AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

The Risk Management Quarterly

SPRING 2013

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PRESIDENT'S MESSAGE

Dear AHRMNY Members,

As we await the arrival of spring weather, the Board hopes you all had a great winter season. Our March 13, 2013 evening educational & networking session was a huge success attended by approximately 100 persons. I have brought Judge Schlessinger's decision with respect to the discovery of e-mail to the attention of senior administration of my hospital. This will be followed up with education for the staff. I have received feedback from several members that work in health care environments that will be doing the same.

Here are a few current items that we find ourselves in the process of completing:

We are now in election season for the Board and Officers of AHRMNY. Don't forget to vote!!! Anticipated voting dates will be on or about May 6, 2013 through May 17, 2013.

The purchase of general liability insurance for AHRMNY has recently been completed. We find that more and more venues are requiring this insurance.

We have signed an affiliation agreement to continue our affiliation with the national organization, ASHRM.

Preparation of our June 7, 2013 full day conference is in full swing. In addition to our keynote speakers, we will be having break-out sessions again and we look forward to seeing you there. Details to follow!

We continue to encourage you to consider participating on any of the following working committees: Bylaws, Education, Finance, Membership, Nominating, Publications, or Public Relations. We welcome your expertise and encourage you to join and help our organization achieve its goals and mission of enhancing healthcare risk management and patient safety.

Here's wishing everyone a sunny spring season!!!

Alvin

Alvin J. Safran
AHRMNY President
July 1, 2012-June 30, 2013

EDITOR'S CORNER

The Risk Management Quarterly (RMQ), the official journal of the Association for Healthcare Risk Management of New York, Inc. is published four times a year.

RMQ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulations, as well as other relevant information of interest to risk managers. The articles are usually written by ***AHRMNY*** members, so the journal serves as an opportunity for members to showcase their writing talents.

For the official ***RMQ*** Author Guidelines visit our website http://www.ahrmny.com

Reminder:

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

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The information presented in
THE RISK MANAGEMENT QUARTERLY
is for educational purposes only

WE WANT TO HEAR FROM YOU FOR THE SUMMER AND FALL EDITIONS

We are asking our readers to submit articles for the summer and fall editions of the ***RMQ*** that focus on patient safety, environmental or staff safety, risk management, claims management, insurance issues and other relevant topics.

RMQ is published four times a year with a distribution of approximately 300 copies per quarter. Please forward any ideas or submissions for publication in the ***RMQ*** to "**Editors"**, via email with attachments to: ahrm@optimum.net

The deadline for submission and consideration for the next journal is **May 4, 2013**.

Save-The-Date for these Upcoming Programs and Events

AHRMNY Annual Educational Conference

Date: June 7, 2013 8:00 am – 4:30 pm
Place: Lighthouse International, NYC
Sponsors: **Kipnes Crowley Group**
MLMIC
Safety National

Topics Include: Enterprise Risk Management with the changing face of healthcare, Avoidable v. Unavoidable pressure ulcers; CPLR Article 50A Workshop; Behavioral Health-risks and liabilities; managing complex property damage and business interruption claims and Chronic Pain Management-risk and liabilities

EVERYONE IS A RISK MANAGER
ASHRM
HRM WEEK
JUNE 17-21, 2013
E★R★M

Celebrate Healthcare Risk Management week - June 17-21. This year's theme is, "Everyone is a Risk Manager." During this special week healthcare organizations can show appreciation to all staff members involved in the day-to-day risk management processes. Motive your hard working teams with a promotional gift featuring the Risk Management logo.

Visit the American Society for Healthcare Risk Management's website http://www.ashrm.org for upcoming HRM webinars, announcements and promotional gift orders.

15th Annual NPSF
Patient Safety Congress
May 8-10, 2013
Hyatt Regency | New Orleans, Louisiana
Patient Safety Solution Evolution

Massachusetts Society for Health Care Risk Management
MSHRM

23rd Annual New England Regional Healthcare Risk Management Conference
May 19-21, 2013

MITIGATING RISK IN HOSPITAL MERGERS AND CONSOLIDATIONS THROUGH CAREFUL CONSIDERATION OF WORKPLACE LAWS

By Paul J. Siegel, Roger P. Gilson, Ana C. Shields, Adam G. Guttell and Michael J. Passarella

The healthcare industry in the New York metropolitan area has been transformed in the last two decades through merger, acquisition and consolidation. Venerable independent institutions have been acquired by hospital systems; massive teaching hospitals have joined together to create even broader systems. Some institutions have disappeared.

When hospitals undergo consolidation there are economic benefits but there also can be unfortunate human consequences. The public and media focus on its impact on neighborhoods and community access to care. Of great concern, but less often publicized, are the many labor, employment and human resources issues that arise. While mergers or consolidations may increase efficiency, eliminate duplication, reduce healthcare costs and better serve the patient population, a smooth transition is necessary to realize these goals. To avoid unnecessary workplace disputes, diminished morale, reduced productivity and costly litigation, risk managers and human resource professionals must anticipate and plan for the many workplace issues they may confront during a merger or consolidation.

Redundancy and Layoffs

Increased efficiency and cost savings are among the benefits of mergers and consolidations. Staff reductions are one means to this end. While consolidations rarely result in mass lay-offs (e.g. involving 500 employees or 33% of the workforce) requiring 60 days' notice within the meaning of the Worker Adjustment and Retraining Notification Act ("WARN"), many commonly result in the closure of unprofitable, redundant or obsolete operations or services. Under federal WARN, such closures will be deemed a "plant closing´ requiring 60 day federal WARN notices if they result in the employment loss of only 50 employees. State WARN statutes can also require notice even if federal WARN does not. For instance, under New York law, employers with more than 50 employees must provide notice when a layoff will affect 33 percent of the workforce or at least 25 workers.[1]

If the rate of unemployment is relatively high, staff reductions can spawn discrimination claims filed by those who cannot find alternate employment. To reduce exposure to age discrimination and other fair employment claims, layoff criteria must be adopted [and a disparate impact analysis should be performed] before final decisions are made. Therefore, in addition to determining whether WARN notices are required, employers should consider:

- Identifying appropriate selection criteria (e.g. seniority, documented job performance data);
- Evaluating how individuals are selected for layoff and ensuring consistent selection processes;
- Reviewing layoff decisions to assess the risk of disparate impact upon protected classes, as well as the justification for each decision;
- Reviewing the results from previous reductions in force to avoid challenges from failure to follow precedent; and,
- Compliance with collective bargaining agreements, individual employment agreements and personnel policies.

If severance is paid beyond that which is already required by agreement or policy, employers should obtain a general release where possible.

Unions and Contracts

Managing union relationships can be a delicate and adversarial process even in the best of times. During a merger or consolidation, these relationships must be handled with even more care. Most institutions in New York employ a wholly or partially unionized workforce. Often, more than one union is involved. The hospital or health system must anticipate and prepare for the following:

- Nearly every union contract requires written notice well in advance of any merger or consolidation.
- An employer must bargain about the decision to transfer work when any part of the reason for the transfer is within the union's control, such as labor costs and work rules.
- Even if the employer does not have to bargain about the decision, an employer has the obligation to bargain about the effects of a closing or consolidation decision, unless a "clear and unmistakable" waiver has been negotiated in advance.
- With a bargaining obligation comes the duty to furnish, on request, detailed information concerning the organization's plans, including changes in operations that affect employees, anticipated reductions and the like.
- The Union may also propose severance, re-training or placement services for affected workers if they are not already provided by the labor contract.
- Prior to the announcement of the merger or consolidation, the due diligence process should involve an analysis of the various bargaining units, the potential accretion (i.e., combining) or elimination of some units or even groups of non-union employees by the surviving unions.
- While union contracts often remain in effect, there may be questions where there are job sharing or jurisdictional disputes between unions.
- Some unions may engage in corporate campaigns, regulatory interference, negative publicity and political or community organizing to block an acquisition, merger or consolidation that could cost their members' jobs.

- If the acquiring entity takes over a hospital with union-represented employees, the new entity may be legally obligated to take over the existing contract under certain circumstances. Even where there is no legal obligation to assume the Union's contract, the buyer may have to assume all or most of the terms in order to avoid a work stoppage that could severely derail a smooth transition. Even where the acquiring employee can avoid the contract most end up hiring a majority of the predecessor's workers and thereby become a "labor law successor" with an obligation to bargain with the employees' union representative.[1] In some circumstances, it might have to determine whether certain provisions of the acquired hospital's collective bargaining agreement survive the acquisition.
- Even though the human resource and risk management professionals may have developed relationships with one union, a different union may become a new negotiating partner.
- Along with different unions come possibly conflicting collective bargaining agreements ("CBA"). The provisions of different CBAs may obligate the new entity and its employees to new wages and hours, employee scheduling procedures, employee grievance procedures, seniority rules, benefits, work rules and negotiating terms. The acquiring hospital should audit its labor relations practices to ensure compliance with the new CBA to avoid union challenges to practices that may have been commonplace under the prior CBA but may run afoul of the new CBA.
- Increasingly, acquiring hospitals are taking over financially distressed sellers which desperately need a cash infusion and the stability that comes with being part of a larger health system. While the price may be right, due diligence is required to avoid inheriting statutory or legally imposed liabilities even where they buyer only acquires the seller's assets and it disclaims any of the seller's liabilities. Of particular concern are cases where the seller is participating in an underfunded multiemployer pension plan. Many of these plans, according to the IRS, are in now the "red zone" and cannot meet all of their vested liabilities when they come due. Any circumstance that terminates the Employer's obligation to pay contributions (e.g., the acquisition, termination of the labor contract, the seller's withdrawal from the plan) could potentially trigger a "withdrawal" from the plan. This withdrawal, in turn, could trigger "withdrawal liability" which represents the unfunded vested liabilities of the seller's employees. While the seller is generally responsible for such liabilities, courts have been imposing on the buyer the responsibility for unpaid pension contributions and withdrawal liability if the purchaser is aware of them and nevertheless acquires and maintains the continuity of the seller's operations. Prior assessment of these risks is absolutely essential. While there are ways the buyer can avoid a "withdrawal" by standing in the seller's shoes, it may have to fund the plan consistent with the Rehabilitation Plan established by the Fund. Such plans may impose increased funding obligations on buyer above and beyond those agreed to in CBA. The specter of withdrawal liability or trustees of red zone plans requiring additional contributions (now or in the future) can often be the most critical issue when considering an acquisition.

In addition to reconciling new or different CBAs, the acquiring hospital must be aware of other contracts for which it may assume obligations. For example, the shifting status of physicians in the medical profession has resulted in many private practices becoming professional corporations of the hospital. In doing so, the hospital may have arranged to honor existing employment agreements of physician-employees of the practice. The acquiring hospital must be aware of these obligations which may multiply exponentially depending upon the number of professional corporations involved and how recently the acquisition was made. Although the structure of the captive professional corporation model warrants a much longer and detailed explanation, at a minimum, it is important for the acquiring hospital to be aware of recent arrangements.

Policies and Procedures

Different hospitals often have different policies and procedures, medical staff bylaws, corporate compliance rules and human resources and compensation policies. These differences must be addressed. Employees of the new entity require guidance in the workplace. The acquiring hospital needs to determine whether the existing personnel policies are consistent with its own agreement and its organizational culture. Generally, changes in workforce rules can complicate any transition, but in time these need to be reconciled to ensure consistent rules and a cohesive and integrated workforce. Questions that must be answered include: Which hospital's policies will survive the merger and which policies will be discarded? How will these policies be accessible to employees – hospital intranet, handbooks issued to each employee, etc? How will physicians be credentialed as members of the new entity's medical staff? A significant feature of the organization's plan must be to incrementally move (where possible) to one identity with one set of policies and an integrated compensation and benefits structure.

The silver lining is that any merger or consolidation is an opportunity to move toward best practices by regularly updating and revising existing policies. A merger or consolidation provides a natural opportunity to do so. This process is best handled by a team of the organization's General Counsel, Risk Management Department, Operational Leadership, inside and outside employment counsel, human resources staff and lead practice managers who will review existing policies for compliance with any changes to the law and completeness.

If a hospital acquires a professional corporation, that practice should be examined to identify outdated policies or gaps in policies. If the hospital intends to exert control over the employees in the practice and exert the ability to hire, terminate, and discipline, managers should be trained about the hospital policies and practices.

Frequently, the purpose behind the merger is to address the diminished financial state of one entity caused by issues such as benefits compliance or underfunded multi-employer pension plans. These problems may have affected how the prior institution addressed certain obligations. For example, unpaid or late benefits contributions to a union benefit fund may result in proceedings that the new entity must defend. Thus, a comprehensive understanding of the new entity's liabilities prevents surprises once the transaction is complete.

Additional Considerations

A litany of collateral issues also should be addressed. For example, the acquiring hospital must reconcile benefits obligations, both ERISA covered and non-covered (paid time off, vacation, sick time, etc.) benefits. Record keeping systems should be analyzed and data preserved. Time records, crucial to the defense of wage and hour class or collective litigation, must be maintained. Information technology and payroll personnel must interface with software vendors to determine how time and pay systems can be integrated and utilized to safeguard historical data.

The unending details and innumerable issues involved in hospital mergers and consolidations may seem daunting. However, risk management and human resource professionals can mitigate risk by addressing the foregoing considerations. If you have questions, please contact Paul J. Siegel, Roger Gilson, Ana C. Shields, Adam G. Guttell, Michael Passarella or the Jackson Lewis attorney with whom you regularly work.

[1] N.Y. Lab Law 860.

[2] See "Hospital Merger Moves Forward," YALE DAILY NEWS, Sept. 30, 2011, available at: http://yaledailynews.com/blog/2011/09/30/hospital-merger-moves-forward/ (merger between Yale-New Haven Hospital and Hospital of Saint Raphael's resulted in Yale-New Haven Hospital recognizing Teamsters Local 443).



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AREA HEALTH CARE FACILITIES MAY NEED TO SHARPEN FOCUS ON CONTINUITY AND SUPPLY CHAIN RISK MANAGEMENT

By Jill Dalton

As hospitals and other health care facilities throughout the region and across the country face the challenges of elevating the quality of care they provide and doing so with thinning margins, few can afford the consequences of any significant disruption of their ability to treat patients whether through an outage at their facility or a break in the supply chain.

With respect to a health care facility's supply chain, whether it involves a critical drug or any of a number of medical products utilized in the day-to-day delivery of patient service, a shortage or crucial outage may compromise patient safety, delay procedures or force patients to seek treatment elsewhere. Such an event may have significant short- and long-term consequences for any hospital or health care facility, including potentially substantial financial losses.

The elongation of supply chains around the world makes understanding and managing related exposures more complex. For example, with manufacture of many pharmaceuticals and other critical medications, medical devices, implants, and vital diagnostic and laboratory equipment and electronics increasingly conducted on a global scale, supply disruptions can be caused by myriad events, ranging from large-scale natural disasters, to pandemics, product recall, ingredient contamination, and manufacturing plant and warehouse closures due to fires, floods, other natural hazards, worker actions, industrial sabotage and terrorism.

With so many risks and so much at stake, health care financial executives are teaming with risk management, procurement, pharmacy, quality assurance, information technology, compliance, and physician chiefs of medical departments, nursing and other clinical staff to conduct thorough assessments of their critical medical supplies, vendors and related suppliers.

These assessments should encompass not only an understanding of supply chain vulnerabilities and alternatives, but, significantly, the quantification of the value represented by each direct supplier. With respect to a hospital's top-tier suppliers, the evaluation should include an extensive analysis of the chain associated with those suppliers delivering the greatest value to the hospital. Such an evaluation should encompass everything from raw material and ingredient sourcing to assembly, manufacture or formulation, production, warehousing (if applicable) and distribution through delivery to the health care facility.

Among health care executives in the New York region, Superstorm Sandy demonstrated some of the unfortunate circumstances that can occur when a regional natural disaster event causes widespread damage, flooding and power outages. Hospitals and other health care facilities that lost electrical power and whose backup generators subsequently failed needed to relocate patients to facilities with working systems or more effective resiliency initiatives. Surgeries and other medical procedures had to be scheduled at other hospitals, leading some physicians, nurses and other medical professionals to move to other hospitals temporarily and others to change hospitals altogether. With several million dollars in lost revenues on top of hundreds of millions of dollars in damage, some hospitals ultimately may take years to recover.

While the consequences for many disrupted facilities and their relocated patients could indeed have been much worse, the lessons learned are clear: If they haven't done so already, health care facilities throughout the region need to reassess their emergency response and business continuity plans in the context of another severe weather event or similar potential disaster.

As part of the process, they should examine both their business interruption and potential contingent business interruption (CBI) exposures. In order to understand the level of their financial protection for such incidents, they should work with their insurance advisors to check their applicable coverage, including property insurance policy limits and sub-limits, exclusions, loss definitions, coverage triggers, reporting procedures and time requirements.

Additionally, health care facilities need to consider the risk implications of such developments as:

- Growing reliance on "cloud computing." Health care risk managers, supply chain executives and chief technology officers, all must place the excitement over the growing number of potential applications involving the cloud in the context of potential computer hacking exposures among other risks.

- Solvency of trading partners. Among health care facilities whose providers utilize international supply chains, sustained regional economic difficulties may have stark financial consequences for trading partners, leaving them with slackened demand, tighter bank credit lines, and an increased risk of insolvency and financial failure.

- Product recall. The ever-present potential for a product recall involving a critical drug or implantable medical device, heart valve, hip or knee replacement, stent or other product continues to be a significant risk. There has been a litany of recent recalls, as well as allegations of contaminated pharmaceutical products manufactured outside the U.S.

- Pandemic. It almost goes without saying that while most enterprises have to understand and prepare for the implications of a pandemic, health care facilities need to be doubly prepared. They have to ensure resiliency of their supplies when a pandemic might disrupt them; they also need to maintain adequate inventories of necessary medications and be ready to implement appropriate infection control measures to protect patients and staff.

- Natural hazards in emerging economies. While China, India, Mexico and other emerging markets continue to be desirable regions for low cost production of some medical supplies, sourcing from these countries may entail an array of complex risks. For example, China has extensive natural catastrophe risks, especially earthquake and flood. Its fragile and developing transportation infrastructure could prove difficult to navigate for extended periods following a disaster event.

- Terrorism. The threat of terrorism continues to loom large in many parts of the world. Health care facilities need to be aware of measures their suppliers are (or are not) taking with respect to necessary and appropriate security precautions to protect employees, customers, equipment and facilities. They also should review related insurance coverage, ensure that direct suppliers and their trading partners have taken similar measures, and are working with national governments and local authorities to safeguard against terrorism events.

Cost-cutting and Elevated Risk Levels: A Dangerous Combination

As health care facilities look to streamline their supply relationships to obtain better pricing, they need to understand the risks of consolidated sourcing, both in terms of reliability of supply and possible ethical considerations if there are any perceived conflicts of interest with respect to selection of medical devices, implants/replacements, prescribed medications and other treatments where patient choices may appear to be compromised.

Unfortunately, the imperative to control costs may lead struggling health care facilities to cut back on certain risk management initiatives and insurance purchases. For the most part, property insurance, including business interruption (BI) and contingent BI, continues to represent a vital first line of defense against any supply chain outage resulting from direct physical damage or other covered perils. Business continuity and supply chain risk assessments go hand in glove with insurance and can help health care facilities in their efforts to make sure insurance is adequate, appropriate and obtainable at competitive costs.

To take a lesson from the private sector, today's leaner organizations generally can function efficiently when things are going right. However, a disruption along the supply chain can have disastrous consequences for any enterprise that hasn't factored into its model a thoughtfully conceived and properly tested program of risk assessment and risk management.

Reassessing Health Care Supply Chain Risk

For businesses in general, one of the most significant lessons learned from large-scale regional disasters is that leaders need to be careful not to underestimate the implications of a regional disaster or the potential downtime of a key supplier. Hospital and health care risk managers, procurement, supply chain and administrative executives all need to focus on understanding and quantifying exposures and then prioritize them based on probability and magnitude.

With respect to their supply chains, it's important for health care executives to understand the breadth of their time element coverages and recognize the limitations of those insurance policies. They need to work with their insurance brokers, insurers and legal counsel to understand what types of events will trigger coverage, and those losses for which there is unlikely to be any coverage. Once understood, broadly communicating the terms and limitations to stakeholders, such as administration executives, CFOs, general counsels, board members, and in some cases lenders, is a critical step in managing the risk.

The limitations of traditional CBI and other time element coverage need to be reviewed annually in conjunction with the changes in exposures and possible adjustments to the policy provisions. How far down the chain does the coverage extend? Does it cover all suppliers, including those that are directly linked to the health care facilities (tier 1), as well as their suppliers (tier 2) and those who might provide a critical ingredient or chip (tier 3 suppliers)?

If these modifiers as respects suppliers are on a policy it should be clear to all parties what they mean. If downstream suppliers are not included and if protection down the chain is needed, will the insurers provide the needed extensions? Many of these issues surfaced in the measurement and quantification of claims from the earthquake and tsunami in Japan, as well as the flooding in Thailand.

As the contingent and unknown exposures have grown, many insurers have taken measures to limit their exposure to these types of losses by restricting CBI language to apply only to direct or "named" suppliers or customers.

In addition to reviewing insurance programs, business continuity plans, contractual relationships with suppliers should be continually examined. How quickly can a critical supplier be replaced in the event a disruption causes it to fail or be down for a significant period of time? Where are the alternative suppliers located and how fast can they get up to speed to meet demand? Is the alternative located in another part of the world, where it will not be affected by a regional disaster that might affect the primary supplier? Are there any regulatory/FDA requirements that will need to be met?

For health care risk managers and other members of the supply chain team, the assessment of a supply chain, its resiliency, and potential exposures is a critical exercise that needs to be revisited regularly. Supply chain risk and related insurance programs should be assessed annually or if there are any significant changes to a supplier, resource, or in the health care facility's structure and functionality. Adjustments in insurance coverages should be made, accordingly. In addition, program modifications may be necessary to reflect changes in commercial insurance market conditions and related coverage reductions or restrictions sought by insurers.

Insurance programs may need adjustments to accommodate changes in a health care organization's structure, operations, mergers and acquisitions, and to reflect any developments that lead to an increase or decrease in patient demand for specific procedures or services.

Quantification, a Key to Health Care Supply Chain Risk Management

Given the imperative for health care to improve quality as well as efficiency in the context of increasingly complex supply chains, the best starting point for health care executives is to quantify their supply chain exposures. The knowledge gained through quantification helps drive an efficient supply chain risk management process that ultimately enables the health care organization and its suppliers to apply resources against the most serious vulnerabilities of the supply chain. The process also uncovers opportunities for cost savings, identifies potentially dangerous gaps in insurance coverage, and can improve the chain's overall efficiency. The basic steps for quantifying supply chain risk include:

1. Assess the potential financial consequences of a supply chain disruption (both negative and positive). These include the possible interruption of revenue streams, increased expenses to mitigate loss and maintain the ability to deliver necessary patient care, as well as the implications of having to obtain alternative sources for supplies or transfer patients with acute care needs to facilities able to provide treatment.

2. Develop a management checklist for quantifying supply chain risk, including:
   - work with suppliers and other partners to map the entire supply chain for all critical medications, devices, equipment, and products;
   - analyze risk by supplier, location of facilities, power sources, potential political exposures, distribution points, shipping and transport providers and routes, and related infrastructure concerns;
   - chart interdependencies; develop and quantify worst-case scenarios.

3. Use a team approach. A multidisciplinary approach yields the best results. For many health care facilities the team should include any or all of the following:
   - supply chain management
   - risk management
   - administration
   - clinical care (medical department heads, nursing, pharmacy, etc.)
   - accounting/finance
   - marketing
   - communications
   - procurement
   - compliance and legal
   - information technology
   - human resources
   - senior leadership
   - group purchasing organization(s), pharmaceutical and medical device manufacturers, and other critical suppliers

Significantly, for many health care organizations already engaged in an enterprise-wide risk management initiative, an effective supply chain quantification process can be structured as a single focused step as part of an overall health care enterprise risk management (ERM) initiative to fit within the ERM framework.

In addition to improved planning, the supply chain risk quantification process can find gaps in insurance coverage, and identify opportunities for premium cost savings. For example, after going through the quantification process a manufacturing company found that its loss estimates were lower than insurer's projections. As a result, the company was able to achieve a reduction in premium.

Quantification also yields an improved understanding of interdependencies along the supply chain, which often becomes a vital element of an effective risk management program. A large pharmaceutical company discovered it had failed to list a critical supplier on its contingent BI policy.

Another key result is that risk quantification can help health care organizations prioritize their risk management investments more effectively. That's a critical benefit in light of limited risk management resources and a tightening insurance market with higher premium costs and more coverage restrictions.

Throughout the risk management community, it's widely acknowledged that supply chains are only as strong as their weakest link. This message is now resonating with senior leadership across the health care sector. With so much at stake, it pays for hospitals and other health care facilities to take steps to pinpoint their supply chain risk, and to mitigate, manage and address it in the most cost-effective way.



Jill Dalton is a Partner and head of Dempsey Partners' New York office. In that role she is responsible for the delivery of claim preparation and exposure value analysis assignments involving the firm's New York area corporate clients. Jill is the leader of the firm's proprietary X-V Analysis® business and she is also providing risk consulting services to clients in the form of property policy wording reviews and coverage analysis. Jill is a frequent speaker at RIMS chapter meetings and for the Insurance Brokers Association of New York.

Dempsey Partners mission is to offer a broad portfolio of risk management consulting and claims services to risk managers, including X-V Analysis®), its MegaLoss Disaster Response service, and an enhanced Forensic Analysis capability directed toward the prevention and investigation of occupational fraud claims.

Prior to joining Dempsey Partners, Jill was a Managing Director in Marsh's Global Property Practice and leader of its Financial Institutions Center of Excellence for Property Risks. In 2008 she was named a Risk & Insurance® Power Broker in the financial institutions category. She led the Property Departments of both Boston and New York operations. Following the terrorist attacks of September 11, 2001, she served as an industry expert on terrorism risk, publishing Marsh's Terrorism Marketwatch reports, testifying before the United States Congress prior to the most recent extension of the Terrorism Risk Insurance Act (TRIA), and serving on two industry associations as a board member. She is a graduate of Boston College and holds an MBA from Fordham University.

DISCOVERY OF A DEFENDANT'S SOCIAL MEDIA PRESENCE

By Martin B. Adams

Social media is a true internet growth industry. Social media and networking sites includes Facebook, LinkedIn, Twitter, Pinterest, and Google+.

"Social networks are internet-based communities that individuals use to communicate with each other and view and exchange information, including photographs, digital recordings and files. Users create a profile page with personal information that other users may access online. Users may establish the level of privacy they wish to employ and may limit those who view their profile page to 'friends' – those who have specifically sent a computerized request to view their profile page which the user has accepted."[1]

Social networking websites "allow users to send and receive messages, through posting on user-created 'profile pages' or through private messaging services."[2] A "profile is a webpage that allows a user to aggregate and present her personal information, photos, web journals, favorite hyperlinks, and the like into one location."[3]

Popularity of social networking sites

Millions of Americans use social networking sites. The users check their accounts several times each day. Many users gain access through mobile phones and other mobile apps.[4]

Physicians and other health care providers also enjoy using online social media and networks. "Nearly 90% of physicians use at least one site for personal use, and over 65% for professional purposes", reports QuantiaMD.[5] Many physicians use social media, as well as other electronic communication such as e-mails, to communicate with patients.[6] Many hospital nurses use mobile devices such as Smartphones "while on the job for personal and clinical communications."[7]

About one quarter of all hospitals in the United States participate in social media, according to an infographic prepared by Demi & Cooper Advertising and DC Interactive Group. A majority of those hospitals participate in Twitter. A vast majority of the hospitals participate in Facebook.



Technology-savvy medical school students and residents serve as a sign of the important role for social media in health care for years to come. One study found that about half of the students enrolled in a medical school and half of residents employed by a hospital had Facebook profiles.[8]

Physicians also are members of professional networks such as doximity.com. Professional networks allow physicians to connect with colleagues and market their practices. Securely communicating and collaborating over a physicians-only network, though, still requires attention to patient confidentiality and other medical ethical concerns.

Blogs, or weblogs, is another popular means of expression on the internet. Blogs are online diaries updated frequently. Topics covered by blogs include medicine and health care issues. Medical discussions dominate blogs geared toward health care.

Benefits of a social media presence

Social media presence by physicians and hospitals provide substantial and long lasting benefits.

Participation in social media can enhance the health care provider's reputation. Social media presence offers educational opportunities for patients and the public at large. Feedback from the community provides not only constructive criticism, but also praise for the physician's and hospital's medical services.[9]

Referrals can be made through social media. Donations for hospitals can be promoted online. Live online streams of medical experiences may be shown by hospitals and moderated by physicians. Information such as medical videos can be made available for patients. Updates and status reports can be posted when a hospital is confronted with a community medical crisis.[10]

Twitter and physicians

Twitter is an online social networking service that enables its users to post ("Tweet"), repost ("Retweet"), and read the Tweets of other users. Tweets can include photos, videos, and text-based posts of up to 140 characters. Users can monitor, or "follow" other users' Tweets.[11]

A substantial majority of Twitter users post status updates as active tweeters.[12] Patients and other online users may follow physicians' Twitter feeds. Physicians may actively tweet to patients and fellow physicians and colleagues. "Surgeons are… using Twitter as a teaching tool" for medical students.[13]

Cyberloafing

Workers do not necessarily spend their social networking time at work for matters relating to their jobs. Cyberloafing, or wasting time on the internet, can include visiting and using social media sites. "Between 60 and 80 percent of people's time on the Internet at work has nothing to do with work", reports a study undertaken by Kansas State University.[14]

Physicians have found many useful clinical uses for the internet, including telemedicine, e-prescribing, online clinical consultations, health-related websites, use of electronic media for clinical collaboration, and e-mailing patients. Physicians also have used the internet for nonclinical purposes, including use of social networking sites, blogs, and other means to post content online.[15]

Physicians need to consider the boundaries of the physician-patient relationship when participating in social networks and posting online. Allowing a patient to view online personal information about the

physician can have repercussions. The American Medical Association recommends that, "to maintain appropriate professional boundaries physicians should consider separating personal and professional content online."[16]

Online hoaxes
Online hoaxes are a fact of internet life. Manti Te'o, a linebacker for the Notre Dame football team, was recently involved in a high-profile internet hoax involving a "catfish" who pretended to be Te'o's online girlfriend. A "catfish" is a person who assumes a false identity to lure an innocent online victim in online dating.[17] A health care provider can fall prey to an online hoax, whether perpetrated by a "catfish", a competitor, or a disgruntled patient.

Permanence of postings
Health care providers participating in social media do not necessarily select the most restrictive privacy settings to protect personal information or information about patients. Even if privacy settings are used, the postings still may be discoverable and may be a permanent presence on the social media site.

Online postings offered by physicians may be permanent. Posts can be cached for future review by outsiders. A post can be saved by a reader through a screen shot before the author deletes the post.

Adverse consequences of posting online
A health care provider's online post can start privately and be disseminated publicly. Private Facebook status updates and tweets, when made public through litigation or dissemination by a reader [such as a patient] can trap a physician or hospital employer in a civil lawsuit, in-house disciplinary proceeding, a state medical board proceeding, or a government investigation of a privacy violation. The post can be misinterpreted and taken out-of-context by readers, including patients.

Humor or sardonic remarks in an online setting can become anything but funny when subjected to public scrutiny or when placed under a litigation microscope. A physician found herself under public criticism after posting on her Facebook page that she had a patient "who has chosen to either no-show or to be late… for all of her prenatal visits, ultrasounds, and NSTs. She is now 3 hours late for her induction. May I show up late to her delivery?" The comment was unprofessional if not a violation of HIPAA.[18]

The comments made by a physician or other health care provider online can have substantial adverse consequences to professional status of the provider, if the comments defame or breach the privacy rights of a patient or are otherwise inappropriate.

A hospital employee faced termination from the hospital after the employee posted a patient's medical information on the employee's Facebook page to make fun of the patient's medical problem.[19] Nurses and other hospital staff who took photos of a dying patient and posted the photos on Facebook were fired or disciplined.[20] Employees of a medical center faced firing after they shared patient information on Facebook.[21]

The prospect for adverse consequences from use of social networks can be magnified by a physician who shares a user ID or password with staff members or others. Participating through an unsecured network, and failing to log-off a computer after completing a social network session can also lead to trouble for the physician or hospital.[22]

State medical board discipline
A state medical board can discipline a physician for unprofessional conduct arising out of postings or misuse of social media networks.

Misrepresenting credentials or treatment outcomes, depictions of intoxication, violations of patient confidentiality, discriminatory speech, and use of an online dating service to interact with a patient are some online activities that can spark an investigation by a state board.[23]

Violations of online professionalism around the country have included inappropriate patient communications online including sexual misconduct, use of the internet for inappropriate medical practices such as prescribing without an established clinical relationship, and misrepresentation of credentials.[24]

Rhode Island state regulators sanctioned a physician for writing on Facebook about some of her clinical experiences. The physician did not use patient names or intend to reveal patient information. The discipline was based upon the ability of a third party to identify the patient based upon the injuries sustained by the patient.[25]

Criminal investigations
Criminal investigations can arise from improper posting of patient information on a social network site. A case involving breach of a patient's privacy can be referred to the federal government for a possible HIPAA violation. Potential criminal charges such as voyeurism may be made against a health care provider who misuses patient information through social media.

Distracted physicians and nurses
Interruptions during interactions with patients can cause procedural and clinical errors. The interruptions force the health care provider to divert attention from the patient to another task.[26]

The ready-availability of mobile electronic devices such as smart phones and tablets raises the risk that physicians and nurses will be distracted by engaging in social media during their clinical practice. The health care provider may be engaged in personal business, or professional business other than the patient being tended to at the time of the distraction. The result can be an adverse patient event, and a malpractice lawsuit based upon that distraction.

The proliferation of portable medical devices means that "doctors and nurses can be focused on the screen and not the patient, even during moments of critical care", explained one reporter.[27] Sending text messages, accessing e-mails, and checking and posting on social networking sites using smart phones are types of activities that sometimes occur during surgeries.[28]

Texting, snapping photographs of patient injuries, doing crossword puzzles, and texting are problems arising from mobile device distraction. A wrong-site surgery and a near-miss involving leaving a specimen in a patient are two recently reported adverse events possibly associated with personal use of a mobile device.[29]

A resident who began to enter into her smartphone an order from the attending physician to stop anticoagulation on a patient was distracted by a text message from a friend regarding an upcoming party. The resident text messaged her confirmation of her attendance at the party. Unfortunately, the resident never completed the order to discontinue anticoagulation

therapy. The patient continued to receive the anticoagulation therapy, and no one checked the patient's international normalized ratio (INR) because the team thought the medication had been stopped. The patient developed hemopericardium necessitating emergency open heart surgery, as a result of the over-thinness of his blood.[30]

On-line postings used in litigation

On-line postings can be discoverable and used against the physician in a malpractice lawsuit. Violations of patient confidentiality, use of profanity and discriminatory language, depictions of intoxication, sexually-suggestive postings, and admissions of careless medical care can haunt the defense of a malpractice case.

The comments could reflect badly not only on the physician, but also upon the physician's employer and affiliated hospitals. The reputations of the health care provider as well as the hospital can be damaged through media publicity concerning inappropriate comments and postings on social networks.

A plaintiff suing a physician or hospital is entitled to "full disclosure of all matter material and necessary in the prosecution" of his or her lawsuit.[31] A physician or nurse's postings on a social network profiles may be a document that is discoverable by plaintiff.

Social networking site content may also be subject to discovery under the federal rules governing production of documents in federal cases.[32] "…social media information may be a source of relevant information that is discoverable" in federal lawsuits.[33]

Relevance of social network pages

Social networking information may be ordered by a court to be disclosed upon a showing that the information is relevant to a factual dispute that the jury will be asked to resolve. Information from a social website page may be relevant and material for impeachment and for substantive contradiction at trial.[34]

A court may grant a party access to an adverse party's current and historical private social network pages and accounts, including all deleted pages and related information.[35] A court may order a party to download and disclose the contents of any internet social networking sites, including deleted postings.[36]

Innovative ways to disclose social network pages

A typical remedy for a party who seeks social network information is to demand a properly-executed consent and authorization as may be required by the operators of the social network site. The authorization permits the demanding party to gain access to the records of the social network company, including records previously deleted or archived.[37]

In a discovery demand for social network account data for a particular period of time, the demanding party can helpfully explain that the data could be accessed by: (1) logging onto a Facebook account, (2) selecting "account settings", (3) clicking on a link entitled "download a copy of your Facebook data," and (4) following the directions on the data download page.[38]

A party maintaining a social network site can be directed to upload onto an electronic storage device, information from his or her social network accounts for a specific time period. The electronic storage device and an index of redacted social networking site communications would then be provided to counsel for the demanding party. The court can direct that counsel for the demanding party can disclose the information only to counsel's support staff as necessary. Counsel could provide a list of material identified as discoverable. The parties would then file with the court a joint report, including (i) a copy of the material, and (ii) each party's position on the discoverability of the material, for the Court's review.[39]

A court can direct that counsel shall exchange the passwords of the client's Facebook password with counsel for the demanding party. Counsel for the demanding party can be instructed not to give the password to the demanding party himself.[40]

To expedite discovery regarding a Facebook account, a judge could create a Facebook account. If the party will accept the judge as a "friend" on Facebook for the sole purpose of reviewing photographs and related comments *in camera,* the judge can review and disseminate any relevant information to the parties. The judge would then close the Facebook account.[41]

Another federal court judge recently directed the social network member to provide to a special master relevant information to access social media websites for a particular time period. The court would then review *in camera* the information and require disclosure of only relevant information. The producing party then would conduct a privilege review and disclose nonprivileged material along with a privilege log. Both parties bore the cost of the forensic evaluation.[42]

Tailoring a Proper Demand for a Social Network Page

A discovery request for social networking site content must be reasonably calculated to lead to the discovery of admissible evidence. The request for discovery needs to describe the information to be produced with reasonable particularity.[43]

The proper means to obtain disclosure of relevant information contained in a social media accounts is a narrowly-tailored discovery request seeking only relevant social-media-based information.[44] The demanding party of an adversary's restricted social media account "should first demonstrate a good faith basis to make the request."[45]

Improper Demands for Social Network Information

A demand for unlimited access to social network accounts may be considered by a court to be overly broad, a fishing expedition, and palpably improper.[46] A demand for disclosure of the "entire contents" of a social website account is not a narrowly-tailored disclosure request.[47] A demand for unlimited access to social media accounts is a palpably improper fishing expedition.[48]

A demand for a downloaded zip or compressed file of a party's social network page or any other social media account fails to specifically identify social network information that is relevant in that it contradicts or conflicts with a claim or defense. The court can direct the social network member to be deposed "with respect to the types of information which he posted on the site" so that the demanding party can establish a factual predicate for relevancy of the information on the site.[49]

A request for unrestricted access to a page at a social–networking website is overly broad.[50] Access may be denied to a party's social network page absent a showing of need for information from the party's social networking accounts.[51]

A party who fails to specify a factual predicate with regard to the relevancy of a social network account may be denied access to information about the account.[52] The party demanding disclosure is obliged to establish a factual predicate with respect to the relevancy of the information that the social network sites may contain.[53] A court may issue a protective order against postings on a social network profile since the date of the medical care at issue, absent a showing that disclosure will result in the disclosure of relevant evidence.[54]

Privacy and Disclosure of a Social Network Page
Relevant information is not shielded from discovery merely because the information is "locked" or "private". Merely locking a profile from public access does not prevent discovery.[55]

Denial of access to a private social network profile pages "would condone" the social network member's "attempt to hide relevant information behind self-regulated privacy settings". A party may be granted access to current and historical private social network pages and accounts, including deleted pages and related information. The member of the social network may be directed to provide an authorization allowing access to such records.[56]

Postings on a party's "online Facebook account, if relevant, are not shielded from discovery merely because" the party "used the service's privacy settings to restrict access…"[57] However, the demanding party should "show with some credible facts that the adversary subscriber has posted information or photographs that are relevant to the facts", before disclosure of a closed or private social media account will be ordered.[58]

The Stored Communications Act
The Stored Communications Act ["SCA"] prohibits unauthorized access to stored electronic communications.[59] A social networking website is an electronic communications service under the SCA.[60]

The SCA does not apply to a user of an electronic communications service. The SCA does it impose civil or criminal liability when action is taken in good faith pursuant to a court order.[61] Consent and authorization ordered by a Court should satisfy the SCA.[62]

In Camera Inspections
A Court can direct an *in camera* inspection of social network postings to determine relevance.[63] A party can be directed to provide a court with copies of social network postings, including deleted material, so that the Court may perform an *in camera* inspection to assess the materiality and relevance of the material.[64]

A court should conduct an *in camera* inspection of postings on a social network profile to determine which materials, if any, are relevant and to determine material "of a private nature that is not relevant" to the lawsuit.[65]

Trial Courts have held *in camera* inspections of social network postings. A party can be directed to "produce for an in camera review to the Court any and all postings, documents, and photographs from" accounts with social network sites for specified time periods, "including any deleted or archived items" with the documents "being Bates stamped".[66] A trial Court can "review the contents of the Facebook page in camera and disclose all images and text that are relevant…"[67]

An in camera inspection, though, is not an "all-purpose" solution when the review involves hundreds of transmissions. If a special master is to be assigned to assist in the in camera review, then the demanding party in a tort case should bear the costs of the review.[68]

Use of a Referee regarding Social Network Disclosure
A court can appoint a referee to review the postings and advise the trial Court as to any relevant, discoverable postings.

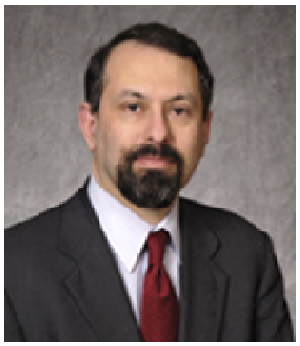
A trial Court, "on its own initiative without notice", can appoint a referee to "supervise all or part of any disclosure procedure."[69] The referee can review the discovery *in camera* and identify discoverable information.[70]

A trial Court can direct production of an authorization for the content of a Facebook account. The demanding party can be directed to prepare a "so-ordered" subpoena for the content of the Facebook page. The documents produced as a result of the subpoena would be delivered to the Chambers of the trial Court for an *in camera* inspection.[71]

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[33] *Reid v. Ingerman Smith LLP*, 2012 WL 6720752 (E.D.N.Y.)(Sexual harassment action).
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[35] *Romano v. Steelcase*, 30 Misc.3d 426, 907 N.Y.S.2d 650 (Sup. Suffolk, 2010)(Plaintiff was directed to provide an authorization allowing defendant to gain access to social network records; the Court rejected plaintiff's arguments that plaintiff had a reasonable expectation of privacy in her home computer, the discovery demand was not relevant, and the demand was designed to intimidate and harass).
[36] *Sourdiff v. Texas Roadhouse Holdings*, LLC, 2011 WL 7560647 (N.D.N.Y., 2011).
[37] *Romano v. Steelcase Inc.*, *supra*.
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[39] *Thompson v. Autoliv ASP, Inc.*, 2012 WL 2342928 (D.Nev.)(Product liability case arising from a motor vehicle accident; the court held that counsel for the demanding party "may ***not*** make a copy of the material on the storage device" [emphasis original]).
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[46] *Scariff v. Wall Street Mail*, Sup. Queens, Index No. 26325/2010 (Butler, Denis, J., Order dated December, 2012)(Defendant demanded unlimited access to plaintiff's Facebook and other social media accounts).
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[49] *Caban v. Plaza Construction Corp.*, Sup. Queens, Index No. 15557/2007 (McDonald, Robert, J.; Order dated September 24, 2012) (Construction accident case).
[50] *Winchell v. Lopiccolo*, 38 Misc.3d 458, 954 N.Y.S.2d 421 (Sup. Orange, 2012)(Motor vehicle accident case; defendants' request for unrestricted access to plaintiff's page at a social–networking website, seeking information in personal injury action as to plaintiff's cognitive abilities, especially in relation to her claimed neurological and psychological injury stemming from subject motor vehicle accident, was overbroad; defendants did not claim that the information contradicted her claims of injury or damages, but they rather asserted a mere hope that they would discover information that they sought; to the extent that plaintiff provided more reliable indicators of her cognitive abilities, defendants made no showing that their request was not cumulative).
[51] *Abrams v. Pecile*, 83 A.D.3d 527, 922 N.Y.S.2d 16 (1st Dep't 2011)(Injunctive relief and monetary damages were sought by plaintiff as a result of defendant's conversion of personal, private photographs of plaintiff appearing topless; the photographs were taken by plaintiff's husband during their honeymoon and were given to defendant to be developed; defendant's attorney refused to return the photographs unless the husband agreed to settle a sexual harassment claim filed by defendant against the husband and the husband's hedge fund for whom defendant worked; plaintiff, meanwhile, claimed emotional distress as a result of defendant publicizing the photographs; no showing was made for access to plaintiff's social networking accounts).
[52] *McCann v. Harleysville Ins. Co.*, 78 A.D.3d 1524, 910 N.Y.S.2d 614 (4th Dep't, 2010).
[53] *Caraballo v. City of New York*, (Sup. Richmond, Aliotta, J; Index No. 103477/08; Order dated March 4, 2011)(Personal injury action).
[54] *Richards v. Hertz Corp.*, 100 A.D.3d 728, 953 N.Y.S.2d 654 (2d Dep't 2012)(Motor vehicle accident case).
[55] *EEOC v. Simply Storage Management LLC*, 2010 WL 3446105 (S.D. Ind.; Lynch, Mag.)(Title VII sexual harassment action on behalf of employees; profiles, postings, and messages revealing, referring, or relating to plaintiffs' emotional feelings or mental state were discoverable; discovery regarding the mental health of two plaintiffs could go beyond matters directly referenced in the complaint, as a restrictive approach might not yield information inconsistent with other potential causes of the claimed injuries; communications by third-parties that place claimants' own communications in context were also discoverable).
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[57] *Patterson v. Turner Construction Co.*, 88 A.D.3d 617, 931 N.Y.S.2d 311 (1st Dep't 2011)(Construction accident case involving an allegation of permanent disability; the trial Court conducted an *in camera* review of Facebook postings, found them to be material and relevant to the defense, and ordered plaintiff to produce an authorization permitting defendants to gain access to Facebook records compiled after the accident at issue; the Appellate Division remanded "for a more specific identification of plaintiff's Facebook information that is relevant, in that it contradicts or conflicts with plaintiff's alleged restrictions, disabilities, and losses, and other claims").
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[59] 18 U.S.C. §2701(a).
[60] *Crispin v. Christian Audigier, Inc.*, 717 F.Supp.2d 965 (C.D.Cal., 2010)(Copyright infringement action; Facebook and MySpace are ECS and remote computing service providers).
[61] *In re Air Crash near Clarence Center, New York, on February 12, 2009*, 2011 WL 6370189 (W.D.N.Y.)(Wrongful death accident; defendants' request for production of decedent's electronic for five years up to the date of the accident, and each claimant's electronic communications from 2004 through the present, including social media accounts, emails, text messages, and instant messages, as they relate to decedent's domicile on the date of the accident, and each claimant's loss of support claims, was granted; the parties dispute where decedent was domiciled on the date of the aircrash).
[62] Under the SCA, a "provider… may divulge the contents of a communication… with the lawful consent of the originator or an addressee or intended recipient of such communication, or the subscriber in the case of remote computing service…" 18 U.S.C. §2702(b)(3).
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[65] *Richards v. Hertz Corp.*, 100 A.D.3d 728, 953 N.Y.S.2d 654 (2d Dep't 2012)(Motor vehicle accident case).
[66] *O'Brien v. Sweet Construction*, Sup. New York, Index No. 108307/09 (Oing, Jeffrey, J.; Order dated March 8, 2012).
[67] *See, e.g.*, *Abizeid v. Turner Construction Company, et al.*, Sup. Nassau, Index No. 23538/10 (McCormack, James, J.; Order dated September 5, 2012)(Slip-and-fall personal injury action).
[68] *Fawcett v. Altieri*, *supra.*
[69] CPLR §3104(a).
[70] *Newman v. Johnson & Johnson*, Sup. New York, Index No. 104403/09 (Ling-Cohan, Doris, J.; Order dated January 11, 2012)(Wrongful death action; plaintiffs were directed to produce decedent's Facebook content for a four-year time period "for an in camera review, to be supervised by a Special Referee…").
[71] *See, e.g.*, *Abizeid v. Turner Construction Company, et al.*, Sup. Nassau, Index No. 23538/10 (McCormack, James, J.; Order dated September 5, 2012)(Slip-and-fall personal injury action).



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Risky Business

"When Common Sense is Uncommon"

By: Pamela Monastero, MBA

COMMON SENSE TIPS FOR STAFF:
This quarter's column looks at the risk manager as a key decision maker and compares us to risk managers in other industries.

The Risk Manager as Decision-Maker
Where does the healthcare risk manager stand as a decision-maker in the organizational hierarchy? How does our role differ from risk managers in other fields—are their roles more vital? Do our counterparts sit at the table when important discussions take place and when final decisions and action plans are vetted? Regardless of the industry—financial, aviation, pharmaceutical, automotive, manufacturing, etc.—risk managers play an important role in risk identification and recommending risk mitigation strategies. But what actually happens when the rubber meets the road and decisions are made is quite a different matter. What are the circumstances and thought processes that lead to risk reduction recommendations being ignored, watered-down or completely overridden? Prior to examining the input and role that the risk manager plays in the decision-making process, it is first important to actually understand that the decision-making process may not always be logical, statistically-based, rooted in scientific or factual evidence, or even based on a cost-benefit analysis or on common sense. The human factor issue, inclusive of politics, emotions, greed and ego seems to unduly influence decisions at times.

A Quick Overview of Decision Making "101"
College and graduate school texts on business management illustrate countless approaches (refer to bibliography for a list of definitions) for influencing decision-making, managing expectations and offer various tools for consideration such as Cost-Benefit analysis, SWOT analyses (Strengths-Weaknesses-Opportunities-Threats), identification of stakeholders, both internal and external, stewardship ramifications, etc. Steps in making effective decisions include fact-finding, attempts to identify (and limit or contain) any uncertainties, analysis of complexities of interrelated factors, high-risk consequences, alternatives and interpersonal issues (human factors), among others. Therefore, decisions are never uncomplicated and often have far-reaching repercussions that cannot always be anticipated or controlled. Risk analysis always plays an important role in the decision-making process and is described as "a structured approach for assessing threats and for evaluating the probability of events occurring – and what they might cost to manage."[1]

Text and web-based decision-making approaches offer useful information about creating a constructive environment, generation/exploration/selection of alternatives, checking/communicating the decision and acting on the decision. Establishing objectives is key, as is involving the right people, performing a stakeholder analysis, listening to varied opinions, avoiding '*Groupthink*', asking the right questions (*The 5 Whys*), being creative in generating ideas and alternatives (*Brainstorming, Reverse Brainstorming*, etc.) and reviewing alternatives from different perspectives (e.g. *Reframing Matrix, Concept Fan, Appreciative Inquiry*). Risk analysis enters the scene when you reach the stage where alternatives are being explored. There are a myriad of tools available to analyze consequences of decisions such as *Impact Analysis, Six Thinking Hats*, *Cost-Benefit Analysis*, etc. These tools help lead to an organized and systematic decision-making process which should, ultimately, lead to better decisions that are not based on insufficient information and analysis. [1] Yet, even when there are strong foundations in place for credible decision-making, variables can affect the final decision, which only a select few individuals have control over. *(Refer to bibliography for definitions.)*

Taking this into consideration, the following short list may assist the healthcare risk manager in having greater influence in the decision-making process:

1. Whose opinion matters most? Who are the stakeholders? In healthcare, there is an executive team with oversight from a board of trustees (there can also be a system-level board and system-level oversight). There are physicians who can be independent entrepreneurs (voluntary attendings), or a large group practice. There are third party payers and insurers. There are community members, hospital staff and, of course, the "customers," our patients. Deciding whom you need to influence at the outset is just as important as your data analysis and risk reduction recommendations.

2. Regarding the issue to be decided:
    a. Are there internal subject matter experts and were their opinions sought and seriously considered? If not, were external consultants utilized?

b. Was credible and exhaustive due diligence done, inclusive of any primary source verification? Were all avenues explored and all questions or loose ends satisfactorily addressed?
c. Did any undue influence (e.g. politics) come into play? If yes, who do you need to get on your team to support you before you approach the primary decision-makers in your organization? Remember, the more key players you have supporting your recommendation(s), the louder your voice will be in the ultimate decision.

Comparing apples and oranges?

As was previously mentioned, risk management is "a structured approach for assessing threats and for evaluating the probability of events occurring – and what they might cost to manage."[1] Therefore, we should essentially be comparing apples to apples when reviewing risk management functions across different industries. This is part of the reason why the healthcare industry has historically looked to other industries for tools to adopt and customize to identify and assess risk, and to develop strategic plans to minimize exposures. In our quest, we have adopted tools from aviation, automotive and manufacturing sectors such as Crew Resource Management,[2] the TOYOTA Production System/Method ("Lean"),[3] black belts in quality, total quality management, continuous quality management, root cause analyses, failure modes and effects analyses and other safety/quality control measures. More recently, enterprise risk management, has emerged as a newer discipline that calls for organizations to identify all the risks they face, to decide which risks to manage actively and then to prepare a plan of action.[4] So, armed with these tools, we identify and analyze our risk exposures and make recommendations, but do our recommendations hold the same weight as our counterparts in other industries? To answer this question, a review of risk management-in-action in finance and aviation proved very enlightening.

Finance

Recall the September 2008 credit crisis when "the nation's financial system was in free fall…Lehman Brothers had filed for bankruptcy, Merrill Lynch was forced to sell itself in a fire sale to Bank of America, AIG was nationalized and Goldman Sachs and Morgan Stanley turned themselves into highly regulated banks, seemingly surrendering their ability to take big risks—the very risks that made them rich."[5] Many articles and several books were written describing how banks and other Wall Street financial organizations ignored the advice of their own risk managers, contributing to financial disaster and economic loss. Poor investments were made, resources were stretched thin, financial positions and exposures could not be covered, among other problems. Subsequent speculation highlighted that, had certain risk management recommendations been heeded, economic losses sustained could have been less substantial. Many questions arose as to "where was risk management?"

Financial risk management can be described as the practice of creating economic value in a firm by using financial instruments to manage exposure to risk, especially credit risk and market risk. Retrospectively, one wonders if the risk managers at these financial organizations had senior decision-making status at all. Several financial risk managers even went public, stating that their admonishments were ignored or overridden by aggressive efforts to earn higher returns on investments. Of particular interest, in November 2007, almost a year before the 2008 financial meltdown, an article was published called "Pension Risk Matters"[6] and it quotes Doug Miles, the Chief Executive Officer of Globalprivateequity.com Inc., as saying that the current credit crisis was a "Black Swan Event" (*Taleb*).[7] Interestingly, Miles "predicted the valuation fallout associated with complex derivative instruments…and that banks could not know the extent of their problems any time soon."

According to Taleb, there are three attributes to a Black Swan Event. First it is an outlier *(an uncertainty in decision making, as described under Decision Making 101 above)*, as it lies outside of the realm of regular expectations, because nothing in the past can convincingly point to its possibility. Second, it carries an extreme impact *(a risk or impact analysis in decision making, as described under Decision Making 101 above)*. Third, in spite of its outlier status, human nature makes us concoct explanations for its occurrence after the fact, making it explainable and predictable *(a human factor or interpersonal issue, as described under Decision Making 101 above)*. Taleb describes the human brain as designed to retain, for efficient storage, past information that fits into a compressed narrative…this distortion, called hindsight bias, makes it difficult to learn from past mistakes. Using Taleb's description of hindsight bias and getting back to the comments made in the Pension Risk Matters article, if we are "blind to randomness what then is the proper role of risk management?" The author also refers to his comments in a 2003 Pension Risk Matters' article where he stated that risk managers lives are "challenging and that in addition to a plethora of data analysis skills, a risk manager must be a diplomat, motivator and a keen student of human behavior because most people do not want to hear bad news since it usually means more work for them, added stress and potential damage to one's career of being tainted with a problem." Sound familiar to anyone?

The 2007 article concluded that there would be tough questions ahead about due diligence and assessment of attendant risks with lawsuits citing that poor controls were in place, encouraging the acceptance of risky loans and inappropriate appraisals of those loans. Again, amazingly, these were comments made in 2007, a year prior to the financial disaster. Based on what we have learned since 2008, risk management recommendations made prior to the financial crisis were most likely unheeded in pursuit of greater profits.

History, however, does seem to repeat itself. Similar to the healthcare risk manager who may see repetitive patterns and trends in terms of negative outcomes for patients (either via claims analysis, sentinel event analysis or other quality trends), the financial sector repeats their own basic mistakes as well. In May 2012, it was reported in Reuters.com[8] that J.P. Morgan's Chief Investment Office was responsible for $2 billion in mark-to-market losses and "appears to have made some classic mistakes in the risk management of trading desks and the monitoring of traders." The Chief Executive of the firm, Jamie Dimon, stated that "the strategy was flawed, complex, poorly reviewed, poorly executed and poorly monitored." The article describes the complexities of financial risk management and attributes problems to disconnected trading and risk management silos that sometimes lead to trading desks that are "lightly risk managed because if a trader is doing well, the tendency is to let them get on with making money and not to call time because they've breached their position limits….when risk management professionals talk about a firm's risk culture and the risk managers' ability to impact upon how the firm is run, they often talk about a clout factor. If a chief risk officer and his team have insufficient influence to stand up to senior management and the board of directors, their warnings and recommendations go unheeded. Or senior management might brush off concerns calling them a "storm in a tea cup" like Dimon did instead of following through and taking remedial action." Disappointingly, the author further states that even in the aftermath of the financial crisis, risk managers do not enjoy as much influence as they should, despite being bolstered by regulators…they still lack clout. Another chief executive, Marco Delzio of Martingale Risk in Rome, states that risk management units have no power and don't speak directly to senior management. He believes that "banks have these units so they can tell the authorities that they are doing something about risk, but they have no real impact on management decisions." Again, anything sound familiar? Silos? No real impact on management decisions?

A quick review of regulation in the financial industry reveals that there are many 'cooks in the kitchen' – the U.S. Treasury, the Federal Reserve, the Office of the Comptroller of the Currency, the Securities and Exchange Commission, the Commodity Futures Trading Commission, among others, including individual State regulators such as the New York Federal Reserve Bank. It is important to understand the role of the regulator as we continue to compare the role of the risk manager in finance, aviation and healthcare. Read on…

Aviation

It is commonly stated that the rate of dying from a medical error is significantly higher than the risk of dying in an airplane crash (1 in 300 for medical errors vs. 1 in 10 million for airplane passengers[9]). So, what makes communication and teamwork more effective in the airline industry than in healthcare? Crew Resource Management[2] (CRM), as adopted from aviation and applied to the healthcare environment, suggests that errors are more likely occur due to breakdowns in communication, poor teamwork, or inefficient hand-offs, not due to a lack of subject matter expertise. Reviewing literature that explores various communication and quality frameworks is one thing, practical application and experience is entirely different.

The aviation industry embraced CRM to improve air safety. It focuses on interpersonal communication, leadership and decision making in the cockpit and originated from NASA in 1979, which found that the primary cause of most aviation accidents as human error. CRM aims to foster a climate or culture where the freedom to respectfully question authority is encouraged. The primary goal of CRM is enhanced situational awareness, self-awareness, leadership, assertiveness, decision-making, flexibility, adaptability, event and mission analysis and communication. It recognizes that a discrepancy between what is happening and what should be happening is often the first indicator that an error is occurring. There are assertive statement processes that are taught in CRM to get attention, state the concern, state the problem as you see it, state a solution and obtain agreement. CRM in healthcare ideally fosters communication and teamwork, resulting in conflict resolution and better decision making which ultimately improves patient safety. Therefore, ideally, CRM can be an important tool in the risk manager's arsenal.[10]

During a discussion last year with an acquaintance in the aviation industry, I was very interested to learn that CRM does not always pertain to the cockpit. My acquaintance is an aviation engineer who works for a private jet company and safety is part of his function. While we spoke, we compared notes on risk management and he relayed an interesting story that I wanted to share with our members.

About two years ago, he and his staff identified a metal fatigue issue that had the potential to cause serious safety problems for their fleet of private jets (there are actually excerpts of Federal Aviation Administration [FAA] minutes posted on line regarding to this). When asked about the company's tracking mechanism to identify those specific jets that were manufactured with the questionable steel, he stated that they had been unable to do this because of the way they tracked their inventory at that time. Therefore, his company was faced with a dilemma and the decision had to be made whether to ground the entire fleet, which entailed notifying corporations and very wealthy and powerful international individuals—not an encouraging prospect. My acquaintance relayed that, in his role, he had the authority to make this decision. Of course, he notified senior management but it was his call to determine if the situation presented enough of a risk to recommend grounding the fleet. Apparently, his role at the company is somewhat dual in that he has a separate reporting responsibility to the FAA and this role/relationship is what empowers staff like him to make decisions related to safety. When compared to the roles of the risk managers in the financial sector, this was refreshing to say the least.

A review of the regulatory bodies overseeing aviation indicates that the FAA is the body charged with regulating airline safety and they make the rules for pilots, aircraft design and maintenance, air traffic control and operations standards. "The FAA makes the rules and is the jury, judge and executioner for those who violate those rules. It is the law and any rule it makes is the equivalent of the law, provided it does not contradict the general rules laid down by Congress in the legislation that gives the FAA its existence and authority."[11] While it is not the intent of this article to explore the merits of loose or stringent regulation, it is interesting to understand this in relation to the where the risk manager fits into the puzzle. Having regulatory support certainly empowered the aviation safety/risk manager to make a very difficult and, quite possibly, unpopular decision with both political and economic ramifications.

Healthcare

We have come full circle and are back to comparing the healthcare risk manager with our counterparts. Clearly, a more extensive review and research would be necessary to draw any concrete conclusions about the impact of risk management recommendations in the various industries. That said, in reviewing the material for this column, several interesting thoughts emerged:

1. Is the decision-making role of the risk manager more heavily influenced by the individual's place in the hierarchy of a particular organization or by the industry itself?
2. Does the relationship between the regulatory body and risk manager directly impact the risk manager as a senior decision maker?

In finance, regulatory oversight seems to be somewhat dispersed. Also, the nature of that industry is that risk-taking can reap great rewards in terms of profits and market share. Being too conservative can be viewed negatively by shareholders, yet a lack of due diligence can result in financial disaster—quite the delicate balance. Given past and present financial crises, inclusive of the 2008 debacle, it is plausible that the role of the risk manager as decision-maker is somewhat diluted in this industry and will continue to be downplayed based on the need to maximize profits.

In aviation, regulatory oversight appears to be limited to one body, the FAA. The nature of the business seems to be more safety driven, given that a single event can result in a catastrophic loss of life. The risk manager/safety engineer appears to have an independent reporting responsibility to the FAA, in addition to reporting to the senior management of their respective organization. It would seem that the role of the risk manager as decision-maker is more vital in aviation and will continue to be so as long as safety is a driving factor in decision-making.

In healthcare, regulatory oversight is somewhat dispersed and runs the gamut from oversight for reimbursement, quality measures, incident reporting, to physician misconduct, etc. We are regulated by the Centers for Medicare & Medicaid Services, which oversees reimbursement, health information privacy, electronic health information and quality measures such as Never Events (described by the National Quality Forum as conditions such as stage III-IV pressure ulcers, falls and trauma, air embolism, retained foreign objects, etc.). There are also local and State Department of Health agencies that provide oversight and some, like New York State, have mandatory incident reporting programs that require completion of root cause analyses for sentinel events. In New York State we also have conditions that require the reporting of individual physicians to the Department of Health for episodes of medical misconduct.

While, in theory, risk and/or quality managers have the responsibility of tracking and reporting certain events to regulatory bodies, we may not do this independently and often vet events at incident review committees or with senior management prior to any reporting. The same stigma applies to reporting disruptive staff, serious safety issues or suspected wrong doing to regulatory authorities because, without whistleblower statutory protection, we risk losing our livelihood. In reality, only a very few health care risk managers hold executive leadership titles that allow for autonomy in senior level decision-making.

Tying this together, it would seem that an organization's corporate culture and the risk manager's place in the hierarchy as decision-maker has impact on the risks being taken, regardless of the industry. In addition, the relationship of the risk manager as a 'reporter' to the respective regulatory body may also affect risk management decision-making clout within the company. If the chief executive and board of trustees are diligent and engaged, it is likely that the recommendations of the risk manager will be properly vetted and addressed.

We are left wondering whether real, quantifiable strides in patient safety are sluggish because many risk and quality managers are not part of the inner circle of the executive decision-making team. Imagine a world where the health care risk manager had unilateral decision making authority to prevent problematic physicians from being accepted on the medical staff, to prevent impaired or disruptive physicians from performing surgery, to influence major equipment purchases or nursing practices and, most importantly, terminate the services of physicians and staff who jeopardize patient safety. To analyze risk points and prevent harm, we are encouraged to focus on system-related fixes (without attributing blame to individuals) but is the key to preventing harm tied more to the actual decision-makers who are indirectly responsible for designing the systems?

By the very title of this column, we acknowledge that common sense is not common. We continue to adopt safety practices, tools and checklists from other industries, yet we have not seen a real impact in terms of quantifiable decreases in medical errors and serious adverse events. Does this relate directly to the egos of clinical providers and staff or do the right people (e.g. risk managers, quality managers) not have the requisite authority to influence important decisions?

Definitions

Cost-Benefit Analysis: systematic process for calculating and comparing benefits and costs of a project, decision or policy to determine if it is a sound investment/decision and as a basis to compare projects to see whether benefits outweigh costs.

SWOT Analysis (Strengths-Weaknesses-Opportunities-Threats): structured planning method to evaluate strengths, weaknesses, opportunities and threats involved in a project or business venture. Can be completed for a product, place, industry or person and attempts to identify the internal and external factors that are favorable and unfavorable to achieving an objective.

Stakeholder: a person, group organization, member or system who affects or can be affected by an organization's actions.

Stewardship: ethic that embodies responsible planning and management of resources, often with a view towards sustainability.

GroupThink: psychological phenomenon that occurs within a group where the desire for harmony and conformity results in an incorrect or deviant decision-making outcome. Group members try to minimize conflict and reach a consensus decision without critical evaluation of alternative ideas and viewpoints.

The 5 Whys: technique used to question why until you make sure you are asking the right question to identify the real underlying problem that you face.

Brainstorming: method to generate a list of ideas spontaneously contributed by members in an effort to problem-solve. The method focuses on generating the greatest number of ideas, withholding criticism and judgment, welcoming unusual and quirky ideas and combining ideas to form a single better idea.

Reverse Brainstorming: a method that starts by asking people to achieve the opposite outcome from the one wanted, and then reverse these actions.

Reframing Matrix: uses four Ps (product, planning, potential, people) as the basis for gathering different perspectives.

Concept Fan: stepping back from a problem and approaching it from a wider perspective.

Appreciative Inquiry: focus on the problem based on what is 'going right' rather than what is 'going wrong.'

Impact Analysis: a technique to brainstorm the 'unexpected' consequences that may arise from a decision.

Six Hats Analysis: a method to help evaluate the consequences of a decision by looking at the alternatives from six different perspectives.

Hindsight Bias: the inclination to see events that have already occurred as being more predictable than they were before they took place.

Black Swan Effect: The Impact of the Highly Improbable, **Nassim Nicholas Taleb, 2007*:*** focuses on the extreme impact of certain kinds of rare and unpredictable events (outliers) and humans' tendency to find simplistic explanations for these events retrospectively. The term essentially means that a 'black swan' is improbable and was referred to as such by Aristotle.

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Dear Risk Manager: This column, which will appear regularly in the AHRMNY Journal, is designed to support both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to pamela.monastero@nychhc.org or mail to AHRMNY utilizing the RISKY BUSINESS form which can be found on our website at http://www.ahrmny.com/downloads/FORM_Risky_Business_Form_7_2009.pdf. The form permits confidentiality.

POSSIBLE EXPANDED LIEN RECOVERY FOR MEDICARE ADVANTAGE PATIENTS

By Elliott J. Zucker

A new decision from the Second Department emphasizes the need to be diligent while investigating liens at the time a lawsuit is settled. In Trezza v. Trezza, 957 N.Y.S.2d 380, handed down by the Second Department on December 26, 2012, the Appellate Division ruled that an ostensible private insurer – in this case, Oxford Health Plans – might well be entitled to assert a lien on the settlement of a personal injury action. While this might seem to contradict the language and intent of recently-amended provisions of the General Obligations Law, the Court held that the fact that Oxford was providing coverage through a Medicare Part C program overrode that state statute.

By way of background, it will be recalled that in November of 2009, the state's General Obligations Law was amended with the specific intent of promoting settlements by, essentially, forbidding lien claims asserted by private insurance companies against the proceeds of a settlement. Section 5-335 of the G.O.L. was changed at that time to create what is in many instances a "legal fiction," specifically that all settlements are made only to compensate for pain and suffering. To that end, the newly-amended statute stated that when a plaintiff settles with one or more defendants in a personal injury, malpractice or wrongful death case, "it shall be conclusively presumed that the settlement does *not* include any compensation for the cost of health care services, loss of earnings or other economic loss" (emphasis added). The statute goes on to state that "no party entering into such a settlement shall be subject to a subrogation claim or claim for reimbursement by a benefit provider and a benefit provider shall have no lien or right of subrogation or reimbursement against any such settling party."

The thinking behind this amendment was straightforward. If an injured party's medical care was covered by insurance and did not represent a true out-of-pocket loss, then when that plaintiff received money in settlement for that particular type of loss, he or she should be obligated to reimburse the insurance carrier who did in actuality put out the money. If, however, settlements were presumptively declared never to include the items that a nonparty insurer might have covered (such as medical expenses), then there would be nothing to seek reimbursement for. With the possibility of such reimbursement claims being eliminated and with plaintiffs not having to worry whether their settlements were going to be whittled away by insurers asserting liens, the public policy of promoting settlements would be fostered.

There was, of course, an exception to the General Obligations Law amendment. Liens, even under the amendment, could still be asserted where there was a "statutory right of reimbursement." Such a statutory right of reimbursement certainly exists within the federal Medicare Act, which explicitly recognizes a right to reimbursement and is therefore widely understood to "preempt" the General Obligations Law. If an injured plaintiff's medical bills were paid by Medicare, a plaintiff settling his or her case will still find the settlement proceeds subject to a lien, regardless of New York's presumption that the settlement was meant to cover pain and suffering only.

The question faced in Trezza concerned how this plays out for plaintiffs covered in Medicare Advantage programs (also known as Medicare Part C or Medicare + Choice programs). The Medicare Advantage program was created in 1997, and allowed the federal government to contract with *private* managed care organizations to provide individuals with the same Medicare benefits they would normally have been entitled to receive under the "regular" Medicare program for hospital (Part A) or outpatient (Part B) services. The Trezza plaintiff was enrolled in just such a program, with Oxford being the private managed care organization in question. Under normal circumstances, Oxford, as a private organization, would seemingly be barred from asserting a lien and claiming a right of reimbursement on a settlement under the General Obligations Law. Did the fact that Oxford was, in this instance, providing coverage through the Medicare Advantage program change the equation?

The Second Department ruled that it did. The Appellate Division went back to the language of the statute which created the Medicare Advantage program, and noted that it allows – but does not require – these "Medicare Advantage organizations" to create a right of reimbursement for themselves in their insurance agreements with their insureds. Since this "right of reimbursement" was authorized by statute, the Court reasoned, it preempted the normal scheme of the General Obligations Law.

Yet even here there is a caveat, for the "right of reimbursement" created under the Medicare Advantage statute is not an automatic one; it is instead an optional one, created by the contract between the provider and the insured. It is possible that a contract might not provide for a Medicare Advantage provider to have a right of reimbursement as against settlement proceeds recovered by a plaintiff (although that possibility seems likely to grow smaller as insurers realize the import of the Trezza decision and its impact on their ability to recoup their losses), in which case the provider would still seem be unable to assert a lien.

There are several lessons to be drawn from all of this. The first is that one should not assume that because medical costs were covered by a nominally "private" health care organization (such as Oxford), no liens can be asserted on the settlement. It is important to look at what *type* of coverage is being offered by an entity like Oxford. Second, even if one determines that an entity like Oxford is providing coverage through the Medicare Advantage program, which does not mean that said entity would automatically be allowed to then assert a lien. One must instead look at the insurance agreement between the plaintiff and the organization, for unless that entity has explicitly asserted its right to reimbursement in that contract, there will still be no right to assert a lien. Finally, one must anticipate that insurers may try to latch on to the ruling in Trezza to suggest other ways in which private insurers can get around the General Obligation Law's prohibition on lien/reimbursement claims. Indeed, we have seen arguments already that the insurers of an ERISA plan should be able to avoid the G.O.L.'s strictures, and while existing federal case law suggests that such arguments may be incorrect, that will not stop the arguments from being made.



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ENVIRONMENTAL RISKS FOR HOSPITALS

By Suzanne M. Avena, Esq.

Introduction

Environmental legal liabilities and risks have become a moving target for the healthcare industry in recent years. In response, methods for reducing, allocating or transferring those environmental risks have also evolved. This article will discuss new environmental risks to hospitals, what kind of legal consequences and damages result from those risks, how hospitals may be currently financing for coverage for those risks (or not), and new environmental insurance policies specially tailored for healthcare institutions which cover these risks.

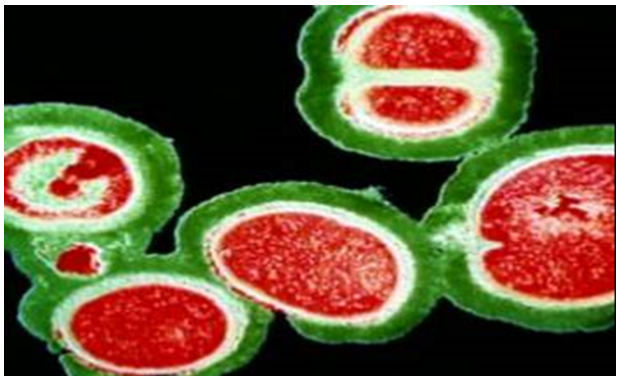
Hospitals Have New and Increasing Environmental Risk

Hospitals have become mini – cities in their operations, with huge infrastructures, especially with recent mergers and acquisitions of facilities into healthcare systems. Accordingly, environmental legal liabilities have amplified and diversified for the healthcare industry. The universe of real estate owned or operated by healthcare systems today includes not only hospitals, but ambulatory health care centers, skilled nursing care facilities, assisted residential care units, hospices, and other medical facilities (i.e., chemotherapy infusion centers). The nature of environmental risks may be different at these various types of facilities. In some cases, in fact, the number of offsite properties to be considered in the calculation of overall environmental risk can be larger than the bedded facilities.

The universe of potential exposed populations at health care facilities includes not only patients, but varied third parties such as workers and visitors. Health care facility occupants, such as immuno-suppressed children and the elderly, are particularly sensitive to environmental exposures. Traffic through health care facilities is high; thus, increasing the number of potential incidences of claims. Many hospitals have older facilities. Hospitals are in a continual state of evolution due to expansion and construction. Hospital workers may not be trained in all facets of environmental risks present, such as asbestos and lead paint, thus exacerbating or even causing environmental damages. Lastly, because of the continuous nature of hospital operations - 24 hours a day/7 days a week/365 days of the year - risk factors and populations are multiplied. Some of the more notable, costly and evolving environmental risks are discussed below.

<u>Hospital Environment Risks from Facility-Borne Viruses or Bacteria</u>

Healthcare Associated Infections (HAIs) are infections acquired as a result of treatment in a hospital. HAIs, such as MRSA, clostridium difficile (C-Diff), and legionella have become most concerning risk to hospitals. In New York State, since 2007, pursuant to NYS Public Health Law 2819, hospitals now must report to NYS using the Centers for Disease Control and Prevention's ("CDC's") National Healthcare Safety Network ("NHSN").[1] The NHSN has become the standard for reporting in the United States, with 28 states using the NHSN for mandatory reporting.



MRSA

This online system allows hospitals, NYS, and CDC to concurrently monitor the same data because of the manner of dispersal of HAIs. However, losses can be catastrophic and financially devastating to a hospital. According to the CDC, in 2002 approximately 2,000,000 patients contracted an HAI at a healthcare facility and approximately 100,000 died as a result of these infections.[2] Also according to the CDC, the annual estimated medical costs of HAIs in U.S. hospitals is between $28 and $45 million (adjustments to 2007 dollars).[3] Furthermore, medicare is denying payment to healthcare facilities for the treatment of HAIs if the HAI could have been reasonably prevented.[4]



LEGIONELLA

That is why HAIs are at the forefront of emerging issues affecting the drive for specialty Hospital Pollution Liability (HPL) insurance. Ordinary liability insurance and even ordinary environmental insurance do not cover the risk of HAIs. Costly disinfection expenses required to control HAIs such as H1N1 and other infectious viruses or bacteria are not covered because HAI contaminants are not defined as "pollutants" under typical environmental policies. By way of example, in 2006, New York Presbyterian Hospital faced a number of wrongful death lawsuits from legionalla. Despite extensive controls, in 2010 the hospital still found widespread legionella in the drinking water of one of its facilities, resulting in a complete ban on the use of facility drinking water until the issue resolved.

However, because legionella is not ordinarily defined as a "pollutant", a general environmental insurance policy would not have covered such losses. Alternatively, a HPL policy can be specifically manuscripted to cover the multiple bodily injury claims, evacuation, disinfection, remediation and legal defense costs that could arise from HAI risks.

Hospital Environmental Risk from Terrorism

Terrorism is another evolving risk for hospitals, obviously more so for facilities in a more urban area. Terrorism risk can include direct damages from a terrorist event within the hospital or indirect damages from victims of a terrorist event ending up at hospital facility for treatment. If a dirty bomb or other terrorism event occurs in the area, evacuation of patients would be necessary. In the event of a terrorist attack, affected citizens would likely seek treatment at local hospitals which could result in contamination of the facility. Resulting losses include remediation, potential bodily injury, evacuation expenses, decontamination, business interruption associated with hospital closure or quarantine, adverse publicity and legal costs. Terrorism insurance covering these aforementioned losses can be added to HPL policies.





Hospital Environmental Risk from Hazardous Chemical Use in Hospital Specialty Areas

Hazardous materials and wastes used in healthcare facilities originate from a variety of sources and when incorrectly managed or disposed of or inadvertently spilled or released into the environment, can cause costly damages. These hazardous materials can include: (i) mercury generated by broken or obsolete medical equipment such as sphygmomanometers and thermometers; (ii) chemotherapy chemicals and formaldehyde generated in laboratories, pharmacy, pathology and autopsy; (iii) photographic chemicals generated by "wet" x-ray processing and silver from photo processing; (iv) solvents generated by pathology, histology, the morgue, and laboratories; (v) pharmaceutical wastes, such as coumadin and nitroglycerine; (vi) radioactive and mixed radioactive wastes from nuclear medicine procedures; and (vii) universal wastes such as batteries, fluorescent bulbs and computer electronics. Damages can include potential bodily injury and/or property damage, remediation of spills, adverse publicity and legal fees. Damages resulting from a release of these substances would be covered under most environmental insurance policies as "pollutants".



Hospital Environmental Risks from Fuel Oil Storage Tanks Leaks and Spills

Releases of heating oil, fuel, or other hazardous materials from underground or aboveground storage tanks may impact the hospital facility and neighboring properties. Healthcare facilities, at minimum, have a tank containing fuel for emergency backup generators. Average remediation expense for leaking storage tanks can range from $50K for just soil contamination to over $1 million if groundwater is contaminated. Almost all underground storage tanks will leak if they are old and not replaced. Damages include potential emergency expenses, on-site and off-site remediation and potential natural resource damages, potential third party bodily injury and property damage, construction delay damages, business interruption and legal fees. Storage tank coverage for these losses can be added to environmental and HPL policies, with appropriate underwriting.

Hospital Environmental Risks from Acquisitions and Divestitures of Contaminated Property Construction and / or Deconstruction and Decommissioning Projects

As healthcare providers expand through acquisitions and mergers, environmental issues arise from historic pollution conditions, such as asbestos and lead-based paint or mold. Additionally, sometimes latent conditions are not discovered until "the eleventh hour" when construction "build-outs" or deconstruction is conducted.



Damages can include remediation, property damage and restoration, potential bodily injury and business interruption. Site-specific pollution liability policies provide coverage for third-party bodily injury arising from exposure to asbestos or lead based paint.

Legal Consequences and Costs to Environmental Risks

The legal consequences and costs to hospitals arising from environmental risks include multiple fines and penalties under both federal and state environmental statutes ($37,500 per violation per day). Unexpected inspections and enforcement actions initiated by federal, state and even local environmental regulatory agencies can result in large, unbudgeted attorney fees and unbudgeted consultant fees, as experts are needed to be retained to deal with such specialty issues as, laboratory cleanouts, radiological exposures, soil and groundwater investigation and cleanup, asbestos and/or lead based paint removal or restoration from mold contamination. Claims can include property damage, bodily injury, and disruption to business schedule and operations. In material cases, a report is usually made to the hospital Board of Trustees. Finally, adverse publicity and reputation risk may be the least measurable but most potentially damaging to the hospital.

Current Status of Environmental Insurance at Hospitals

Hospitals don't all recognize environmental risk as an insurable claim or may be mistakenly relying on general property or casualty policies, which ordinarily contain exclusions for environmental claims. Most insurance policies include a pollution exclusion. For example, general liability insurance policies, directors & officers' liability and hospital professional liability policies contain such exclusions. Hospitals may self insure – either consciously or unconsciously funding environmental occurrences from operating budget. Hospitals typically employ many forms of environmental risk engineering and mitigation, such as environmental compliance audits and training to control environmental risk. Discussions with environmental insurers, reveals that, depending on their geographic location and modalities of services that are rendered, healthcare facilities are most concerned about insuring waste issues, Hospital Acquired Infections and leaking storage tanks.

The Development of Environmental Insurance in the U.S.

Due to the enactment of the Clean Air Act in 1970, the Clean Water Act in 1974, the Resource Conservation and Recovery Act in 1976, and finally the Comprehensive Environmental Response, Compensation and Liability Act in 1980, environmental responsibility that had never before existed was now being imposed on business and industry. Thus, an increasing number of environmental claims started being made against Comprehensive General Liability (CGL) policies.

Many insurers looked at the claims, at the policy wording, and at the price tag for cleanup and said "no coverage." Their position was that the pollution had been going on for decades and insurers should not be forced to bear the cost to clean up the mess. Thus, in 1973, insurers rushed to the market with the "Gradual Pollution Exclusion" to be inserted into CGL policies. With this exclusion, pollution claims were only covered if they were "sudden and accidental". However, because of the vagueness of the wording and the significant costs involved, litigation quickly followed. Although many of the environmental claims were the result of years of accumulated contamination, initially many courts found CGL coverage still applied since "sudden and accidental" really meant "unexpected or unintended." Insurers were ordered by courts to pay hundreds of millions in remediation costs. Thus, in 1986, the "Absolute Pollution Exclusion," was inserted into CGL policies by insurers, which broadly excluded all pollution whether pollutants were released quickly or gradually.

These pollution exclusions created an insurance "gap" for environmental exposures. Recognizing an opportunity, carriers introduced the first environmental insurance policy in 1975. However, because there was so little data yet collected on these types of losses and casualty underwriters were unfamiliar with underwriting environmental exposures, insurers "lost their shirts" in claims. The market collapsed in the late 1980's. However, the market got smart in the late 1990's and started employing environmental engineers and attorneys to underwrite and appropriately draft the policy forms. AIG, Zurich and Chubb dominated the field and sold specialty policies, responding to new legal requirements for financial surety for underground storage tanks, landfill closures and other site operations and exposures. Today, due to market growth, competitive pricing and loss control, total annual premium for environmental insurance is in the billions. The current focus of the major players – Chartis (AIG), Chubb, Ace Environmental, Allied World, and Ironshore - is on specialty industries such as healthcare, which is experiencing unique new environmental exposures.

Environmental Insurance – What does it Cover?

General site-specific environmental policies cover on-site and off-site remediation and third-party bodily injury and property damage, including natural resource damages arising from "pollution conditions". Hospital environmental policies cover mostly "new pollution conditions", arising for the first time after the inception date of the policy. However, "pre-existing pollution conditions" can be covered with a retro-active date if the insurer is comfortable with pre-existing hospital

risk management. These environmental policies can cover all of the above described environmental exposures with the appropriate endorsements. Coverage for a non-owned disposal site can also be endorsed onto the policy to cover the possibility of the hospital being named as a "potentially responsible party" (PRP) at a landfill which is later declared a Superfund.

New Healthcare Pollution Liability Policies

The new HPL policies contain the same previously described coverage grants of environmental insurance policies, plus more. Most importantly, HPL policies provide "biological agents coverage", i.e. HAI's from bacteria and viruses, and the particular damages and costs that arise from HAIs. For example, HPL policies provide "evacuation expenses", which means the removal from one or more of the Insured's covered properties to any other location of a majority of the patients. Evacuation expenses include transporting and lodging for evacuated patients. HPL policies include "disinfection & remediation expenses" for a "disinfection event", which usually includes cases of MRSA or other facility-borne infectious virus, bacteria or disease that require reporting to local, state or federal government. Disinfection expenses include reasonable fees and costs incurred within 30 days of discovery of the disinfection event. HPL policies provide coverage for "emergency expenses" which include all reasonable and necessary expenses, including legal costs. HPL policies also provide "business interruption expenses", which means normal operating expenses, such as payroll expense for employees, and net profit or loss, including rental value (before taxes) that would have been earned or incurred by the Insured during the Period of Interruption. Lastly, HPL policies provide coverage for "crisis management", which must be "significant adverse national or regional news media coverage" and require the hiring of an outside public relations or crisis management firm from a pre-approved list provided by the insurer. Paid costs include medical consultants, psychological counseling, funeral expenses, and temporary living expenses to secure the scene.

Environmental Policies – Things to Know In Negotiating Coverage

Environmental policies, including HPL policies, are claims-made policies, not occurrence-based. This means that claims must be incurred and reported during the policy period. Alternatively, CGL policies which are occurrence-based, allow claims to be made at any time after the expiration or termination of the policy. However, Insureds can purchase Extended Reporting Periods ("ERP") for 48 months for typically 200% of premium, beyond the automatic ERP which applies for 90 days. Although an ERP extends the "tail" of the reporting period, a claim must still have arisen from a pollution incident which commenced during the policy term. Environmental policies, including HPL policies, are typically written as multi-year policies. Currently, one-to-five year policies are generally available, payable with either a one-time premium payment or financed throughout the term. These policies can have multiple insureds.

What Information Is Needed To Underwrite Environmental Risk?

Information necessary to underwrite environmental insurance policies is dependent on the specific risks the hospital is looking to cover. Underwriting documents to be submitted to the insurer can include environmental compliance audits, tank tightness testing and closure reports, other environmental investigations such as those conducted for legionella or other indoor air quality testing, Phase I and Phase II environmental site assessments, environmental due diligence reports and documents for acquisitions, water intrusion and mold management plans, asbestos and lead based paint surveys and operations & maintenance plans and emergency and risk management plans. General liability, property and environmental loss runs for the last five years will additionally provide insight to the environmental underwriters as to the hospital's risks.

Current Environmental Insurance –Favorable Factors

The U.S. market for environmental insurance is currently stable and competitive. In fact, pricing in the environmental market has been soft in recent years, thanks to continually increasing capacity. Currently, over 40 insurance companies are writing environmental insurance and about 5 are writing specific healthcare coverage. These include Chartis, Chubb, Ironshore, Ace, and Allied World. Depending on the carrier, HPL insurance can be offered "blanket" coverage, or can be offered specialty endorsements. Multiple properties can be covered on a portfolio basis, as long as sufficient underwriting information is available and the hospital properties are appropriately scheduled onto the policy. Limits of liability to purchase and cost of premium depends on the number of beds, the modality of services being rendered, the level of risk management in place, geographic location of the hospital and the hospital's overall appetite for risk. The premium cost is underwritten on a site-specific basis. Limits of liability, self-insured retentions, deductibles and sub-limits are all negotiable.

It doesn't cost anything to get a premium indication on environmental insurance and HPLs from a broker. However, clients should work with a specialty environmental insurance attorney who knows these specialty policies. The attorney will advocate on behalf of the client and understand the legal implications of the policy language. The broker can work with the attorney and the client in obtaining the broadest coverage, thus overcoming any particular allegiance the broker may have with a carrier. For example, the unique coverage grants, definitions, exclusions, conditions and endorsements to these specialty environmental policies can be confusing, which can result in an uninsured loss if the policy and/or the endorsements are not drafted to appropriately address the hospital's concerns. Also, the environmental underwriting information provided can make a difference in not only the breadth of insurance to be obtained, but whether or not a claim is ultimately paid.

In view of the evolving and potentially catastrophic risks, hospitals need to be as knowledgeable as possible and enlist expert counsel before purchasing HPL to ensure that maximum coverage is provided.

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[1] *Hospital Acquired Infections*, New York State 2011, NYS Department of Health, Albany, NY, September 2012. Reports for the last five years can be found at www.health.ny.gov/statistics/facilities/hospital/hospital_acquired_infections

[2] Klevens RM, Edwards JR, Horan TC, Gaynes RP, Pollack DA, Cardo DM. Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. *Public Health Reports* 2007; 122:160-166.

[3] Scott RD. The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention. CDC, Division of Healthcare Quality Promotion, Atlanta, GA, March 2009. Report CS200891-A. http:/www.cdc.gov/HAI/pdfs/hai/Scott_CostPaper.pdf (accessed July 30, 2012).

[4] The Deficit Reduction Act of 2005l, Pub. L. 109-171 S. 1932, 120 Stat 4, enacted Feb 8, 2006. *see* 42 USCA § 1305;Title V Medicare (Section 5001(c)).



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Ms. Avena counsels in all matters of environmental law and regulatory compliance, including conducting compliance and due diligence, audits, negotiating with federal and state agencies regarding violations and representing clients in environmental litigation. She represents parties engaged in hazardous cleanups, litigation related to toxic substances, remediation, insurance and cost recovery actions. She has particular experience in structuring contaminated (Brownfield) commercial property transactions, including negotiating cleanup agreements, overseeing remediation contractors, drafting related contracts, facilitating development permits and forging deal-specific environmental insurance policies. Ms. Avena represents hospitals, universities, municipalities, manufacturers, real estate buyers, sellers, developers, property management firms, lenders, investors, environmental contractors and consultants, and other business owners.

For five years prior to GW, Ms. Avena was with the New York Environmental Practice at Paul Hastings Janofsky & Walker, LLP. Before that, she was an attorney at AIG Environmental, serving as Director of the Contaminated Property Group. Prior to AIG, Ms. Avena was Regional Director of the Environmental Risk Consulting Practice at Sedgwick (now Marsh). During law school, Ms. Avena clerked at the NYS Department of Environmental Conservation in Stonybrook, Long Island and the Environmental Crimes Unit of the Suffolk County District Attorney's Office.

Ms. Avena received her Bachelor of Science from Cornell University and her Juris Doctor degree from St. John's University School of Law. She is admitted to the New York State Bar, Second Department and the US District Court Eastern and Southern Districts. She lectures and writes frequently on such topics as Superfund liability, green buildings, indoor air and environmental quality issues, environmental due diligence and environmental insurance.

INSURANCE UPDATE

By Robert Marshall

New York Hospital Excess Liability Pool – Section 18

A December 2012 report issued by the Superintendent of Financial Services and the Commissioner of Health of the State of New York to the Governor and the Legislature identifies the problems confronting Section 18 and proposes immediate and longer term options to ensure that the pool functions as a public asset that enhances the viability of New York State's medical malpractice and health care systems.

A copy of this report can be accessed at www.dfs.ny.gov/reportpub/.../hosp_excess_liab_pool_dec2012.pdf

Since this report has been issued there have been some short term proposed revisions to Section 18 that can generally be summarized as follows:

1. The excess limits available under section 18 will be named "Excess medical malpractice liability coverage pool."
2. The superintendent of financial services will determine the number of physicians or dentists that it will purchase excess policies based on the funds allocated in the state budget.
3. The priority will be given to high risk classified physicians or dentists in high risk territories.
4. Eligible physicians or dentists requirements for Section 18 will be:
   - Physician or dentist has professional privileges at the hospital, and
   - From time to time provides emergency medical services (more fully described in legislation), and
   - Accepts Medicaid, and
   - Primary $1.3M/$3.9M limits must be carried from an admitted carrier
5. Insurance carriers writing the Section 18 will submit the list of physicians or dentists for which excess limits coverage is requested to the State.
6. If funds are insufficient for all physicians than each physician not eligible will be responsible for paying their own premium. The insurer will bill physician/dentist directly. If premium unpaid then policy is void back to inception. Insurer must notify Ins. Dept. of who paid and who didn't.

We'll continue to follow any short term or long term changes that are ultimately adopted by the New York Governor and the legislature.

Workers Compensation Update

As part of Governor Cuomo's 2013 State of the State report, the governor spoke about plans to further reform workers compensation and unemployment insurance through legislation that will produce an estimated $1.3 billion in savings for employers in New York. By reducing or combining some funds the governor proposes to save almost $300m to New York State employers and by selling bonds would help about 10,000 self-insured employers who were left with nearly $900 million of liabilities. Proceeds of the bind sale will go to purchase assumption of liability policies for claims associated with defaulted Self Insured Plans. As a result, the state can then offer much more flexible repayment plays that will result in settlement and release for insolvent members.

This news is favorable as many healthcare organizations in New York continue to struggle with escalating workers compensation expenses.

THE CASSANDRA EFFECT ON ELECTRONIC CHARTING

By Dylan C. Braverman

It is quaint to say that electronic charting is the wave of the future. That wave has washed ashore, gone out to sea and come back again. The benefits of electronic charting are many, allowing patients to receive increasingly more effective health care delivery. Some of the biggest benefits of electronic charting are ease of interdisciplinary communication, transferring charts between physicians and hospitals, and ease of deciphering the content of progress and consultation notes.

Sadly, when seen through the prism of litigations, real-world benefits can be twisted to the advantage of potential claimants. For this issue's column, I wanted to write about the "Cassandra" witness, the litigation ramifications and hospital best practice.

The "Cassandra" Spouse

One featured witness in many medical malpractice/ wrongful death claims is the "Cassandra" prophet. Invariably, a family member will testify that they pleaded with medical care providers to consider and work up a patient for the condition that eventually resulted in a patient's death. Invariably, it is inferred that if the doctors listened to this lay prophet, then the life of the patient would have been saved - even despite the medical malpractice of the defendant.

This is the Cassandra witness. In Greek mythology, Cassandra is the daughter of King Priam and Queen Hecuba of Troy. She was the subject of the unrequited love of Greek God Apollo, who gave her the power of prophesy, but at the same time cursed her so that nobody ever believed her or heeded her advice. The prophecies of Cassandra are always true, but people around her treat her like a madwoman. For example, as the daughter of King Priam of Troy, she prophesies the destruction and fall of Troy to the Athenians. Cassandra is, of course, ignored.

When confronted with a Cassandra witness, my clients usually fall into two categories. The first category is the "denial" defendant, where the physician accuses the Cassandra witness of misrepresenting the facts and denies that the lay witness recommended the life-saving medical care. This denial can be outright, or it can be subtle. For example, a witness may claim that he demanded a biopsy of his wife's axilla, which eventually turned to be cancerous, when he actually asked for a biopsy of an already known nodule in the breast tissue.

The second category is the "I don't remember" defendant. This physician understandably does not recall events that happened most likely years ago. However, the physician usually gives testimony that his custom and practice would be to chart any conversation with the patient and his or her family.

Indeed, when properly charted, these arguments can be persuasive, since most lay witnesses are unaware of specific medical indications and are unable to make clinical assessments. Thus discredited, the plaintiff has actually helped strengthen the defense's position.

In fact, ideally a medical chart should reflect when a loved one accompanies a patient or when a conversation is held with the loved one. I have found such entries to be included in many handwritten progress notes. While these conversations are not overtly medically significant, they can crucial in litigation.

However, electric charting was not created for litigation. Electronic charting was formulated to rapidly and accurately record relevant clinical data and other information pertinent to the healthcare of a patient. Thus, these conversations are rarely charted electronically, due to a lack of appropriate entry field.

The end result is that the Cassandra witness gains credibility, and becomes damaging to the defense of a malpractice case.

Examples abound. Assume that a patient's wife claimed that she demanded a consult with a liver specialist, which would have saved her husband's life. However, the hand written chart clearly sets forth that the patient instead demanded an abdominal CT scan, which was performed and showed no abnormalities. Thus, the Cassandra witness's testimony will not be effective for the plaintiff.

On the other hand, let's say a witness claims that he warned a radiologist technician that his daughter suffered an iodine allergy, and that this was ignored on a routine CT scan resulting in death. If the charting is electronic, and thus did not include an entry for conversations with the radiologist technician, it will be very hard to defend the claims of this Cassandra witness.

Flip the Switch

The solution is easy. Electronic charting normally allows for entry fields to suit the needs of the medical practitioner. Thus, it is highly recommended that a field for family/loved one conversations be added, and physicians, nurses and other healthcare providers instructed to chart these conversations in detail. This will force anyone placing an entry into the chart to confront this issue. Accordingly, electronic charting will not only bolster efficiency and effectiveness, but also lower the costs of healthcare by providing a further shield against Cassandra witnesses and potentially frivolous malpractice claims.

Dylan Braverman is an attorney associated with Lewis Johs Avallone & Avilles, LLP. He specializes in trials and appeals representing medical institutions and professionals, as well as engineers and other professionals, insurance companies, contractors, technology companies, various manufacturers and trucking/ shipping companies. He is the author of our Emerging Technology column, and can be reached via www.ahrm@optimum.net should you have any questions that you wished discussed in a future issue.

REGULATORY UPDATE

NEW HITECH RULES POSE RISK MANAGEMENT CHALLENGES

By Zachary B. Cohen

The United States Department of Health and Human Services ("DHHS") recently released the Health Information Technology for Economic and Clinical Health Act final rule ("HITECH Final Rule") which modified the regulations promulgated under the Health Insurance Portability and Accountability Act ("HIPAA"). The HITECH Final Rule is intended to strengthen the privacy and security protections available for individuals' health information by altering a number of HIPAA regulatory provisions, including those relating to, among other things, enforcement of HIPAA violations, breaches of protected health information ("PHI"), and responsibility for business associates.

Understanding the changes implemented by the HITECH Final Rule, as well as the accompanying commentary offered by DHHS, is critical for covered entities to accurately manage the risks associated with failing to comply with HIPAA. Unfortunately, covered entities must come to grips with these changes quickly given that, with only a few exceptions, covered entities must comply with the requirements of the HITECH Final Rule by September 23, 2013 (the "Effective Date").

As an initial point, it is important to understand the basis for the penalties associated with violations of HIPAA. The HITECH Final Rule modified the increased and tiered civil monetary penalty structure provided under the interim final rule which preceded the HITECH Final Rule (the "Interim Final Rule"). The tiered structure establishes four categories of violations that reflect increasing levels of culpability. The most serious penalties are for instances where DHHS determines that a violation was due to a covered entity's "willful neglect." If DHHS determines the covered entity acted willfully in violation of HIPAA but corrected the violation within thirty days, the minimum fine is $10,000 and the maximum fine is $50,000. If the covered entity did not timely correct the willful neglect violation, the minimum fine is $50,000. For a violation that is determined to be due to "reasonable cause," and not to willful neglect, the minimum fine is $1,000 and the maximum fine is $50,000. The lowest tier of penalty, which carries a minimum fine of $100 and a maximum fine of $50,000, can be imposed when it is determined that the covered entity did not know and, by exercising reasonable diligence, would not have known of such violation.

The HITECH Final Rule also clarified the differences between willful neglect and reasonable cause. Willful neglect means a conscious, intentional failure or reckless indifference to comply with HIPAA. Reasonable cause occurs when an offender has knowledge, or with reasonable diligence would have knowledge, that an act or omission violated HIPAA, but the act or omission does not rise to the level of willful neglect. More specifically, reasonable cause occurs when there are circumstances that would make it unreasonable, despite the exercise of ordinary business care, for a covered entity to comply with HIPAA; or where there are circumstances where the covered entity had knowledge of the violation, but lacked conscious intent or reckless indifference.

Once DHHS has established the tier of penalty, it will then use several factors to determine the exact amount of the fine. These facts include: (i) the nature and extent of the violation; (ii) the nature and extent of the harm resulting from the violation; (iii) the covered entity's history of prior compliance with the administrative simplification provisions; (iv) the financial condition of the covered entity; and (v) such other matters as the DHHS determines justice may require.

The commentary accompanying the HITECH Final Rule also clarified how DHHS counts violations. Where multiple individuals are affected by an impermissible use or disclosure, the number of identical violations would be counted by the number of individuals affected. When determining the number of violations, such as lack of appropriate safeguards, the number of identical violations would be counted on a per day basis, such as the number of days the entity did not have appropriate safeguards in place to protect the PHI. The maximum amount for a single violation is $1,500,000, but a covered entity may be liable for multiple violations of multiple requirements, and a violation of each requirement may be counted separately, resulting in numerous violations of up to $1,500,000 for each violation.

In addition to the adjustments concerning enforcement, the HITECH Final Rule also modified the standard for determining whether a violation that has occurred constitutes a breach. A common way that violations are identified by the Office of Civil Rights ("OCR") is through the breach notification reporting requirement. A breach is defined as an impermissible acquisition, access, use or disclosure of unsecured PHI which compromises the security or privacy of the PHI. Breaches must be reported to the OCR and the affected individuals. Before the HITECH Final Rule, the term "compromises the security and privacy of PHI" meant there was a significant risk of financial, reputational, or other harm to the individual.

The HITECH Final Rule changed this standard. Under the HITECH Final Rule, an impermissible acquisition, access, use, or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates that there is a low probability that the PHI has been compromised based on a detailed risk assessment. If the covered entity determines in its written risk assessment that a breach has not occurred, no report needs to be sent to the OCR or the affected individuals.

The four factors that must be evaluated in a risk assessment are the following: (i) the nature and extent of the PHI involved, including types of identifiers and likelihood of re-identification (e.g., was financial or particularly sensitive information involved?); (ii) the unauthorized person who used the PHI or to whom the disclosure was made (e.g., does the individual have an independent obligation to protect the PHI?); (iii) whether the PHI was actually acquired or viewed (e.g., in the case of a stolen laptop, forensic analysis that demonstrates that PHI was not accessed); and (iv) the extent to which the risk of the PHI has been mitigated (e.g., did the covered entity receive satisfactory assurances from the person who received PHI that he or she destroyed the information and did not share the PHI?).

A civil monetary penalty for a single violation of HIPAA, as discussed above, can cost a covered entity up to $1,500,000. An organization that has a breach of unsecured PHI will also incur expenses associated with notifying individuals affected by a breach, legal fees, investigations and forensics, and other costs. A study by Ponemon Institute stated the average cost of a breach to a healthcare organization is about $240 per compromised record. Given that electronic media (e.g., backup tapes, thumb drives, etc.) can contain tens of thousands of records, the cost of a breach can be considerable. Effective security measures can significantly reduce the likelihood of such a breach. For example, in order to protect data, DHHS encourages covered entities to encrypt their PHI, which, if done in accordance with DHHS' guidance will render the PHI secure. No breach notification is required following an impermissible use or disclosure of secured PHI.

Another significant change contained in the HITECH Final Rule relates to a covered entity's vicarious liability for its business associates. Before the HITECH Final Rule, a covered entity was not liable for the improper acts of its business associates if the covered entity did not know of the improper acts and if there was a business associate agreement in place between the parties. The HITECH Final Rule eliminates this exception and makes a covered entity liable for a civil monetary penalty for a violation based on the act or omission of any agent of the covered entity, including a workforce member or business associate, acting within the scope of the agency.

Whether an agency relationship exists with a business associate is a fact-specific analysis based on the Federal common law of agency, which considers multiple factors including the following: control over the services provided by the business associate; direction and supervision over services provided by the business associate; and whether the services provided by the business associate are part of the regular business of the covered entity.

DHHS provided some examples of instances where a business associate would likely not be considered an agent of the covered entity. The first is when a company is hired to perform de-identification of PHI for a small provider because the small provider would not possess any expertise to provide instructions to the company regarding this service. Another example is a business associate performing accreditation functions for a covered entity because the covered entity is otherwise prevented from performing such functions. Covered entities may want to closely assess the terms of its relationship with its business associates, as well as the language of the business associate agreements to determine if an agency relationship exists and what steps should be taken to avoid or address an agency relationship (e.g., more closely overseeing the business associate).

The changes reflected in the HITECH Final Rule, only some of which were discussed above, suggest that DHHS will continue to tighten its enforcement of HIPAA. Covered entities, in order to properly manage their risk, must become familiar with the HITECH Final Rules and have policies and procedures in place by the Effective Date to ensure compliance with HIPAA. Covered entities should consult with their in-house counsel or health care attorney for more detailed analysis and advice.

Zachary Cohen is an Associate at Garfunkel Wild, P.C., which he joined in 2010. He is a member of the firm's Health Care and Health Care Information and Technology Groups, which advise clients on a host of business, regulatory and transactional matters.

Mr. Cohen received his B.A. from the University of Michigan and his J.D. from Georgetown University Law Center.

SUMMARY
Evening Educational & Networking Event

Alvin Safran and the Education Committee once again exceeded expectations with the Annual evening educational and networking event attended by over 100 members and guests. The event was held at the Lighthouse International. After a cocktail hour where networking and professional development, there was a buffet dinner.

The featured speaker was the Honorable Justice Alice Schlesinger of the New York Supreme Court. Justice Schlesinger, who has presided over numerous medical malpractice trials, spoke on Discovery Issues including Electronic Discovery. Legal issues concerning e-discovery, social media and spoliation of evidence were reviewed.

Justice Schlesinger stressed that healthcare providers have to be extremely careful when using the electronic medical record. Discovery issues involving texting, Facebook post were reviewed.

The session ended with numerous questions from the audience posed to Justice Schlesinger about the challenges that healthcare providers and attorneys have in the both clinical practice and malpractice trials with discovery issues.

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