the manner in which they would use or disclose health information.

The advocacy groups also contended the amended rule violated HIPAA itself because the statute permits the Department of Health and Human Services to enact only those regulations that enhance privacy and not any regulations that detract from it. And they argued that the amended rule conflicted with Congress' intent in that it disturbed individuals' reasonable expectations of privacy in their medical information.

But the court rejected the contention that medical policy is the controlling policy underlying HIPAA, saying such a one-dimensional view ignores HIPAA's other goals of administrative simplification and improving health system efficiency and effectiveness. According to the court, the goal of protecting privacy must be balanced against these other equally important objectives.

Raul tells *HIPAA Regulatory Alert* he does not expect the case will be pursued any further, especially since HIPAA does not permit private actions, but limits compliance to criminal cases by the government against violators.

"This was a complex legal challenge to a complicated federal regulation and a decision that upholds the government's authority to issue such regulations," he says.

The decision makes no change to the status quo for the average patient, Raul says, and should not result in transformation of any practices that affect individuals. "Had the decision gone the other way," he says, "there would have been a major

change to the status quo."

Download the decision at www.ca3.uscourts.gov/opinarch/042550p.pdf. ■

CMS: PHI can be disclosed for payment purposes

'Payment' includes determining eligibility

The Centers for Medicare & Medicaid Services (CMS) says a state Medicaid agency and Medicare Advantage plan may share protected health information to identify dually eligible enrollees. In a question and answer session posted at the Department of Health and Human Services web site, CMS said the HIPAA privacy rule permits a covered entity to disclose protected health information for its own payment purposes and for the payment purposes of another covered entity that receives the information.

The privacy rule defines payment to include activities to determine eligibility or enrollee coverage. Thus, the note says, a Medicaid state agency and Medicare Advantage plan may disclose to each other protected health information about their enrollees to identify those enrollees who are dually eligible under both plans.

In general, an electronic inquiry and response from one health plan to another to obtain information about an enrollee's eligibility to receive health care must be done using the HIPAA standard transaction for eligibility. While the disclosure between the state Medicaid agency and the Medicare Advantage plan are conducted using the standard, the privacy rule's minimum necessary requirements don't apply to disclosures of the data elements required or situationally required by the standard transaction. In contrast, where disclosures are made outside of a standard transaction, both the Medicare Advantage plan in its request for protected health information, as well as the state Medicaid agency in its response, must make reasonable efforts to limit the necessary protected health information for the purpose of identifying dually eligible enrollees.

Because the Medicare Advantage plan must limit its request to the minimum necessary protected health information to identify dually eligible enrollees, the state Medicaid agency may rely, if reasonable, on that request for protected health information as satisfying the minimum necessary requirement for these purposes, CMS said. ■

EPIC warns about DTC marketing databases

Concern over targeting vulnerable groups

The Electronic Privacy Information Center (EPIC) West Coast Office has told the U.S. Food and Drug Administration (FDA) it is concerned about an issue in direct-to-consumer (DTC) medical marketing that it believes has received inadequate attention — use of databases of personal information to target individuals with medical ailments through direct mail or other forms of direct marketing.

"We are concerned that heightened attention to traditional mass-circulation print and broadcast advertising will result in marketers increasing information collection efforts for targeted solicitations," EPIC senior counsel **Chris Hoofnagle** said in comments to FDA.

EPIC said there are several reasons why a shift to more direct marketing presents risks to privacy and consumer welfare. First, it said, data brokers (companies that amass personal information and sell it to marketers and others) can enable targeting of DTC advertising to vulnerable populations. That risk is exacerbated by the fact that, unlike mass-circulation print and broadcast advertising, targeted solicitations are harder for public health authorities to monitor.

Second, according to EPIC, medical information often is gathered in a deceptive fashion, such as consumers being presented with product warranty or registration cards that solicit medical information, with the false implication that completing the card is necessary to have protection for a product. And finally, EPIC said medical information is being gathered outside the protections of HIPAA's privacy regulation since individuals who give their medical ailment information to marketers have no ability to opt out of the data collection, to access their data or correct it, or to order that the data be deleted.

EPIC urged the FDA to consider risks posed by an increase in use of personal information to target DTC advertising. It said new database technology makes it simple for marketers to target vulnerable groups. ■