



# THE HEALTH LAWYER

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## CRIMINAL PROSECUTIONS OF HOSPITALS: UNNECESSARY TREATMENT

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### Introduction

Hospitals depend on revenue from Medicare and Medicaid for their existence. When a hospital is the subject of a U.S. Department of Justice (“DOJ”) criminal fraud investigation involving Medicare or Medicaid, the risk of losing those revenues trumps all other concerns. Defending against such fraud charges at a criminal trial is generally considered an unacceptable risk because losing means the hospital will automatically be excluded from participation in those programs for a minimum of five years, an organizational death sentence.<sup>1</sup> Even prior to the filing of such charges, the U.S. Department of Health and Human Services (“HHS”) may suspend Medicare payments to a hospital for up to 180 days pending completion of an investigation of “credible allegations of fraud,” also a likely death sentence.<sup>2</sup> And even without a criminal conviction or proceeding, the HHS Office of Inspector General (“OIG”) may seek

administratively to permissively exclude a provider from participation in Medicare and Medicaid for fraud, kickbacks, excessive charges, unnecessary medical services and other prohibited activities.<sup>3</sup>

Historically, HHS, the DOJ and the OIG have – with rare exceptions – declined to use any of these weapons against hospitals. Prior to 2012, the DOJ had only prosecuted one hospital system criminally for federal health-care program fraud in roughly ten years: the University of Medicine and Dentistry of New Jersey (“UMDNJ”).<sup>4</sup> This reluctance is in marked contrast to the DOJ’s attitude towards other healthcare providers, such as home health agencies and durable medical equipment (“DME”) companies. The OIG’s list of entities and individuals barred from participation in Medicare is peppered with the names of home health agencies and DME companies that have been prosecuted criminally, convicted and mandatorily excluded.<sup>5</sup> Because of their importance to the communities in which they are located and to avoid putting them out of business, the DOJ and the OIG have instead generally permitted hospitals to resolve fraud allegations with: (1) no criminal prosecution, (2) a settlement of the hospital’s civil False



**William W. Horton**  
Vice Chair

**“Shut Up,” He Explained**

No one much reads, or even knows about, Ring Lardner anymore. Lardner was one of the most popular American humorists of the early 20th Century, but if he is remembered at all today, it is usually because his son, Ring Jr., wrote the screenplay for M\*A\*S\*H\*.

Lardner did leave behind some memorable turns of phrase, though – quotes still remembered in some corners even though Lardner himself is forgotten. The favorite one in my household is the one that forms the title of this column. In one of Lardner’s books, this exchange occurs between the young narrator and his father, who are trying to find their way down the Grand Concourse in the Bronx: “‘Are you lost, Daddy?’ I asked tenderly. ‘Shut up,’ he explained.”

Well and good, you may say, but what does that have to do with health law or health lawyers? Unfortunately, it seems to me that those four words are a fair paraphrase of a lot of conversations that go on in and around the healthcare industry these days. In countless discussions and negotiations, we and our clients retreat to dogmatic positions based on the kinds of clients we have or the industry sectors in which we work or the political positions we espouse, and we lose the ability to hear the ideas and concerns and hopes and fears that are across the table from us.

Hospitals and physicians should be joining together for greater coordination of care, but too often get bogged down in battles over turf and control. Payors and providers should be focusing on creating a reimbursement system that rewards cost-effective preventive care and rewards innovation, but are too often blocked by the fear that any change in the system will give one side an unfair advantage in the fight over healthcare dollars. Too often, ideas that offer real opportunities for improvements in patient care and cost control run aground on the shoals of “That’s not the way we do it.” *Shut up, he explained.*

Countless dollars are diverted from patient care to pay penalties for alleged “frauds” that often are – let’s be honest – nothing more than technical violations of ridiculously complicated regulations. Countless more dollars are diverted from patient care to pay lawyers to document arrangements that often are – let’s be honest – nothing more than efforts to avoid the intended effect of those regulations. Too often, cases are brought and defended not on the basis of what best protects the integrity of the healthcare system, but on who can score the most points in the battle of the technicalities. *Shut up, he explained.*

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# Criminal Prosecutions of Hospitals: Unnecessary Treatment

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Claims Act<sup>6</sup> (“FCA”) treble damage and civil penalty liability and (3) the hospital’s agreement to live under the terms of a five year OIG corporate integrity agreement (“CIA”).

The year 2012, however, saw two hospitals charged criminally for Medicare/Medicaid fraud: Pacific Health Corporation,<sup>7</sup> a privately held 673-bed Los Angeles area hospital system, and WakeMed Health and Hospitals,<sup>8</sup> a non-profit 870-bed system in Raleigh, NC. These actions suggest that the DOJ’s attitude towards hospital violators may have changed and that criminal charges and a DOJ Deferred Prosecution Agreement (“DPA”) may be added to FCA settlements and CIAs to resolve such matters.

UMDNJ, Pacific Health and WakeMed are three of approximately 25 hospitals currently operating under OIG CIAs. The other 22 were not charged criminally or compelled to enter into a DPA (as well as a CIA) to avoid a criminal trial. This article will examine the conduct and circumstances involved in the UMDNJ, Pacific Health and WakeMed cases in an attempt to understand why the DOJ proceeded criminally in these three instances and whether such charges are necessary in view of the other weapons at the government’s disposal.

## DOJ Deferred Prosecution and OIG Corporate Integrity Agreements: Are Both Necessary?

In its “Principles Of Federal Prosecution Of Business Organizations,” the DOJ directs prosecutors to consider a number of factors before deciding to prosecute a business organization criminally. One such factor is the collateral consequences of a criminal conviction to “a corporation’s employees, investors, pensioners, and

customers, many of whom may, depending on the size and nature of the corporation and their role in its operations, have played no role in the criminal conduct, have been unaware of it, or have been unable to prevent it.”<sup>9</sup> This factor is especially applicable to the possible prosecution of a hospital. A criminal conviction of UMDNJ, for example, would have put the state of New Jersey’s only teaching hospital out of business.<sup>10</sup>

The DPA is a settlement agreement which permits the DOJ to prosecute violators criminally, while permitting a basically law-abiding corporate or organizational defendant to continue in business. The DOJ can impose a DPA in lieu of seeking a conviction. From 1992 until 2004, only a handful of DPAs were used to resolve criminal matters involving corporations.<sup>11</sup> The DOJ turned increasingly to the use of DPAs after the demise of Arthur Anderson, then the nation’s fifth largest accounting firm, as a result of its 2002 conviction for obstruction of justice.<sup>12</sup> By the time the Supreme Court reversed Anderson’s conviction three years later, the company was no longer viable and its 85,000 employees – the vast majority of whom were innocent of any wrongdoing – had been scattered to the winds.

A DPA is typically for a term of two or three years. It includes the defendant’s acknowledgement of wrongdoing, a layer of stringent compliance and reporting measures, and the government’s right to determine unilaterally if a material breach has occurred. In some instances, a court will appoint a monitor to oversee compliance with the DPA’s terms and investigate possible violations.<sup>13</sup>

In the healthcare setting, the DPA avoids the automatic or mandatory five year exclusion from participation in federal healthcare programs because it does not require

the hospital to plead guilty. As a result, the OIG takes the position that (despite an acknowledgement of wrongdoing) there has been no “adjudication” of guilt, no “conviction” and, thus, no mandatory exclusion.<sup>14</sup> If the hospital complies with the DPA’s terms, the DOJ agrees to dismiss the charges. If not, then the DOJ may set the DPA aside and prosecute the hospital.

The CIA is also a settlement agreement. Separate and apart from the DOJ’s criminal proceeding, the OIG has statutory authority to permissively exclude a hospital from participation in Medicare and Medicaid for fraud, kickbacks, unnecessary charges and other violations.<sup>15</sup> Entering into a CIA with the OIG allows the provider to avoid permissive exclusion if it complies with the CIA’s terms.

The OIG first began requiring CIAs to resolve healthcare fraud matters in 1994.<sup>16</sup> Since that time, the OIG has entered into more than 1,000 CIAs requiring providers to implement extensive compliance measures, such as appointing compliance officers and committees; developing policies and procedures; conducting education and training programs for officers, caregivers and billing personnel; and instituting hot-lines for employees to inform the compliance officer of violations of healthcare laws and regulations or company policies without fear of reprisal.<sup>17</sup> CIAs also require providers to hire independent outside auditors to review Medicare and Medicaid billings and the provider’s systems and operations. Detailed reports must be submitted to the OIG, and providers are subject to stipulated monetary penalties for breaches of the agreement.<sup>18</sup>

The DOJ and OIG utilize DPAs and CIAs for the same basic purpose, namely, to rehabilitate an organization while permitting it to continue

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in business. The DOJ did not wish to put UMDNJ, Pacific Health and WakeMed out of business and disrupt the lives of innocent patients, physicians, nurses and others, so it permitted each of these hospitals to avoid criminal prosecution by entering into a DPA.

Given the OIG's healthcare expertise and experience with CIAs, are both layers of oversight necessary in the case of hospitals?

## UMDNJ And Pacific Health: Aggravating Circumstances

### UMDNJ: Continuing To Double Bill The Government After Your Lawyer Tells You To Stop

In December 2005, the DOJ filed a criminal complaint against UMDNJ, a public university, for double billing by both the hospital and its faculty practice plan for the same physician services provided in UMDNJ's outpatient clinics. The charges were resolved by a DPA which required UMDNJ to repay Medicaid \$4.9 million and to live under a court appointed monitor, former U.S. District Court Judge Herbert J. Stern, for two years.<sup>19</sup>

The DOJ's criminal complaint alleged that the UMDNJ Legal Department was aware of the double billing as far back as 2001, but took no action to stop it, much less pay back the money.<sup>20</sup> The complaint further alleged that the UMDNJ Legal Department retained a law firm to investigate UMDNJ's billing practices in its outpatient clinics and ignored the firm's written conclusion that the conduct was illegal and should be stopped. The then United States Attorney for the District of New Jersey and current Governor, Christopher J. Christie, reportedly said that senior administrators at the university were

aware of the fraudulent billing for years, yet allowed it to continue until November 2004.<sup>21</sup>

According to the *New York Times*, Mr. Christie's office was also investigating allegations that university officials padded the payroll with patronage employees, curried favor by making contributions to elected officials, doled out hundreds of millions of dollars in no-bid contracts and awarded huge salaries and bonuses to top officials.<sup>22</sup> As a result, the UMDNJ DPA encompassed other issues besides double billing. It directed the monitor to review all of the above issues as well as Medicare and Medicaid cost reporting and billing, and additional governance issues, including potential conflicts of interests of UMDNJ trustees and officers, document retention and destruction and perquisites of senior management. The monitor was directed to report his findings and recommendations on all of these issues to the United States Attorney's Office.<sup>23</sup>

The UMDNJ DPA was not accompanied by a settlement of UMDNJ's civil FCA liability at that time or by an OIG CIA. Four years later, UMDNJ paid the United States an additional \$2 million to settle a 2004 civil FCA action brought by a former employee based on the same conduct.<sup>24</sup>

No criminal charges were filed against UMDNJ officials for participating in the double billing scheme. The monitor's investigation of other issues, however, led to the convictions of the former Dean of the School of Osteopathic Medicine, Dr. R. Michael Gallagher, and State Senator Wayne Bryant for bribery, mail fraud and wire fraud. A jury found that Senator Bryant had used his position as Chairman of the Budget and Appropriations Committee to steer \$10.5 million in grants to the School of Osteopathic Medicine in return for a \$35,000 a year no-show job.<sup>25</sup>

### UMDNJ As Recidivist: The Cardiology Division's Kickback Scheme

What happens if the hospital breaches the DPA?

In April 2006, UMDNJ paid Dr. Rohit Arora, the former head of its cardiac catheterization lab, \$2.2 million to settle a New Jersey Conscientious Employee Protection Act wrongful termination/whistleblower action. Dr. Arora claimed that UMDNJ refused to renew his contract and denied him tenure because he had complained that the Cardiology Division's Clinical Associate Professor ("CAP") program was a sham and a scheme to pay local cardiologists kickbacks in return for patient referrals.<sup>26</sup>

After learning of the settlement from a New Jersey legal publication, the monitor conducted an investigation and agreed that the CAP program was "an illegal scheme to pay cardiologists for patient referrals."<sup>27</sup> Moreover, the monitor asserted that "this scheme reached well into all levels of hospital and University Central Administration who were complicit first in forming and expediting this illegal plan, and later covering it up."<sup>28</sup>

According to the monitor, UMDNJ's failure to notify him of Dr. Arora's allegations and the settlement was a clear breach of the December 2005 DPA.<sup>29</sup> The breach entitled the DOJ to resume the criminal prosecution of UMDNJ for the double billing scheme. The DOJ could have also prosecuted UMDNJ criminally for paying local cardiologists \$5.7 million in kickbacks in return for patient referrals.<sup>30</sup>

The DOJ chose to do neither, because a conviction and mandatory exclusion would have put UMDNJ out of business. Instead, the matter was resolved by UMDNJ settling its civil FCA liability for \$8.3 million<sup>31</sup> and entering into a five-year OIG CIA.<sup>32</sup>

No UMDNJ officials were prosecuted or sued civilly for violations arising out of the kickback scheme.

Physicians, however, are apparently more expendable than public university hospitals. Two cardiologists, Dr. Bakul Desai and Dr. Laxmipathi Garipalli, were prosecuted for embezzling \$840,000 of federal funds in the form of their UMDNJ salaries, convicted and excluded.<sup>33</sup> The DOJ also filed civil FCA cases against eleven cardiologists, nine of whom paid settlements ranging from \$30,000 to \$1.4 million.<sup>34</sup>

The UMDNJ saga shows there are certain hospitals, even recidivist hospitals, that are too important to be driven out of business.

#### **Pacific Health and The Skid Row Patient Recruitment Scheme**

In August 2012, Pacific Health entered into a DPA, a civil settlement and a CIA to resolve allegations relating to a skid row patient recruiting scheme. Pacific Health, its parent and the three of its four hospitals paid \$16.5 million to resolve their civil FCA liability.<sup>35</sup>

The DOJ alleged that Pacific Health and the three hospitals paid kickbacks to individual intermediaries or “marketers” to recruit homeless people to receive unnecessary medical services at the hospitals, which were billed to Medicare and Medicaid.<sup>36</sup> Five individuals were prosecuted criminally for their involvement in this scheme, including the former Chief Financial Officer (“CFO”) of a Pacific Health subsidiary, Newport Specialty Hospital. As part of his plea agreement, the former CFO admitted to orchestrating payments totaling \$2.3 million to skid row recruiters who allegedly guaranteed 40-50 patients a month.<sup>37</sup>

In addition to the DPA, the DOJ insisted that a fourth Pacific Health subsidiary, Los Angeles Doctors Hospital, Inc. (“LADH”), plead guilty to

conspiring to pay kickbacks for patient referrals.<sup>38</sup> As a result of its conviction, LADH was excluded from participation in federal healthcare programs. This sounds like tough enforcement, but LADH is not actually a hospital, did not provide patient care and did not participate in federal healthcare programs. Instead, it simply administered payroll services for the staff at one of Pacific Health’s subsidiary hospitals.<sup>39</sup>

Perhaps the DOJ agreed to have LADH be the entity that pled guilty in hopes that Pacific Health’s hospitals would survive and continue to operate. If this was the idea, it failed. Pacific Health closed Anaheim General Hospital in late March 2013 and its remaining three hospitals in early April.<sup>40</sup>

#### **The WakeMed Case: Billing For Outpatient Visits As Inpatient Stays**

In December 2012, the DOJ filed criminal charges against WakeMed for billing for inpatient stays for cardiac patients who did not stay overnight and should have been billed as outpatients.<sup>41</sup> Simultaneously, the DOJ announced that WakeMed had agreed to enter into a DPA, to settle its civil FCA liability for \$8 million, including a \$2 million civil penalty, and to enter into a five year, 51-page OIG CIA.<sup>42</sup>

The DOJ’s criminal charge alleged that WakeMed’s Director of Patient Access directed the staff at WakeMed’s 41-bed Heart Center Observation Area to routinely generate physician orders electronically designating the patient as an “inpatient” when there were no such physician orders and to ignore physician orders designating the patient as an “outpatient.”<sup>43</sup> The DOJ alleged that this improper billing for outpatients as inpatient continued for approximately seven years.<sup>44</sup>

U.S. District Court Judge Terrence Boyle balked at signing the DPA, however, characterizing it as “a

slap on the hand” for a “too big to fail” corporate giant.<sup>45</sup> As a result, the DOJ was faced with the prospect of either (a) going forward with its criminal prosecution and, if successful, putting Wake County’s largest employer out of business or (b) withdrawing the DPA, dismissing its criminal charges and declining to prosecute WakeMed altogether.

The DOJ responded to Judge Boyle’s refusal to sign by filing a 26-page Memorandum In Support of Deferred Prosecution Agreement (“DOJ Memorandum”) in hopes of persuading him to change his mind and approve the DPA. The DOJ Memorandum states that a conviction of WakeMed “would automatically result in its destruction, a disproportionate impact for various reasons.”<sup>46</sup> The various reasons the DOJ cited as justification for the DPA include the following:

- “WakeMed has operated as a provider since 1966 without sanction from Medicare.”<sup>47</sup>
- WakeMed’s conduct “did not affect patient care.”<sup>48</sup>
- WakeMed’s wrongdoing implicated “less than one tenth of one percent of its overall billings to Medicare and Medicaid.”<sup>49</sup>
- The “wrongful conduct was not directed or knowingly acquiesced in by upper management or the board of directors.”<sup>50</sup>
- There is no evidence “that any WakeMed officer senior to the hospital’s former Director of Patient Access, a mid-level manager, had knowledge of the wrongdoing.”<sup>51</sup>
- During the relevant time period, “WakeMed’s compliance program was adequately designed and applied in good faith....”<sup>52</sup>
- WakeMed voluntarily repaid \$1.2 million prior to settlement negotiations and cooperated with the government’s investigation.<sup>53</sup>
- WakeMed has historically provided several million in uncompensated,

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charitable care to the indigent and uninsured each year.<sup>54</sup>

Ultimately, Judge Boyle approved the DPA, stating: “[t]he court has considered the threat that the provision of essential healthcare to WakeMed’s patients would be interrupted and that the needs of the underprivileged in the surrounding area would be drastically and inhumanely curtailed should the defendant be forced to close its doors as a result of the instant prosecution.”<sup>55</sup>

In retrospect, it is difficult to understand why the DOJ decided that criminal prosecution of WakeMed was warranted in the first place. Federal prosecutors have great discretion to prosecute or decline prosecution even where the evidence is clear that a business organization violated a federal criminal statute. Under the DOJ’s Principles of Federal Prosecution of Business Organizations, the “various reasons” set forth above are all factors in favor of simply declining criminal prosecution.<sup>56</sup>

Moreover, in other situations the DOJ has seen fit to resolve similar allegations against other hospital systems without filing criminal charges or forcing them to enter into a DPA. In August 2013, Shands Healthcare in Florida paid \$26 million to resolve allegations that six of its hospitals had billed Medicare and Medicaid for inpatient procedures for a five year period that should have been billed as outpatient services.<sup>57</sup> In June 2012, AHS Hospital Corp. and Atlantic Health Systems agreed to pay \$9 million to settle their civil FCA liability for billing Medicare for inpatient stays that should have been billed as outpatient.<sup>58</sup> In January 2012, Denver Health and Hospital Authority paid the United States and the state of Colorado \$6.3 million to settle its civil FCA liability for similar conduct.<sup>59</sup> Other hospitals that have been permitted to resolve similar allegations by settling their civil FCA liability and

entering into a CIA include Gibson General Hospital in Princeton, Indiana,<sup>60</sup> Jackson Purchase Medical Center in Mayfield, Kentucky<sup>61</sup> and St. Joseph’s Hospital in Atlanta.<sup>62</sup>

## Are Criminal Prosecutions of Hospitals Necessary?

After determining that a criminal violation occurred, the DOJ, OIG and HHS must decide whether they wish to extinguish the hospital’s business life or permit it to survive. If the former, criminal prosecution is unnecessary. Suspending Medicare and Medicaid payments while the hospital and its employees are under investigation will accomplish the same result. On April 16, 2013, Edward Novak, the owner and Chief Executive Officer (“CEO”) of the Sacred Heart Hospital in Chicago, Roy Payaywal, the hospital’s CFO and four physicians affiliated with the hospital were arrested for allegedly conspiring to pay and receive kickbacks in return for referrals of patients for unnecessary tracheotomies and other services.<sup>63</sup> Sacred Heart Hospital was not charged, only its two top officials. But HHS suspended Medicare and Medicaid payments to the Hospital in early May and it closed on July 1, 2013.<sup>64</sup> Mr. Novak stated that losing the federal funding forced the hospital to close.<sup>65</sup>

What if the DOJ, HHS and the OIG conclude that hospital employees have defrauded Medicare and Medicaid, but the organization should be permitted to continue to operate? Are criminal prosecution and the imposition of a DPA required to bring the hospital into compliance and prevent future violations?

It is the authors’ view that criminal prosecution and a DPA are unnecessary, except in very limited, special circumstances, such as those involved in the UMDNJ matter. That was an “active” DPA because it

directed a court appointed monitor to investigate and evaluate policies, practices and procedures in ten different areas, including corporate structure and governance; the effectiveness of legal finance compliance, internal audit and security functions; Medicare/Medicaid cost reporting and billing; the development of education and training programs; no-bid contracts; the reasonableness of salaries, bonuses and perquisites of senior management; and conflicts of interest of trustees, officers and employees. The monitor then had to report back to United States Attorney’s Office on his findings and recommendations with respect to all of these areas.<sup>66</sup> Given the breadth of this DPA, it appears that the double billing scheme served as a vehicle for a widespread investigation of all sorts of allegations of corrupt conduct.

Also, unlike the Pacific Health and WakeMed DPAs, there was no CIA that accompanied the 2005 UMDNJ DPA.

By contrast, the DOJ DPAs in Pacific Health and WakeMed had no investigative function and were duplicative of the accompanying OIG CIAs. The 20-page WakeMed DPA, for example, imposes compliance and monitoring obligations on the hospital which echo those in the 51-page CIA. Paragraphs 11 through 14 of the DPA<sup>67</sup> impose the same requirements on WakeMed that are contained in the CIA,<sup>68</sup> namely, to maintain its existing compliance program and retain an independent review organization to ensure compliance with the DPA, the CIA and the law and regulations relating to inpatient admissions.

In the WakeMed matter, it also appears that the criminal prosecution added nothing in terms of monetary punishment. The DOJ represented to Judge Boyle that the \$8 million civil settlement amount was based on an assessment of what the government

could have reasonably expected to recover had both the criminal and civil cases gone to trial.<sup>69</sup>

The DOJ may, of course, resume its criminal prosecution of WakeMed if the hospital fails to comply with its DPA.<sup>70</sup> But there is no need to involve the criminal justice system to punish a hospital that has violated its DPA. The OIG has a contractual right to permissively exclude WakeMed, for example, if it commits a material breach of its CIA.<sup>71</sup> In 2006, the OIG excluded South Beach Community Hospital, a 146-bed hospital in Miami, Florida, for five years because it materially breached its CIA.<sup>72</sup> South Beach closed its doors and filed for bankruptcy shortly after being informed that it would be excluded.<sup>73</sup>

## Conclusion

With the exception of the CFO in the Pacific Health case, the DOJ appears to charge hospitals criminally only when the DOJ does not prosecute the hospital officials or employees responsible for the criminal conduct. In September 2013, for example, the former CEO and two additional executives of Hollywood Pavilion, a family-owned 46-bed psychiatric hospital in Hollywood, Florida, were sentenced to lengthy prison terms after a jury found them guilty of conspiring to pay bribes and kickbacks to obtain patients who did not qualify for psychiatric treatment in a \$67 million dollar Medicare fraud scheme.<sup>74</sup> The former CEO and the heads of the hospital's inpatient and physical therapy programs received sentences of 25, 15 and 12 years respectively.<sup>75</sup>

In October 2012, the DOJ charged Earnest Gibson III, the CEO of Riverside General Hospital, an 89-bed psychiatric hospital in Houston, Texas; his son, Earnest Gibson IV, the administrator of a Riverside satellite partial hospitalization program, and five other individuals with conspiring to defraud Medicare by offering and paying kickbacks and

bribes for patient referrals for services that were not medically necessary.<sup>76</sup> The indictment alleges that this scheme lasted for seven years and caused the submission of approximately \$158 million in fraudulent claims to Medicare.<sup>77</sup>

In these cases, as well as in the Sacred Heart Hospital case, the DOJ declined to prosecute the hospitals.

It is the authors' view that, whether or not individuals are prosecuted, a criminal prosecution and imposition of a DPA on hospitals are generally a misallocation of DOJ and judicial resources that are better spent on prosecuting individuals who engage in conduct like that alleged in the Sacred Heart Hospital, Pavilion Health and Riverside cases.

In all but the rare case, a DOJ civil FCA action and an OIG CIA are more than adequate to deter, punish and rehabilitate hospitals whose compliance programs have failed to prevent employees from engaging in fraudulent conduct. The DOJ's Principles of Federal Prosecution of Business Organizations recognizes that civil and regulatory enforcement actions may "adequately deter, punish and rehabilitate organizations that have engaged in wrongful conduct" as a "non-criminal alternative to prosecution."<sup>78</sup>

Perhaps Judge Boyle may have recognized as much in the WakeMed prosecution, when he reportedly told the DOJ: "I'm just window dressing in this case."<sup>79</sup>



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*continued on page 8*

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# IN-HOUSE CONFLICT RESOLUTION PROCESSES: HEALTH LAWYERS AS PROBLEM-SOLVERS

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Conflict is inevitable in healthcare. Disputes easily arise over adverse outcomes, medical necessity and payment determinations, peer review actions, quality evaluations and clinical care decisions, to name a few. Employment relationships between hospitals and physicians are another source of challenges. Although hospital-physician conflicts are not necessarily more frequent or more important, they can illustrate the ways in which health lawyers must understand the role of conflict in healthcare, and the need to build solid, user-friendly structures for conflict resolution into these relationships. Those structures are the focus of this article.

In the case discussed below, numerous issues arose after a hospital purchased a physician practice. The relationship ended in “divorce” – a dissolution of the employment arrangement. This article proposes that built-in conflict resolution processes, ranging from on-the-spot problem solving to formal mediation, might have instead permitted the parties to resolve these problems amicably. Finally, the discussion distills specific suggestions for health lawyers.

## Background: The Rapid Rise of Physician Employment

Hospitals need broadly integrated networks to create Accountable Care Organizations, increase market share, collect facility fees for outpatient services, maximize revenues, minimize readmissions, and control healthcare processes to meet the enhanced quality and satisfaction expectations built into Value-Based Purchasing arrangements.<sup>2</sup>

Physicians, for their part, want better job security, improved work-life balance and reduced time spent on the business side of medicine. Many also hope to avoid paying for the high-cost electronic medical records (“EMRs”) now imperative in their practices.

In 2013 around 26 percent of physicians were employees rather than independent contractors, up from 20 percent the year before.<sup>3</sup> In an even higher estimate, the Medical Group Management Association reports that more than 50 percent of physicians are employed by organizations affiliated with health systems, and in some specialties the figure may be as high as 75 percent.<sup>4</sup>

These relationships are not guaranteed to survive. As readers with a few gray hairs may recall, a tidal wave of such alliances in the 1990s was quickly followed by a tsunami of “divorces.”<sup>5</sup> The same scenario could reappear if these new employment arrangements do not incorporate adequate mechanisms for resolving conflicts. Health lawyers need to play a major role not just in building these relationships, but also in preserving them. The following case illustrates how badly these relationships can go awry and how conflict management can prevent that.

## Anatomy of a Divorce: A True Story<sup>6</sup>

Dr. Graham Keswick is a pediatric gastroenterologist who contracted to sell his practice to, and become an employee of, a large multi-hospital system. After years spending too much time on the business side of medicine, he just wanted to be a doctor. He also saw the trends towards consolidation in healthcare and felt he had little choice but to join a

hospital system. He sold his practice, including office equipment and furniture, in exchange for a fairly substantial sum of money and an employment contract. Unfortunately, the “honeymoon” was quickly over.

### Staffing Issues

The hospital required all employed physicians to use hospital office and nursing staff. For a large system to work well across many service lines, the hospital needed staff who would implement consistent policies to ensure the best quality and efficiency of care while enabling employees to know what was expected of them. The hospital also needed to have a pool of well-trained staff so that, if any area in the system needed to add personnel, employees could step up at a moment’s notice. Additionally, the hospital’s nepotism policy precluded Keswick’s wife and daughter from continuing to work for him.

To Dr. Keswick, the hospital treated its staff like interchangeable cogs. Every few days he saw a different set of nursing and office staff. He was constantly trying to navigate his repeatedly rearranged exam rooms and patient schedules. His patients and families had come to expect certain amenities, like a personal reminder the day before each appointment – not the automated call they now received. Longer waiting times and disappointed expectations sent some of them elsewhere.

Hospital administrators saw these events as the adjustments familiar in every physician practice acquisition; such kinks tended to smooth themselves out quite rapidly. For Dr. Keswick these problems were new and upsetting. Of particular concern was that staff left each day right on time. Important work sometimes remained unfinished in ways Dr. Keswick could not detect until a problem cropped up.

If a nurse was entering information into a patient's chart and the day ended before she'd entered the latest lab values, those lab values might not be added until later. If a different set of staff came in the next day, unfinished tasks might not be passed along at all to the next person.

Per hospital policies to promote "teamwork," after each mishap Dr. Keswick was expected to take the responsible person aside, explain the error, smile, and then let him or her return to work. The hospital knew that mutually supportive, respectful relationships were essential for patient safety and satisfaction, and for effective and efficient delivery of care, and that this mutual respect must include physicians. The problem for Dr. Keswick was that he spent enormous amounts of time educating staff to correct all those glitches in the office's workflow. Worse, as soon as one crew learned his in-house routines, it was replaced by newcomers. Finally Dr. Keswick lost all patience. He expressed his frustration vehemently, and was then written up for "disruptive behavior." Eventually the hospital did assign a single set of nursing and office staff to Dr. Keswick's office. The hospital would have done so earlier had it known how troubled Dr. Keswick was about the situation.

### Computer Systems

Healthcare providers must now adopt EMR systems. Dr. Keswick's hospital committed to this transition earlier than most, and undertook a careful, systematic rollout in all of its facilities and practices. Problems arose at every stage, and the hospital addressed them as quickly and thoroughly as possible. Implementing such a system is incredibly complex, and it was simply not possible for the hospital's IT department to solve every problem immediately. It had to prioritize according to patient safety needs, the seriousness of the problem, and comparable factors.<sup>7</sup>

Dr. Keswick had used EMRs since the 1980s for both billing and patient

care. Understandably, the hospital required that he now use its system. Unfortunately, the two systems were completely incompatible, and no software could transfer Dr. Keswick's old records to the new system. Many of his patients have chronic illnesses, and he needed rapid access to past information. To read old records he had to log out of the new system, log into the old to view the information, then log out of it and back into the first. The exercise was endlessly frustrating and time-consuming.

The hospital could not afford to provide someone to transfer all of the old information, entry by entry, into its software, and neither could Dr. Keswick. The best solution he could devise was to print each page of the old records and scan it as a PDF that was captured in the new system. Unfortunately, these records could not be internally searched. If Dr. Keswick wanted to find out what happened during a patient's episode of pancreatitis several years ago, he had to guess at the probable date, then read every page until he found the needed information.

The software switch also created serious medical hazards. Dr. Keswick is a pediatric specialist and his former EMR system recorded patients' weights in kilograms. Pediatric drug doses are set according to the patient's (metric) weight, so the proper units are essential for pediatricians. The hospital's standard EMR system recorded patients' weight in pounds, not kilograms. The hospital willingly changed that feature for Dr. Keswick's office.

Unfortunately the change precipitated a new problem. On one recent occasion the hospital-supplied nurse, accustomed to recording weight in pounds, entered "30" into the space marked "weight" for a three-year-old child. The 30-pound child's weight was then deemed by the system to be 30 kilos, or 66 pounds. The resulting drug prescription would have overdosed the child twofold. The error

was a very human slip, but had Dr. Keswick not caught it in time it could have been fatal. Dr. Keswick anxiously wonders how many other such errors are out there, as yet undetected. Over the course of nearly a year, the ever-changing staff could have made this kind of mistake numerous times, with little chance of discovering it until a patient's return visit shows an incorrect dosage. The scenario is particularly frightening for patients with chronic illnesses requiring multiple medications.

In yet another software issue, the hospital's billing system requires that all information be complete and clear in the chart, and that the chart then be "locked" for a particular episode of care before billing can be submitted to the appropriate payor. Payors have come to insist on this because late-breaking changes in patients' medical records and accompanying invoices can cost considerable time and money to rectify. However, because EMR and staffing issues led to errors in Dr. Keswick's office, and because some of the errors were not spotted until clinical problems arose later, Dr. Keswick did not want to "lock" a chart (and potentially expose himself to liability) until considerable time had passed. Hospital administrators hesitated to contact Dr. Keswick about this; as the relationship had become strained, they did not want to add friction. Nevertheless, they grew increasingly annoyed with his seemingly chronic "tardiness" in completing/locking his charts. Indeed, the problem had gone on for nearly a year before Dr. Keswick learned that most of his billings were on hold.

### Productivity Targets

Dr. Keswick and the hospital also clashed over productivity demands. He was reconciled to the Relative Value Unit ("RVU") targets that had become the norm in many medical practices. The 1990s taught hospitals that physicians' salaries must be accompanied by incentives to ensure

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that physicians remain productive and attend also to quality of care, patient satisfaction and other important dimensions of care.

Although the hospital said that Dr. Keswick's RVU target was based on national standards for his field, he found it impossible to meet. National standards presumed a context he lacked: allied providers such as nurse practitioners, a smooth-functioning office staff, and a smooth-functioning EMR system. Dr. Keswick could not meet his RVU target no matter how hard he worked, and he watched his salary shrink.

The "divorce" lawyers are busy getting Dr. Keswick and the hospital out of this mess. Dr. Keswick and his attorney did anticipate some of these issues. They knew, for example, that hospital-provided staff would replace his wife and daughter. But neither envisioned the seemingly endless parade of staff-du-jour. Similarly, they accepted the idea of RVU productivity requirements, based on national standards. But Dr. Keswick had never analyzed his practice in terms of such units. He had no idea how many RVUs he typically worked, and thus could not discern what a reasonable target would be. Neither did he anticipate how much time he would spend re-educating staff, or commuting to and from the distant satellite clinics the hospital expected him to serve.

Finally, Dr. Keswick and his lawyer knew he must switch to the hospital's EMR system, that theirs and his were not compatible, and that a transposition of every entry from every chart into the new system would not be feasible. The hospital quickly made the necessary modifications to capture patients' weight in metric units and their ages in days, weeks and months as well as years. Quite unexpected was the hospital's apparent resistance to make further efforts to ease the transition. During

negotiations they had promised to make reasonable efforts to accommodate his needs. But given that neither Dr. Keswick nor his lawyer understood much about the new system, neither could predict just what the needs would be, in order to negotiate the definition of "reasonable efforts."

## Conflict Resolution Processes: A Range of Options

Conflict resolution in healthcare is gathering considerable momentum. Joint Commission<sup>8</sup> standards issued in 2009 require that hospitals' governing bodies "provide[] a system for resolving conflicts among individuals working in the hospital" (LD.01.03.01 EP-7) and that, particularly for senior management, "[t]he hospital manages conflict between leadership groups to protect the quality and safety of care" (LD.02.04.01).<sup>9</sup> Hospitals should identify an individual, inside or outside the hospital, "with conflict-management skills who can help the hospital implement its conflict-management process. . . . This individual can also help the hospital to more easily manage, or even avoid, future conflicts."<sup>10</sup>

In hospital-physician alliances, both sides have strong reasons to maintain the relationship. Here, the hospital needs a pediatric gastroenterologist and, nationwide, pediatric subspecialists tend to be in short supply. The hospital's up-front investment will be lost when the separation is final. Hospitals "lose \$150,000 to \$250,000 per year over the first 3 years of employing a physician – owing in part to a slow ramp-up period as physicians establish themselves or transition their practices and adapt to management changes. The losses decrease by approximately 50% after 3 years but do persist thereafter."<sup>11</sup> Reciprocally, physicians who have sold their practices can face difficulty finding financing to establish a new practice.<sup>12</sup>

Surely it would be better to solve problems like Dr. Keswick's before they destroy a relationship – to build conflict resolution into the original agreement – rather than simply sign the contract and hope that people will be able to resolve on their own the ensuing disputes that are virtually inevitable no matter how carefully the contract is crafted.

For health lawyers, mediation is probably the most familiar form of dispute resolution. A suit has been filed, discovery has taken place, and either the parties voluntarily mediate or a judge requires them to. On mediation day the mediator might meet with everyone together initially, but then will likely separate the parties and shuttle back and forth with monetary offers. Rarely will the mediation focus on repairing a broken relationship.<sup>13</sup>

Whether or not this model is optimal for litigation, it is rarely suitable for ongoing clinical problems as seen in Dr. Keswick's situation.<sup>14</sup> A more nuanced array of conflict resolution processes, at various levels, needs to be available, with those structures built into the relationship from the outset.

At the most basic level, a hospital-physician liaison should be established<sup>15</sup> – a specific person the physician can contact whenever a problem arises and whose job is to help physicians navigate the hospital system. One of Dr. Keswick's greatest frustrations was that the simple question, "whom do I call?" was invariably followed by a series of hand-offs, often with no one actually able to address his issue.

A liaison can also serve as a kind of negotiation coach, helping the physician explain his problems once he reaches the right person/department and, when they cannot be solved, perhaps negotiate a mutually acceptable alternative. Dr. Keswick raised a number of problems regarding the EMR, for instance, and even where IT staff agreed that a modification would be

desirable, they were not always able to provide it. With a bit of coaching, physicians might be better able to establish a priority list. In Dr. Keswick's case, listing pediatric patients' weight in grams/kilograms, and their ages in days/weeks/months instead of years was a serious issue of patient safety, not just convenience. It required, and received, a prompt software change. However, not all EMR problems can be quickly fixed, and Dr. Keswick needed to focus on the most important ones and explain, in appropriate detail, the importance of each.

Not all issues can be resolved at the liaison level or by direct negotiation, so other kinds of conflict resolution will be needed. While this article does not propose specific internal dispute resolution systems – that has been done elsewhere<sup>16</sup> – a few points can illustrate.

When direct negotiation is unsuccessful or too daunting to try, third-party facilitation by trained, neutral conflict specialists can help disputing parties maintain their focus on problem-solving and prevent further conflict. Some of them will be internal to the organization, providing informal conflict management by meeting with parties, gathering information, helping parties identify issues and priorities, and facilitating problem-solving conversations.<sup>17</sup> The advantage of in-house facilitators is that usually they are readily available, familiar with the institution, and sometimes may be best suited to maintaining a collaborative mood.<sup>18</sup>

In areas where disputes are fairly predictable, a conflict prevention strategy might involve systematic communication opportunities. Medical staff conflicts, for instance, might be reduced by instituting regular staff meetings and workshops to air and address workplace concerns, and by identifying a trusted medical staff member to serve as ombudsman, among other measures.<sup>19</sup>

The most contentious cases, as when the issues threaten dissolution of the relationship, may require more formal processes, ranging from an outside mediator to neutral case evaluation and perhaps even arbitration.<sup>20</sup>

Finally, some situations may benefit from a process akin to collaborative law.<sup>21</sup> In collaborative law each side is represented by an attorney, but here each attorney's goal is not to fight against the other, or to gain for one's client at the other side's expense. Instead the aim is to work towards a mutually acceptable resolution. Although collaborative law is most common in the family law/divorce arena, in health law the goal would be to keep the parties together rather than split them up – to sort out problems so the relationship can succeed.

### **How Clinical Conflict Resolution Processes Differ From Familiar Forms of Mediation, and How They Might Have Averted the Keswick-Hospital Divorce**

Conflict resolution in the health law setting has distinctive features. Readers may be most familiar with the sort of mediation a judge or statute might order prior to trial. A shuttling, "give me a number" mediation may work well enough for litigation. But the kinds of conflict resolution discussed here are markedly different.<sup>22</sup>

First, there is no litigation afoot. Parties generally want to preserve, not sever, their relationship. The goal is not to determine who wins and who loses, but rather to identify each party's most important goals and interests, engage in creative problem-solving, and forge solutions that make sense for everyone.

Second, for routine clinical conflict resolution processes, attorneys will generally not be present. Instead, the participants might be the physician,

someone from (for instance) the IT department and, if the parties need or want it, a neutral third-party facilitator. The facilitator might be a trained in-house individual or, where neutrality is particularly important, an outside facilitator or mediator.

Third, those who serve as third-party facilitators or mediators will need to adjust their techniques considerably for these disputes. Shuttling between separated parties usually will be unproductive. The goal, after all, is not just to address the particular problem at hand, but also to help the parties communicate with each other. Except for particularly contentious situations, parties should be encouraged to speak face-to-face so they can have more productive conversations in the future.

Third-party facilitators thus need to bring a highly collaborative emphasis to these conversations. Rarely if ever will the outcome be a legally enforceable contract of the sort that usually caps a mediation during litigation. As a result, mediations in a clinical setting are only successful if the parties reach a genuine agreement. Allusions to litigation may frighten or un-nerve participants to the point of abandoning the process. For physicians in particular, words like "lawsuit," "litigation" or even "mediation"<sup>23</sup> evoke scenarios that could inhibit a full commitment to the problem-solving process.

Returning to the divorce story, a user-friendly conflict resolution process could have solved many of Dr. Keswick's problems if implemented early enough. For instance, as Dr. Keswick's staffing problems emerged, no one he phoned could actually give him answers. With a liaison to connect him to the right people, he might have resolved the problem much earlier. Eventually the hospital did provide a single set of continuous staff, but by that time the animosity was entrenched.

Dr. Keswick's EMR problems were never satisfactorily addressed.

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# In-House Conflict Resolution Processes: Health Lawyers as Problem-Solvers

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Although the hospital genuinely did not have the manpower or money to transcribe every old record into the new software, a compromise might have been to create timelines for his most complex patients' records. If Dr. Keswick still has to search PDFs to find older records, a timeline identifying the major events in a patient's medical history could have saved a great deal of time. Similarly, a conversation about RVU demands could have produced a more realistic productivity target.

Both parties had good reasons for entering into an employment arrangement, and those reasons did not disappear when problems arose. Had there been reliable, welcoming opportunities to discuss problems, this divorce might have been avoided.

## Take-Away Insights for Health Lawyers

As providers become more and more integrated, health lawyers will need to negotiate new features into contracts and play some new roles. In the physician-hospital alliances discussed here, lawyers traditionally help create relationships. Now they must help sustain them by addressing the need for conflict resolution from the outset.

For their own ongoing education and to improve the quality of their service to clients, health lawyers should also welcome detailed information about their clients' experiences as these relationships are begun, as problems arise and, where separation ensues, the specifics of why things fell apart. Attorneys need to know what happens after the ink dries. It may be wise to invite clients to provide periodic updates – and not necessarily bill them for the conversation – to ensure that legal services are sufficiently attuned to what clients really need.

Additionally, health lawyers need to familiarize themselves with conflict resolution processes – coaching, negotiation, collaborative law, third-party facilitation, and formal mediation.<sup>24</sup> If a relationship has deteriorated to the point where separation appears possible, the best way to advocate for one's client may be a process in which both sides seek not just to solve problems, but to rediscover their common interests. Zealous advocacy here is marked by creativity and by a recognition of the other side's needs, even as one pursues the client's most important priorities.

Health lawyers can also serve as background coaches when their clients are involved in informal negotiations. An attorney with a solid understanding of dispute resolution tools and techniques will be far better able to advise his or her client on how to achieve important objectives without inducing needless alienation. When warranted, the attorney can also coach the client on how to create a user-friendly memorandum to summarize the conclusions of these informal negotiations.

Although the specific conflict featured in this article was a hospital-physician “divorce,” the same observations about conflict resolution apply to other tensions arising in the complex world of healthcare. Health law attorneys need to be familiar with conflict resolution tools, to build them into the structure wherever possible, and to help their clients draw on them early and often.



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Professor in the College of Medicine, University of Tennessee, she specializes in health law and bioethics. Her teaching is not the traditional courses-in-classrooms. Rather, Dr. Morreim's work is clinically focused, taking place in the regular rounds and conferences during which faculty and physicians-in-training discuss patients, make medical decisions, and explore broader issues. That vantage-point permits a first-hand view of the conflicts that arise day-to-day for patients, families, physicians, nurses, administrators and others in healthcare. Conflict can arise not just between patients and providers, but in any area of healthcare delivery that now requires intense interdependence among professionals previously accustomed to substantial independence.

Dr. Morreim is vice-chair of the ABA's Task Force on alternative dispute resolution (“ADR”) and Conflict Management in Health Care. She is also vice-chair of American Health Lawyers Association's ADR Affinity Group. Dr. Morreim is a principal in the ADR Institute, which provides traditional mediation training, as well as specific training for conflict resolution in healthcare. She can be reached at [hmorreim@adrinst.com](mailto:hmorreim@adrinst.com).

## Endnotes

- <sup>1</sup> The author would like to express sincere gratitude for very helpful comments on earlier drafts of this article provided by Charity Scott, JD, MSCM, and Deborah Hiser, Esq.
- <sup>2</sup> U.S. Dept. of Health and Human Servs., *Medicare Hospital Value-Based Purchasing Plan Development: Issues Paper*, (Jan. 17, 2007), available at [https://www.cms.gov/AcuteInpatientPPS/downloads/hospital\\_VBP\\_plan\\_issues\\_paper.pdf](https://www.cms.gov/AcuteInpatientPPS/downloads/hospital_VBP_plan_issues_paper.pdf). See also Jack Meyer, Lise Rybowski & Rena Eichler, *Theory and Reality of Value-Based Purchasing: Lessons from the Pioneers*, AHRQ/AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, (1997), available at [www.ahrq.gov/qual/meyerprpt.htm](http://www.ahrq.gov/qual/meyerprpt.htm).
- <sup>3</sup> Anuja Vaidya, *Survey: Number of Hospital-Employed Physicians Up 6%*, BECKER'S HOSPITAL REVIEW, June 18, 2013; available at [www.beckershospitalreview.com/hospital-physician-relationships/survey-number-of-hospital-employed-physicians-up-6.html](http://www.beckershospitalreview.com/hospital-physician-relationships/survey-number-of-hospital-employed-physicians-up-6.html).
- <sup>4</sup> Greg Mertz, *Hospital Employment vs. Private Practice: Pros and Cons*, June 02, 2013;

- available at [www.physicianspractice.com/blog/hospital-employment-vs-private-practice-pros-and-cons](http://www.physicianspractice.com/blog/hospital-employment-vs-private-practice-pros-and-cons). See also Scott Gottlieb, *Hospitals Are Going On A Doctor Buying Binge, And It Is Likely To End Badly*, FORBES (March 15, 2013), available at [www.forbes.com/sites/scottgottlieb/2013/03/15/hospitals-are-going-on-adoctor-buying-binge-and-it-is-likely-to-end-badly/](http://www.forbes.com/sites/scottgottlieb/2013/03/15/hospitals-are-going-on-adoctor-buying-binge-and-it-is-likely-to-end-badly/); Scott Gottlieb, *The Doctor Won't See You Now. He's Clocked Out*, WALL ST. J., March 14, 2013; available at [http://online.wsj.com/article/SB10001424127887323628804578346614033833092.html?mod=WSJ\\_Opinion\\_LEADTo](http://online.wsj.com/article/SB10001424127887323628804578346614033833092.html?mod=WSJ_Opinion_LEADTo); Debra Beaulieu, *Physician Employment Could Hit 75%, Eclipsing Private Practice*, FIERCEPRACTICEMANAGEMENT.COM (July 18, 2012), available at [www.fiercepractice.com/story/survey-hospital-employment-eclipse-private-practice/2012-07-18](http://www.fiercepractice.com/story/survey-hospital-employment-eclipse-private-practice/2012-07-18).
- 5 Robert Kocher & Nikhil Sahni, *Hospitals' Race to Employ Physicians – the Logic behind a Money-Losing Proposition*, 364 NEW ENGL. J. MED. 1790 (2011).
- 6 A few details have been changed to protect confidentiality.
- 7 For example, physicians might be accustomed to seeing certain kinds of information, such as nurses' narrative notes or social work evaluations, in one part of the traditional paper chart. The EMR might place these in a completely different place, perhaps hard to locate or requiring multiple steps to reach the right information. Or physicians might be required to go through multiple pages, requiring myriad boxes to be checked and alerts to be acknowledged, just to gain access to the desired page. These processes often cost considerable time and tend to invite physicians to shorten the amount of time they spent gathering information from and entering information into the medical record. As discussed below, Dr. Keswick encountered significant problems because the new EMR system initially recorded patients' weights in pounds rather than in grams and kilograms.
- 8 The Joint Commission ("TJC"), formerly the Joint Commission on Accreditation of Healthcare Organizations, is the leading organization for accreditation of healthcare organizations such as hospitals. Many states, for instance, require Joint Commission accreditation as a condition for Medicaid reimbursement.
- 9 For an excellent discussion of Joint Commission standards and their respective elements of performance, see Charity Scott and Debra Gerardi, *A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part 1*, 37 JOINT COMMISSION J QUAL & PATIENT SAFETY 59 (2011); *A Strategic Approach for Managing Conflict in Hospitals: Responding to the Joint Commission Leadership Standard; Part II*, 37 JOINT COMMISSION J QUAL & PATIENT SAFETY 71 (2011). See also Jane Reister Conard and Jeanne F. Franklin, *Addressing the Art of Conflict Management in Healthcare Systems*, 16(3) DISPUTE RESOLUTION MAGAZINE 15 (2010).
- 10 Governance Institute, *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership* (Governance Institute White Paper, Winter 2009) at p. 17; available at [www.jointcommission.org/assets/1/18/WP\\_leadership\\_standards.pdf](http://www.jointcommission.org/assets/1/18/WP_leadership_standards.pdf). The Governance Institute's White Paper provided the standards and underlying rationale that were adopted as Joint Commission standards on January 1, 2009.
- 11 Kocher & Sahni, *supra* note 5 at 1790.
- 12 Jerome W. Thompson, *One-Way Ticket for the Employed Physician*, 106(9) TENNESSEE MEDICINE 9 (2013).
- 13 Tamara Relis, *PERCEPTIONS IN LITIGATION AND MEDIATION*, Cambridge University Press, 2009.
- 14 For a more detailed description of the ways in which clinical conflict resolution processes need to diverge from familiar mediation, see Haavi Morreim, *Conflict Resolution in Healthcare*, 18 CONNECTIONS 28 (2014).
- 15 Some hospitals already have such a liaison, sometimes dubbed a "director of physician integration."
- 16 American Health Lawyers Association ("AHLA"), *Conflict Management Toolkit* (2011), Exhibit C, "Sample Guidelines, Checklists and Policy," available at [www.healthlawyers.org/hlresources/ADR/Documents/ADRToolkit.pdf](http://www.healthlawyers.org/hlresources/ADR/Documents/ADRToolkit.pdf). See also Scott & Gerardi, *supra* n. 9.
- 17 AHLA, *supra* note 16 at 5-7.
- 18 The Joint Commission has described in-house conflict resolution in the Elements of Performance for Standard LD.02.04.01.
- "4. The conflict management process includes the following:
- Meeting with the involved parties as early as possible to identify the conflict
  - Gathering information regarding the conflict
  - Working with the parties to manage and, when possible, resolve the conflict."
- Elements of Performance for LD.02.04.01, Element #4. Element #3, initially in the 5-item set but later removed said: "Individuals who help the hospital implement the process are skilled in conflict management. This accreditation stan-
- dard became effective on January 1, 2009.
- Note: These individuals may be from either inside or outside the hospital."
- 19 Marti G. O'Hare, *A Case Study for Effective Conflict Management in the Health Care Workplace: Lessons from Babb v. Centre Community Hospital*, AHLA LABOR & EMPLOYMENT NEWSLETTER (December 2013), pp. 5-7.
- 20 *Id.* at 7-8. Others have also proposed building in conflict resolution to preserve relationships in healthcare. See, e.g., Brian R. Browder and Douglas A. Hastings, *Increasingly Common Bedfellows – Collaborations between Academic Medical Centers and Investor-Owned Health Care Companies*, 17(9) AHLA CONNECTIONS 24, 26 (2013) (proposing that, for joint ventures between academic medical centers and investor-owned companies, informal mediation processes be built into the contract from the outset).
- 21 Kathleen Clark, *The Use of Collaborative Law in Medical Error Situations*, THE HEALTH LAWYER Vol. 19, No. 6, June, 2007.
- 22 For a more detailed discussion of these differences see Morreim, *supra* note 14.
- 23 For physicians the word "mediation" usually means s/he or a colleague has been sued and that the parties have been litigating for a prolonged period, at which point a judge or someone has then ordered parties to mediate. The actual mediation (to the physician) consists of some stranger putting everyone in separate rooms, then shuttling back and forth to tell the physician what a poor case s/he has and why s/he should grant concessions to the other side – even if the physician firmly believes no malpractice has been committed. Given that even a very small payment must be reported to the National Practitioner Data Bank, given also that many physicians' malpractice insurance features a consent-to-settle clause, and given finally that continuing the fight will usually result in a physician victory, mediation represents an annoying and hurtful waste of time in many physicians' eyes. See E. H. Morreim, *Malpractice, Mediation, and Moral Hazard: The Virtues of Dodging the Data Bank*, 27 OHIO ST. J. ON DISP. RES. 109 (2012).
- 24 Many lawyers are now completing state-authorized trainings to become mediators themselves. Even if these attorneys do not then become active mediators, their understanding of conflict resolution processes is greatly enhanced. Alternatively the attorney might take an intensive training in conflict resolution for healthcare. See, e.g., [www.adrinst.com/educational\\_opportunities.htm](http://www.adrinst.com/educational_opportunities.htm).

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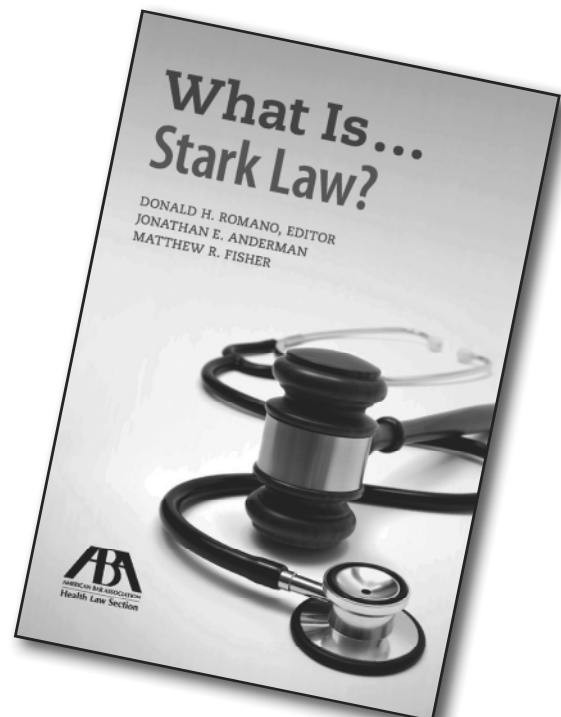
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# WHO'S DROPPING THE BALL: HOW LACK OF REQUIRED COMMUNICATION OF TEST RESULTS HARMS PATIENTS AND HOW SCRIBES CAN HELP

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## Introduction

Despite existing law, accreditation requirements, and the increasing use of electronic medical records ("EMRs"), diagnostic and communication errors continue to occur in hospitals, with sometimes disastrous results. Some physicians miss immediately life-threatening test results, while others miss critical, yet non-emergent test results, like positive cancer screenings; both types of critical test results, when overlooked, are equally dangerous. Missed communication of critical test results not only occurs after emergency department discharge, but also in hospital outpatient settings. The rate of overlooked and unaddressed test results largely remains unknown; however, due to the vast number of diagnostic tests and their significant impacts on wellness, the public health implications are likely considerable.<sup>1</sup> New initiatives to remedy unreported and unaddressed critical test results are necessary.

Doctors order many tests every day, and communicating each test result can be daunting without substantial help. The use of scribes is a promising way to ensure the detection of critical test results. Scribes are typically aspiring medical students who work along doctors and enter notes into EMRs and traditional charts; doctors may also use scribes to locate test results. With this model in place, the doctor and the scribe would both receive the test result.

## The Rory Staunton Case

Twelve-year-old Rory Staunton went into septic shock in April 2012 a few days after cutting his arm while diving for a basketball during gym class.<sup>2</sup> Rory experienced vomiting, a fever, and pain in his leg, causing Rory's mother to take him to see the pediatrician.<sup>3</sup> According to the pediatrician, Rory had the flu and was advised go to the emergency department for fluids.<sup>4</sup> Before receiving Rory's lab results, the emergency department doctors at NYU Langone Medical Center ("NYU Langone") concluded that Rory was suffering from an upset stomach and dehydration and discharged him.<sup>5</sup> The doctors, however, were mistaken; bacteria had entered his blood, probably through the cut on his arm, and Rory was spiraling into a septic crisis.<sup>6</sup> With worsening symptoms, Rory returned to the emergency department and was placed in the intensive care unit ("ICU").<sup>7</sup> Rory succumbed to sepsis at NYU Langone four days after initially visiting the emergency department.<sup>8</sup>

Sepsis has symptoms which are similar to less serious illnesses, but blood tests, blood differentials, and kidney function tests can detect the illness.<sup>9</sup> About three hours after Rory's discharge from the emergency department, his lab results were printed and revealed that he was producing neutrophils and bands, white blood cells, at rates that were "very abnormal and would suggest a serious bacterial infection," according to one doctor.<sup>10</sup> Rory's parents said they were not told about the lab results.<sup>11</sup> Rory's pediatrician revealed that she also did not know about the lab results.<sup>12</sup> Three specialists, who monitored Rory in the ICU, reviewed Rory's lab results from his night in the emergency department

and noticed that at the time of his discharge, Rory had significant signs of infection in his blood.<sup>13</sup> But without knowledge of the test results at the time of discharge, Rory appeared to simply have the flu that was going around at the time.<sup>14</sup>

After the Staunton case became public, some doctors spoke out defending the medical staff. Dr. Jeremy Boal, the chief medical officer of 16 hospitals that are part of the North Shore-Long Island Jewish Health System (of which NYU Langone is not a part) admitted that the Staunton case "could have happened almost anywhere."<sup>15</sup> As it turns out, the problems that were present in the Staunton case, the failure to communicate and address critical test results, remain problematic in health-care settings elsewhere.

## Current Safeguards

Current regulations and accreditation standards seek to eliminate the hazard of unnoticed and unaddressed test results so that tragedies like the Staunton case do not occur.

In 1988 Congress enacted the Clinical Laboratory Improvement Amendments ("CLIA"), which require laboratories to act upon critical test results.<sup>16</sup> CLIA revises and supersedes the Clinical Laboratory Improvement Act of 1967.<sup>17</sup> CLIA applies to all clinical laboratories, including those in hospitals.<sup>18</sup>

CLIA regulations specify that "[t]he laboratory must immediately alert the individual or entity requesting the test and, if applicable, the individual responsible for using the test results when any test result indicates an imminently life-threatening condition, or panic or alert values."<sup>19</sup> CLIA regulations also require laboratories to have

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# Who's Dropping the Ball: How Lack of Required Communication Harms Patients

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and follow a written procedure manual, which must include “imminently life-threatening test results or panic or alert values” and a “system for entering results in the patient record and reporting patient results including, when appropriate, the protocol for reporting imminent life threatening results, or panic, or alert values.”<sup>20</sup> The Centers for Medicare & Medicaid Services (“CMS”) may impose sanctions on a laboratory if CMS or its agents find deficiencies “in the conduct of inspections to certify or validate compliance with Federal requirements, or through review of materials submitted by the laboratory” or through “unsuccessful participation in proficiency testing.”<sup>21</sup> Without a CLIA certificate, laboratories cannot bill services to Medicare or Medicaid.<sup>22</sup>

CMS may impose principal, alternative, or criminal sanctions on violators.<sup>23</sup> Principal sanctions include “suspension, limitation, or revocation of any type of CLIA certificate.”<sup>24</sup> Alternative sanctions include a directed plan of correction, state onsite monitoring, civil money penalty, or civil suit.<sup>25</sup> CMS may bring a civil suit in U.S. District Court “to enjoin continuation of any activity of any laboratory (including a CLIA-exempt laboratory that has been found with deficiencies during a validation survey), if CMS has reason to believe that continuation of the activity would constitute a significant hazard to the public health.”<sup>26</sup> CMS may also impose criminal sanctions on an individual who is convicted of intentionally violating any CLIA requirement.<sup>27</sup>

Washington and New York have state licensure programs that allow laboratories to be exempt from CLIA program requirements.<sup>28</sup> In lieu of meeting CLIA standards, laboratories may instead be accredited by non-profit organizations with “deeming authority.”<sup>29</sup> There are currently six CMS-approved accrediting organizations under CLIA: the American

Association of Blood Banks; American Osteopathic Association; American Society for Histocompatibility and Immunogenetics; The College of American Pathologists (“CAP”); COLA; and the Joint Commission.<sup>30</sup> These organizations offer accreditation programs to laboratories, which meet or are more stringent than CLIA requirements.<sup>31</sup>

Like CLIA, the accrediting organizations have their own protocols for critical values. For example, critical value reporting is part of the CAP Laboratory Accreditation Program, which has checklists that outline specific requirements for critical value procedures.<sup>32</sup> Documentation of reporting and a read-back of verbally communicated results are required procedures for accreditation.<sup>33</sup> Read-backs help to ensure that the physician has correctly heard the values returning from the laboratory and reduces the error rate in verbal telephone communication.<sup>34</sup> CAP does not have a list of threshold critical values, nor does CAP endorse any set list of critical values; instead, laboratories must establish their own thresholds for critical values.<sup>35</sup> Although CAP has revoked accreditation for laboratories in the past, revocation is rare, since revocation for hospital laboratories would result in laboratory closure as well as hospital closure.<sup>36</sup> When deficiencies are found, CAP more regularly applies corrective measures, such as demands for corrective action plans and sanctions.<sup>37</sup>

In addition to laboratories, hospitals are responsible for taking action to improve the timely reporting and receipt of critical test results. The Joint Commission is the organization which accredits most hospitals. If a hospital meets the Joint Commission standards, CMS deems the hospital to have met the Medicare Hospital Conditions of Participation, which are required to receive Medicare and Medicaid payments.<sup>38</sup> In order to maintain its

hospital deeming authority, CMS reviews the Joint Commission standards every five years.<sup>39</sup>

The Joint Commission has safeguards in place to protect against unreported critical values. The Joint Commission established its National Patient Safety Goals (“NPSGs”) program in 2002, and the first set of NPSGs became effective January 1, 2003.<sup>40</sup> The NPSGs were established to help accredited organizations address patient safety concerns.<sup>41</sup> The Joint Commission’s NPSG 02.03.01 requires hospitals to report the results of critical tests and diagnostic procedures in a timely manner.<sup>42</sup> NPSG 02.03.01 applies to all critical tests and results as defined by the hospital and should include lab tests, electrocardiograms, and other diagnostic tests.<sup>43</sup>

The Joint Commission distinguishes between critical tests and critical results.<sup>44</sup> Critical tests, or stat exams, always require rapid communication of results, even if the results show normality.<sup>45</sup> On the other hand, critical results, or critical values, are test results which fall considerably outside the normal range of values and may represent a life-threatening situation.<sup>46</sup> Critical results, like critical tests, require rapid communication.<sup>47</sup> Both critical tests and critical results must be reported to a responsible licensed caregiver within a set time established by the organization.<sup>48</sup> The objective of NPSG 02.03.01 is to provide critical results to the responsible caregiver within an established timeframe so the patient can be promptly treated.<sup>49</sup>

The Joint Commission does not provide a list of set critical values, nor does it set forth a timeframe in which critical test results must be communicated; instead, individual hospitals must establish their own timeframes for reporting critical test results. Not all critical test results need to be acted upon with the same amount of urgency; for example, positive cancer

screenings, although critical, are “essentially nonemergent.”<sup>50</sup> An article published in the *Joint Commission Journal on Quality and Patient Safety* explains that “[i]t is now thought that the definition [of a critical value] should include equally important, but less time-sensitive, ‘vital’ values.”<sup>51</sup> There are shortcomings in communicating test results that are critical yet “essentially nonemergent” as well as imminent life-threatening results.<sup>52</sup>

The findings from 2011 Joint Commission surveys show that eight percent of hospitals surveyed were noncompliant with NPSG 02.03.01.<sup>53</sup> If the hospital is non-compliant with a standard after being surveyed by the Joint Commission, the hospital must submit Evidence of Standards Compliance (“ESC”) to the Joint Commission within ninety days of the completion of the survey.<sup>54</sup> In the ESC the hospital must provide evidence which demonstrates that the organization is in full compliance with the standard and quantifiable Measures of Success (“MOS”).<sup>55</sup> After the Joint Commission has completed its survey and has received the ESC and MOS from the hospital, the Joint Commission assigns the hospital to a category: accredited; provisional accreditation; conditional accreditation; preliminary accreditation; preliminary denial of accreditation; and denial of accreditation.<sup>56</sup>

Unfortunately, hospitals are still experiencing difficulty in reporting critical test results.<sup>57</sup> According to the Joint Commission, reports traveling from laboratories to inpatient hospital units are usually well monitored; the problems arise after critical test results arrive at the units, where practitioners do not always give orders to address critical test results.<sup>58</sup>

Although CLIA and the accreditation standards established by the Joint Commission seek to address the problem of critical test result communication, neither set a definite timeframe for the delivery of results

or a method by which results should be delivered to the necessary personnel. Moreover, they do not specify to whom exactly the test results must be communicated. Laboratories and hospitals are also responsible for defining what test values are considered “critical.” For instance, Rory Staunton’s test results might have been considered critical at one institution but not another. Universal standards have not been established due to institutional differences; for example, institutional organization, clinical demand, patient population, instrumentation and staffing are all factors that vary among institutions.<sup>59</sup> Additionally, universal critical value thresholds would be difficult to generate due to the lack of outcomes-based data.<sup>60</sup> Without universal regulations and accreditation standards, the organizations are responsible for defining their own policies regarding the timely delivery of critical test results.

Despite regulations and accreditation standards in place, critical or abnormal results still go unnoticed and unaddressed. Because the problems seem to arise after the delivery of laboratory results, stricter enforcement of CLIA and accreditation standards will probably not help. CLIA and accreditation organizations address how the laboratories must proceed after the laboratory produces a critical test result and do not apply to how the caregivers must deal with critical test results. Furthermore, realistically, the Joint Commission and CLIA would not be able to establish universal critical values due to the many differences among institutions. Modifying current regulations to be more specific may not be the best way to achieve complete compliance in communicating and acting upon abnormal or critical test results.

## Failure to Report Test Results

Overworked, busy physicians must still find reliable ways to view

and act upon all abnormal and critical test results. Patients will not always be with the physician when their test results return, which presents a challenge. Pending lab results are frequently left out of patient discharge summaries.<sup>61</sup> In one sub-acute division of a hospital, pending laboratory results, critical and noncritical, were left out of 89 percent of discharge summaries.<sup>62</sup> Practically speaking, patients often must leave the hospital before their results are available since the time it takes for some results to return exceeds the patients’ length of stay.

Since laboratory test results guide 70 percent of clinical decision-making,<sup>63</sup> the patient’s treatment often cannot really begin until the test result is analyzed. When critical test results are not communicated or acted upon, the patient loses essential time to treat the disorder. In the Staunton case, the absence of communication resulted in wasted time, which delayed possibly life-saving treatment. Absence of communication can result in delays in diagnosing cancer, missed opportunities to treat heart disease, or failure to recognize complications with prescribed drugs.<sup>64</sup>

Moreover, a study conducted in two tertiary care academic hospitals found that 41 percent of patients left the hospital with at least one pending test result.<sup>65</sup> Of the pending results at the time of discharge, 9.4 percent of them were potentially actionable and could have altered management.<sup>66</sup> In that study, physicians were unaware of 62 percent of the results that came back after discharge.<sup>67</sup> With numbers like these, it is clear that the current safeguards are not meeting their intended purpose of ensuring patient safety.

Another study, conducted within the University of Iowa Hospitals and Clinics integrated system, examined DXA screenings to detect osteoporosis.<sup>68</sup> Out of 428 DXA scans performed, 48 (11 percent) new cases of osteoporosis were detected.<sup>69</sup> Sixteen of the 48

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patients diagnosed with osteoporosis failed to receive any recommendation to begin therapy.<sup>70</sup> In 11 of the 16 cases where no treatment was recommended, the record showed no evidence that the scan result was ever reviewed by a provider.<sup>71</sup> Stated differently, in about 23 percent of the newly diagnosed osteoporosis cases, the screening result was never communicated, received, or reviewed by the provider. Researchers contacted the responsible providers in each of these 11 cases to notify the provider of the potential oversight approximately 24 months after the scan took place.<sup>72</sup> In each of these cases, the provider had in fact failed to view the DXA scan result.<sup>73</sup>

It is true that communicating positive osteoporosis screenings may not be as urgent as the detection of sepsis, as in Rory Staunton's case; however, when abnormal test results forgo review, the patient loses time to begin treatment. Missed review of DXA screenings mean that osteoporosis patients lose the opportunity to begin drug therapy, optimize calcium intake, and make necessary lifestyle changes to curb the effects of the disease.<sup>74</sup>

The healthcare system as a whole also suffers from unnecessary expenditures due to the failure to detect abnormal test results. When the osteoporosis study took place, Medicare paid about \$100 per DXA scan.<sup>75</sup> The authors of the University of Iowa Hospitals and Clinics study explain that "extrapolating our findings to the 950,000 DXA scans performed on Medicare beneficiaries in 2002 would suggest that 24,500 patients with osteoporosis did not have their scans reviewed, resulting in \$2,450,000 in excess Medicare payments."<sup>76</sup> Keeping in mind this is a Medicare waste estimate for only a single type of test, the amount of waste from all undetected abnormal test results likely has huge financial consequences.<sup>77</sup> In addition, payors lose money when a disease advances due to the lost opportunity

to prevent or mitigate its effects. Besides being a tragic story, the Rory Staunton case also unnecessarily cost a lot of money; without immediate treatment, his disease became unstoppable and required intense and costly life-saving treatment in the ICU, which ultimately failed.

Unreported and unaddressed critical or abnormal test results are not just harmful to patients and the healthcare system at large; they are also harmful to the individual physician. Physicians leave themselves open to dreaded malpractice suits when critical or abnormal test results are not acted upon. The absence of communicating critical test results, along with delays in result transmission are one of the most prominent sources of medical malpractice claims in the field of radiology.<sup>78</sup> Patients, physicians, accreditation bodies, and the government all strive for full compliance in the context of communicating critical test results; however, it is evident from the statistics that achieving this goal will require a new approach.

## Electronic Medical Records

Since error is inevitably part of being human, some hypothesize that the problem with critical test communication will end when EMRs are fully functional at all healthcare facilities. As of 2009, only about 11 percent of hospitals in the United States had a basic EMR and only about 1.9 percent of hospitals had a comprehensive EMR in place.<sup>79</sup> These numbers, however are on the rise, primarily due to the American Recovery and Reinvestment Act's ("ARRA") "meaningful use" initiative. ARRA was enacted on February 17, 2009 and includes many measures to modernize the U.S. infrastructure, one of which is the Health Information Technology for Economic and Clinical Health ("HITECH") Act.<sup>80</sup> The HITECH Act encourages EMR

adoption and use.<sup>81</sup> In 2011, 54 percent of office-based physicians had adopted an EMR system.<sup>82</sup> In 2013, 78 percent of them had done so. About three-quarters of physicians who have adopted an EMR system reported that their system meets the federal "meaningful use" criteria.<sup>83</sup>

Healthcare providers may experience improved efficiency and effectiveness with the implementation of EMRs.<sup>84</sup> Researchers at Northwestern Memorial Hospital found that pending test results and information were more reliably communicated to the patient after EMR implementation.<sup>85</sup> Another EMR benefit is its capability to transmit an automatic alert after a set threshold is met for a test result.<sup>86</sup> However, EMRs are not a panacea. Although effective in many instances, EMRs do not eliminate grey areas, such as where an abnormal finding does not meet the set standard for automatic transmission yet may be abnormal and warrant transmission for a special-case patient.<sup>87</sup> Also, constant notification of repeat abnormal test results can be disruptive and unnecessary.<sup>88</sup> One doctor describes an abundance of automated EMR alerts as the medical equivalent of the car alarm that is ignored because it never stops blaring.<sup>89</sup>

Furthermore, despite the progress made with EMRs, automated notification systems are not helpful unless the result is actually viewed by a caregiver and then acted upon. Although EMRs help with communicating critical test results, some safety concerns remain. One 2008 study examined 78,158 tests conducted at a clinic within the Michael E. DeBakey Veterans Affairs Medical Center, a Joint Commission-accredited institution, and its five satellite clinics.<sup>90</sup> The study focused on abnormal tests, which generated a "high priority" mandatory notification to the ordering provider without requiring verbal communication.<sup>91</sup> The institution



used the Computerized Patient Recording System (“CPRS”), in which providers received clinical information in a “view alert” window of the EMR screen.<sup>92</sup> Providers saw all of their alerts upon login and again when switching between patient records.<sup>93</sup> With CPRS the new alerts stayed active in the window for a period of two weeks unless the alerts were acknowledged. Alerts are considered acknowledged after the provider clicked the alert.<sup>94</sup> Without clicking the alert, the provider could still become aware of the alert from simply reviewing the medical record for other purposes.<sup>95</sup> When out of the office, primary care providers selected surrogates to track their alerts.<sup>96</sup> Of the 78,158 tests results gathered, 1,163 (1.49 percent) were electronically transmitted as mandatory “high priority” results. Of these total “high priority” alerts, 10.2 percent went unacknowledged.<sup>97</sup> After 30 days of transmission, 6.8 percent of the “high priority” lacked follow-up.<sup>98</sup> There was a lack of timely follow-up even after providers acknowledged the alert.<sup>99</sup>

Problems with critical test results are not limited to tests from the laboratory; similar issues arise with critical imaging tests. The same researchers from the Michael E. DeBakey Veterans Affairs Medical Center conducted a similar study on the follow-up of abnormal imaging alerts in the same EMR and found similar phenomena.<sup>100</sup> This is alarming because nearly 10 percent of all radiology reports contain critical imaging test results.<sup>101</sup> Researchers at the Medical Center noted that many imaging results, which lacked a timely follow-up, were “suspicious for new cancer diagnosis.”<sup>102</sup> This occurs in imaging because providers may perceive a lack of urgency for imaging tests, which may have less immediate implications.<sup>103</sup>

These studies indicate that the presence of automated notification of abnormal test results is not infallible, even in an integrated healthcare organization such as the Veterans Affairs system. Automated notifications via EMR, even after acknowledgement, do

not necessarily yield timely follow-up actions by providers. The results at Michael E. DeBakey Veterans Affairs Medical Center are consistent with non-Veterans Affairs settings, where about seven percent of abnormal test results were not communicated to the patient, or the communication with the patient went undocumented.<sup>104</sup> In a laboratory study and an imaging study, electronically “acknowledged” and non-acknowledged alerts were equally associated with insufficient timely follow-up action.<sup>105</sup>

It is important to note that the policy of the Veterans Affairs institution in the study required the communication of imminent life-threatening findings via telephone; automated responses were required for “high priority” alerts, which were of less concern than “life-threatening” findings.<sup>106</sup> Nonetheless, it is troublesome that 10.2 percent of the “high priority” abnormal test results went unacknowledged and 6.8 percent lacked timely-follow actions after acknowledgement. Missed abnormal test results significantly increase the chances of outpatient diagnostic errors and adverse events. An article published in *The Joint Commission Journal on Quality and Patient Safety* warns that even though seemingly reliable EMRs are used to communicate test results, problems with communication persist.<sup>107</sup>

A survey conducted within the Midwest Veterans Integrated Service Network found that problems associated with test result management occurred even though the nationally recognized CPRS was in place.<sup>108</sup> The survey found that 15 percent of respondent providers said that their practice did not have a consistent system in place to communicate test results to patients.<sup>109</sup> Of the providers surveyed, 47 percent said that they have encountered at least one patient with an overlooked test result.<sup>110</sup> Furthermore, 37 percent of the providers surveyed reportedly have seen at least one patient who had experienced a delay in diagnosis or treatment due to an overlooked test

result.<sup>111</sup> These findings are similar to findings in previous studies.<sup>112</sup> In sum, EMRs fall short when it comes to solving the problems of communicating and acting upon abnormal or critical test results.

## Recommendation: Enlist the Help of Scribes

In 2010 *The Joint Commission Journal on Quality and Patient Safety* published an article delineating eight logical recommendations to health-care organizations for communicating critical test results. These recommendations are a product of lessons learned from the 2008 study conducted at the Michael E. DeBakey Veterans Affairs Medical Center discussed above.<sup>113</sup> In addition to these eight recommendations, another recommendation could be added to the list: the use of scribes.

Data collected in one study revealed that the average primary care provider reviews 1,000 diagnostic studies per week and spends 74 minutes per day reviewing diagnostic studies.<sup>114</sup> The monotony of the process can yield errors. One person dealing with 1,000 diagnostic studies per day needs support.

Per NPSG 02.03.01, the critical test report must be sent to the responsible licensed practitioner. The standard, however, does not say that the licensed practitioner is the only individual to whom critical results can be sent. Critical test results can also be sent to a medical scribe as well as the licensed caregiver. Scribes are a regional phenomena; in some areas of the country scribe use is very pervasive, yet in other areas scribes have not caught on.<sup>115</sup>

As of December 2012, about 200 hospital emergency departments were using medical scribes to enter patient notes into EMRs and aid doctors with follow-ups on prescriptions, laboratory tests, specialty consultations, and records from other hospitals.<sup>116</sup> The Joint Commission has acknowledged

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that scribes have worked to solve the problems in hospitals around the country.<sup>117</sup> Individual physicians tend to hire and pay for their own scribe services.<sup>118</sup> Although emergency departments have been more prone to scribe use, other departments can equally benefit from scribes.<sup>119</sup> The doctors who use scribes can devote more time to the patient and then later check the accuracy of the scribe's chart, making any necessary additions or deletions before signing off on it.<sup>120</sup> Scribes require intense training (one program requires 100 hours of book and on-site training);<sup>121</sup> however, this should not deter potential scribes because the scribe program offers a great learning experience for motivated, aspiring physicians. One doctor explains, "[scribes] learn the whole thought process right on the front line. When I was a pre-med student, I would have done this for free."<sup>122</sup> Scribes are relatively inexpensive, typically earning between \$10 and \$16 per hour depending on geographical location and the type of employer.<sup>123</sup>

Why not add the review and communication of test results to a scribe's duties? The scribe can ensure that every test arriving from the lab or imaging center is measured against the defined critical values. If a critical value is found, the scribe then can ensure that the results are communicated to a provider who can take action. If the ordering provider is unavailable, the scribe can ensure that the results are communicated verbally to an available provider. The scribe also has the ability to follow up with the provider in person to make sure action was taken on a critical test result and can record that the action was taken. Scribe use by the emergency department and the primary care physician could hasten communication between the two.

Scribes do need to be used within certain parameters. For instance, if scribe use is adopted, the hospital

needs to ensure that the scribe role is clearly defined.<sup>124</sup> Scribes are not allowed to carry out orders unless assigned by someone with permission to give that order.<sup>125</sup> Although the Joint Commission has acknowledged that scribes can be helpful, the organization issued a directive regarding the use of scribes in 2012.<sup>126</sup> The directive states that "[t]he Joint Commission does not endorse nor prohibit the use of scribes." The directive also states that "[t]he Joint Commission does not support scribes being utilized to enter orders for physicians or practitioners due to the additional risk added to the process."<sup>127</sup>

Some may argue that scribes will not solve the problem of unaddressed critical test results since they do not have enough training to accurately read a result; however, scribes relay reports from laboratories and radiology departments which identify the critical result. As previously stated, physicians sometimes overlook critical test results communicated to them even via an EMR from laboratory and radiology departments. The scribe can act as a second set of eyes dedicated to detecting critical test result communications. Unlike the electronic notifications, which can be clicked and discarded, the scribe is physically interacting with the provider and can prompt the provider to act on critical results in real time. Moreover, as scribe use is not mandated, and scribes are already employed, providers would not incur significant increased costs. Indeed, catching more of these missed results would reduce costs and improve patient care.

## Conclusion

The Rory Staunton story is one tragic case that represents the pervasive problem of unaddressed critical test results. Despite the current safeguards in place, an alarming number of doctors are unaware of test results returning after discharge or treatment

of the patient and are not communicating them. Although EMRs can help communicate critical test results, EMR systems are not infallible. New regulations, standards, policies and procedures may be ultimately necessary, but often take time to adopt and implement. Using scribes to review test results won't solve the problem of unaddressed critical test results, but from a practical, immediate standpoint scribe use can aid in solving this dangerous problem.



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Lauren D. Goldberg, Garfunkel Wild, PC, Hackensack, NJ (Chair)

John D. Blum, Loyola University, Chicago School of Law, Chicago, IL

Lisa L. Dahm, South Texas College of Law, Houston, TX

Marla Durben Hirsch, Editor, *The Health Lawyer*, Potomac, MD

Kari Loeser, Genentech, Inc., South San Francisco, CA

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The writing competition is open to all current law students. Contact Wanda Workman at [wanda.workman@americanbar.org](mailto:wanda.workman@americanbar.org) for information on the 2014 – 2015 competition.

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# RECENT TRENDS IN ACADEMIC MEDICAL CENTER MERGERS, ACQUISITIONS AND AFFILIATIONS

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## Introduction

The Academic Medical Center (“AMC”) is the cornerstone of the United States’ health system. Recent developments and changes in the healthcare landscape have forced AMCs to reevaluate their business model and deploy new operational strategies to ensure their financial future. As part of this strategic shift, AMCs are increasingly partnering with community hospitals and other providers to expand their geographical footprint and manage the challenges of reimbursement reform, reimbursement decline and brand dilution. This recent trend in AMC acquisitions and affiliations has created new strategic networks focused on providing high quality, low cost accountable patient care and on broadening the scope of available specialty care.

## Overview: Academic Medical Centers

AMCs are multi-faceted healthcare organizations comprised of patient care and research facilities that also operate a medical school or are affiliated with a medical school and university. Therefore, AMCs are organized around a tripartite mission: patient care, education and research. The patient care provided is heavily focused on highly specialized care and often serves a large number of medically indigent patients.<sup>1</sup> The research and education initiatives traditionally stem from the affiliations with academic institutions. Innovative medical research, quality education and clinical opportunities are emphasized in

the culture of AMCs.<sup>2</sup>

As a result of recent trends, AMCs now tend to fall into one of three categories along a consolidation continuum: anchoring multi-hospital, integrated networks (e.g. University of Pittsburgh Medical Center); pursuing partnerships with large non-academic systems (e.g., Georgetown/Medstar); or staying independent while entering into affiliations to achieve aspects of their mission (e.g., University of Iowa Hospitals and Health System).<sup>3</sup> Moreover, the leadership of AMCs tend to either be reactive, opportunistic or proactive in their stance on consolidation. The approach chosen by leadership is influenced by the nature and intensity of competition in the AMC’s market, which in turn is a function of physician consolidation, vertical integration of health plans, presence of other competitive multi-hospital systems and the like.<sup>4</sup> These factors and others described in the following paragraphs depict the complexity of the motivation driving consolidation and affiliations as well as the forces that shape the resulting relationships.

In addition to local competitive pressures, AMCs are facing pressure from sweeping efforts to curb the growth in healthcare expenditures in the larger environment. The three-pronged mission of AMCs has created a complex organizational and funding structure that has led some analysts to predict a negative outlook for future revenue growth.<sup>5</sup> For instance, the Patient Protection and Affordable Care Act<sup>6</sup> (“PPACA”) has affected AMCs’ share of revenues. Under PPACA, AMCs are likely to experience a decline in rates paid by commercial insurers and declines in government reimbursement even as Medicaid becomes a larger source of revenue.<sup>7</sup> Growing government budget constraints will continue to diminish

funding received by AMCs for education and research: Graduate Medical Education dollars were reduced in 2013 and funding from the National Institutes of Health has declined in real dollars over the last several years, including actual cuts sustained in 2013 due to sequestration.<sup>8</sup>

The value of the AMC “brand” has also become a concern. The AMC brand has traditionally been prestigious enough to carry it through these challenges.<sup>9</sup> However, AMCs have not dominated recent hospital quality performance reports, which suggests that competition with community-based hospitals for recognition as top quality performers is intensifying.<sup>10</sup> Profits have also decreased because patients are less willing to pay a higher premium for access to care at AMCs with fewer healthcare dollars available.<sup>11</sup> AMC leaders are exploring creative solutions to these challenges and drawing from a range of strategic options to meet them.

## Recent Trends

The sustainability of AMCs in the face of new healthcare reforms and patient care expectations is not guaranteed. In order to remain competitive and achieve financial growth, AMCs have expanded their reach and explored strategic partnerships that offer the ability to restructure the way patient care is delivered and lower costs of delivering care. As noted above, the recent trend of AMC affiliations has been fueled, in part, by competitive pressures, changes and declines in reimbursement, lower quality rankings and unwieldy organizational structures. Acquisitions or other partnerships between AMCs and community hospitals in the local market offer opportunities to develop referral networks and provide high quality, low cost specialized care to patients in a larger geographical area.<sup>12</sup> Other types

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of affiliations outside the local market provide opportunities for extending their brand reach or in developing new capacity or competencies (e.g., purchasing collectives). Partnerships are emerging with other types of organizations, such as for-profit hospital systems or investors, to enable AMCs to access a different type of management expertise or strategically leverage capital. In fact, for-profit/non-profit deals account for some of the largest deals in overall hospital merger and acquisition activity. Examples in recent years include HCA's acquisition of HealthOne in Denver in 2011 for \$1.4 billion and Health Management Associates' acquisition of Mercy Health Partners for \$532 million in Knoxville, Tennessee to create Tennova Health System.<sup>13</sup>

In deciding to consolidate, AMCs can choose from several transactional approaches ranging from formal ownership to informal affiliations. The most common transactions involving AMCs have been mergers and acquisitions, joint ventures and affiliation agreements. AMCs must assess their business goals as well as the financial and legal considerations of each transactional model in order to determine the most effective method of collaboration.

## Mergers and Acquisitions

Several AMCs have chosen to expand their network through mergers and acquisitions. The number of merger and acquisition transactions involving hospitals has grown from 56 in 2002 to 86 in 2011.<sup>14</sup> In 2012, the number was even higher, totaling 105, over twice the number in 2009.<sup>15</sup> In the third quarter of 2013, merger and acquisition activity increased 20 percent over the same period in the prior year.<sup>16</sup> AMCs have taken an active role in the rise in merger and acquisition transactions, accounting for approximately 20 percent of health-related mergers and acquisitions in 2010.<sup>17</sup> In 2012, AMCs were identified as still actively involved in mergers and

acquisitions, according to a report that reviewed how AMCs tended to approach consolidation.<sup>18</sup>

The term "mergers and acquisitions" covers a spectrum of transactions. A traditional merger involves the merger of one corporation into another whereby the merging corporation ceases to exist and the surviving corporation assumes all of the merged entity's assets and liabilities. Sometimes two entities will consolidate into a newly formed third entity. Often in the non-profit world, control over another non-profit hospital corporation is achieved through member substitution: one corporation becomes the sole member of another corporation which stays intact but is now controlled by its new sole member. An acquisition can be achieved through the purchase of the assets (rather than stock) of another provider, a tactic that is typically employed when acquiring physician groups. Mergers and acquisitions can offer advantages to AMCs and community hospitals, including access to specialized care and research, lower costs and a broader geographical reach.

A disadvantage of this approach, however, is increased federal antitrust scrutiny, which is adding to the risk of merging with or acquiring other hospitals or providers such as large physician groups. The Federal Trade Commission ("FTC") has actively investigated and challenged hospital mergers and physician practice acquisitions and warned about the consequences of healthcare industry consolidation on competition, which in its view is significant.<sup>19</sup> In addition, the FTC has opposed state legislative efforts to permit the formation of "collaboratives" that would permit otherwise independent healthcare providers to negotiate collectively when otherwise such collective negotiation would not be permissible by immunizing these collaboratives from state and federal antitrust enforcement.<sup>20</sup> The FTC is wary of any efforts that might shield joint pricing by independent healthcare providers.<sup>21</sup>

In the past few years, AMCs have been active participants in merger and acquisition transactions.<sup>22</sup> In 2011, Livonia Michigan's Loyola University Health System ("LUHS") merged into Trinity Health in an effort to improve the quality and effectiveness of Catholic healthcare and education.<sup>23</sup> Under the agreement, Trinity Health became the owner of LUHS.<sup>24</sup> Both LUHS and Trinity Health are "committed to investing in patient care, infrastructure, facilities, and research."<sup>25</sup>

Effective January 1, 2013, North Dakota-based Hillsboro Medical Center ("Hillsboro") and Sanford Health ("Sanford") executed a formal merger.<sup>26</sup> Under the merger agreement, Hillsboro will now be known as Sanford Hillsboro Medical Center.<sup>27</sup> This deal is the culmination of a long-standing partnership between the two organizations and is also interesting because Hillsboro is a critical access hospital, which are small hospitals (25 beds or less) located in rural areas that receive enhanced federal reimbursement.<sup>28</sup> Critical access hospitals are increasingly looking to AMCs to secure needed expertise or capital. Sanford has had a clinic located within Hillsboro since 2000; the two hospitals also formed an affiliation in April 2012.<sup>29</sup> The goal of the merger is to improve and continue the commitment to patients and rural communities.<sup>30</sup> Additional examples of recent and pending mergers and acquisitions include:

- UC San Diego Health System acquired the Nevada Cancer Institute in Las Vegas.<sup>31</sup>
- University of Colorado Hospital partnered with Poudre Valley Health System.<sup>32</sup>
- Yale-New Haven Hospital and the Hospital of Saint Raphael merged into one hospital with two campuses.<sup>33</sup>
- Boston-based Beth Israel Deaconess Medical Center acquired Milton Hospital to formalize and enhance their long standing collaboration and clinical affiliation.<sup>34</sup>

- NYU Langone Medical Center and Continuum Health Partners reached an agreement on June 6, 2012 to pursue a merger.<sup>35</sup>

### Joint Ventures

Another path that an AMC can pursue is to enter into a joint venture with a hospital or with a discrete clinical division of a health system. A joint venture in the healthcare field can occur when two or more parties enter into a contractual arrangement to collaborate on a specific project, or it can arise when two or more parties create a new legal entity to offer a new service or pursue a separate strategy.<sup>36</sup> A joint venture transaction can appeal to an AMC and community hospital more than a merger or acquisition because it offers access to capital and shared financial risk without having to give up full ownership control.<sup>37</sup>

There have been several joint ventures involving AMCs in recent years. For instance, in 2012 New Jersey's Regent Surgical Health ("Regent") entered into a joint venture agreement with New Brunswick, New Jersey-based Robert Wood Johnson University Hospital ("Robert Wood") to transfer Robert Wood's outpatient department to a freestanding surgical center.<sup>38</sup> The agreement provides for a split ownership of the surgical center among Regent, Robert Wood and private practice physicians in the community.<sup>39</sup> The partnership and creation of the surgical center is meant to foster more efficient management and care while also helping Robert Wood "strengthen ties with private practice physicians."<sup>40</sup> Also in 2012, Hackensack University Medical Center ("Hackensack UMC") in Hackensack, New Jersey entered into a joint venture partnership with community physicians and United Surgical Partners International ("USPI") as a way to better position itself for growth under healthcare reform.<sup>41</sup> The underlying goal of this partnership is to "form strategic relationships with physicians in order to better access and serve the community."<sup>42</sup> Under the agreement, Hackensack UMC and USPI share

ownership of a joint venture company that will then partner with physicians to own and operate a network of ambulatory surgery centers.<sup>43</sup>

In 2010, a more targeted joint venture effort in the Albany, New York area was established between Saratoga Hospital and Albany Medical Center. The parties created a partnership to provide outpatient care by emergency medicine-trained physicians and staff at a new urgent-care center.<sup>44</sup> The joint venture agreement established a new, non-profit corporation, Healthcare Partners of Saratoga, which operates the outpatient care center that opened in June 2013.<sup>45</sup>

Joint venture agreements continue to be pursued by AMCs to improve medical services and care through strategic alliances with other health service providers. Pending joint venture agreements include:

- Tufts Medical Center (Boston, MA), Vanguard Health Systems (Nashville, TN) and the New England Quality Care Alliance have entered into exclusive negotiations to create a new health system in Massachusetts. Services being considered include enhanced chronic care and population health management. Under the proposed joint venture deal Tufts would remain independent.<sup>46</sup> In August 2013, the two announced joint projects for the delivery of cardiology services through heart disease centers.<sup>47</sup>
- UC Davis Medical Center (Sacramento, CA) and Dameron Hospital (Stockton, CA) announced that they will be forming a joint venture to help Dameron improve its medical services and localized care. The joint venture will form the Dameron Davis Management Company, LLC, which will own and operate Dameron Hospital.<sup>48</sup>

The Tufts Medical Center/Vanguard transaction is interesting as an example of a non-profit and investor-owned enterprises affiliation that may be evidence of a trend: non-profit

AMCs gain access to new sources of capital while investor-owned enterprises gain the credibility associated with a non-profit, academic and community-focused mission.<sup>49</sup>

### Affiliation Agreements

There has been a rise in informal affiliation agreements involving AMCs in the past few years. While a kind of joint venture, affiliation agreements are a more flexible alternative for AMCs and community hospitals or other entities that are looking to form partnerships but do not want to relinquish ownership or control. This transactional model allows AMCs to expand their networks with minimal investment and allows, for example, community hospitals to improve access to specialty services while remaining independent. Affiliation agreements can range in size, commitment level and purpose.

There are several recent examples of service-line affiliations that have been created to provide access to a particular specialized care. In 2010, the Southcoast Health System ("Southcoast"), a group of community hospitals in Southeastern MA, signed a three-year affiliation agreement with doctors from MD Anderson Cancer Center in Houston, TX ("MD Anderson").<sup>50</sup> The purpose of the agreement is to help improve Southcoast's patient care by utilizing the cancer treatment expertise at MD Anderson and to position itself as a competitor in oncology services.<sup>51</sup> The affiliation will also allow Southcoast physicians to engage in video conferences with MD Anderson physicians to discuss cases.<sup>52</sup> California's San Joaquin Community Hospital announced in January 2013 that its AIS Cancer Center has partnered with the UC Davis Comprehensive Cancer Center for a small annual affiliation fee.<sup>53</sup> This strategic partnership will provide San Joaquin's AIS Cancer Center with meaningful access to clinical trials and resources at UC Davis.<sup>54</sup> San Joaquin wanted to find a practical partnership that would provide access to "second opinions, and education for the cancer center's staff," and these goals

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aligned well with UC Davis' mission to improve cancer care in the local area.<sup>55</sup> In a similar agreement, the Mayo Clinic in Arizona and the Yuma Regional Medical Center ("YRMC") formed an affiliation in November 2012 to expand the care available to cancer patients in Yuma.<sup>56</sup> This partnership will provide YRMC with valuable expertise and care advisement as it looks to the future development of a local cancer center.<sup>57</sup>

In addition to general affiliation agreements, some AMC's have become members of larger collaboration agreements. By partnering with multiple health service entities, AMC's are creating healthcare alliances that can provide broader access to improved care and technologies. A recent example of this is The BJC Collaborative, L.L.C. that was formed in October 2012 when BJC HealthCare of St. Louis partnered with Saint Luke's Health System (Kansas City, MO), CoxHealth (Springfield, MO), and Memorial Health System (Springfield, IL).<sup>58</sup> Each member will remain independent while the members work together to develop and share best practices focused on clinical and service quality, health management, financial services and technology.<sup>59</sup> The value in this collaboration comes from the members' service and reputation as leading non-profit health systems in their regions. The goal is to tap into the resources and practices of each entity in order to improve access to and quality of patient care while lowering costs and increasing efficiencies.<sup>60</sup> Two other healthcare systems, Blessing Health System and Southern Illinois Healthcare have since joined the Collaborative and together the health systems will work on several initiatives, including population health management, clinical and service quality, capital asset management, financial services and information systems and technology.<sup>61</sup>

In addition to the previously highlighted examples of affiliation agreements, the growing activity of transactions can be further shown by the abundance of recent and pending

affiliation agreements, including:

- West Tennessee Healthcare ("WTH") and Vanderbilt University Medical Center entered into an affiliation agreement in January 2013. All of the WTH's hospital affiliates will maintain their ownership and management structures. The partnership will provide resources to improve the quality, access and cost of care.<sup>62</sup>
- Vanderbilt University Medical Center, Maury Regional Medical Center, Northcrest Medical Center and Williamson Medical Center formed a partnership through an affiliation agreement to create "jointly operated programs and services." The main purpose of the agreement is to expand primary and specialty clinical services. All four medical centers will remain independent while collaborating to provide more efficient, cost effective patient care.<sup>63</sup>
- Albany Medical Center and Glens Falls Hospital recently announced that they plan to partner in an effort to improve patient care while finding ways to reduce costs. This partnership would help strength the medical resources and skills of both institutions. The two organizations are forming a leadership committee to identify opportunities for collaboration.<sup>64</sup>

These affiliations may become a more popular choice for AMC's than traditional mergers and acquisitions. They permit targeting of initiatives that can demonstrably improve quality or access to care or reduce cost without the complexities involved in the change of ownership or control. Moreover, the FTC and the Department of Justice jointly provided guidance suggesting that they will not challenge joint ventures among independent healthcare providers that make available expansion of clinical services or sharing of expense to reduce the overall cost of providing care in a

community.<sup>65</sup> Affiliations and joint ventures such as these may pose less risk than other strategies that lead to increased provider consolidation.

## Conclusion

As AMC's continue to face challenges from increasing competition, healthcare reform, brand dilution and complex organizational structures, the trend in acquisitions and affiliations is likely to continue. The ability to expand their network and utilize cost saving structures creates a new platform for AMC's and their financial future. Partnership opportunities need to be carefully planned to align the goals of the AMC's and community hospitals or other providers or sources of capital to allow for a purposeful and effective collaboration. AMC's are essential to the advancement in medical care, research and education. Their ability to adapt their traditional business model to the changing healthcare landscape is a necessary part of their future success.



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## Chair's Corner

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In this country, we are engaged in an ongoing national debate on how best to create a system that lowers the barriers that prevent people from accessing our healthcare resources and produces better clinical outcomes. And yet that debate is obscured by diatribes, slogans and fabrications ("dhimmitude", anyone?), as each side strives to depict the other as venal, foolish or even un-American. Too often, our views on healthcare reform are shaped not by an honest assessment of its strengths and weaknesses, but by our political support of or opposition to the current Administration. *Shut up, he explained.*

As lawyers, I believe we have a role to play in changing these sorts of attitudes. What are we trained to do as lawyers? We are trained to objectively assess facts. We are trained to see both sides of the story. We are trained to figure out how parties – even adversaries – can find common ground and reach a result that leaves them better off than they were. We are trained to listen and analyze and clarify and explain, and to help our clients separate what is important from what is unimportant.

Call me naïve, but maybe we can put that to use in changing our healthcare system for the better. If we apply our skills – especially those skills of listening and explaining – maybe we can help our clients get past the lines in the sand that people like to draw. Maybe we can help them see that "We've always done it this way" and "That's not how we do things" aren't answers, but merely obstacles that keep the different constituencies that make up our healthcare industry from working

together to improve the system. Maybe we can even help our clients – whether those clients are private-sector players or government regulators, providers or payors, physicians or institutions – learn to listen better and reason together.

Maybe a good first step in doing that is to find a place where lawyers from all sectors of the industry can listen to and learn from each other. And what better place to do that than the Health Law Section's Conference on Emerging Issues in Healthcare Law, coming up this month? Because EMI brings together the best the Section has to offer – government lawyers, private practitioners, in-house counsel; lawyers who represent payors and physicians and hospitals and device companies; relators' counsel and defense counsel; seasoned old pros and energetic young minds – and gives them a chance to talk and listen and enjoy some of the best educational programs and social events the healthcare bar has to offer. If you haven't made your reservation for EMI, stop reading this and do it now. You'll learn things, you'll have fun, you'll see old friends and make new ones. And, with any luck, you'll come away with the ideas that help you change the healthcare system for the better, as you help your clients get past the barriers that keep them – and sometimes us as well – from hearing each other.

Because "Shut up!" is not an explanation we can settle for anymore.

See you in Arizona!

Bill

The Editorial Board of *The Health Lawyer* is pleased to provide these updates of presentations made at the Annual Emerging Issues in Healthcare Law Conference, held in Miami, Florida, February 2013. This is an additional benefit provided to Section members to keep you apprised of new developments in healthcare law. We hope that you find these updates useful.

## Update to 2013 Emerging Issues Conference Presentations:

### OUR NATION'S VETERANS' COURTS AND CRIMINAL JUSTICE SYSTEM: A PUBLIC HEALTH POLICY APPROACH

Submitted by:  
Melanie G May, Esq.  
Chief Judge  
Fourth District Court of Appeal  
West Palm Beach, FL

In early October, 2013, the National Drug Court Institute hosted the Doing Justice Summit, where leaders in the criminal justice field from across the country gathered to discuss evidence-based sentencing practices and the need for valid risk and needs assessments prior to disposition of the cases. Dr. Doug Marlowe facilitated the plenary sessions and presented the ARK (Annals of Research and Knowledge), a three-dimensional visualization of sentencing dispositions based on an offender's assessed risk and need. Drug courts figured prominently, but were only one piece of the puzzle. Other innovative approaches such as HOPE (a pro-active probationary program), and other diversion programs were significant topics of discussion.

Participants broke into various groups to discuss opportunities, obstacles, and challenges. The goal: to develop a strategic plan to implement evidence-based sentencing nationally. Each group reported to larger groups on the second day. It was a first-of-its-kind gathering, bringing representatives of the leading national organizations of researchers, prosecutors, defense lawyers, probation officers, law enforcement, policy makers, treatment professionals, and judges together to work collaboratively on the issue.

In December, 2013, the National Association of Drug Court Professionals hosted the first conference dedicated to Veteran's Treatment Courts.

### WHAT'S FOR DINNER? FOOD REGULATION AND PUBLIC HEALTH

Submitted by:  
Thomas Merrill, Esq.  
General Counsel  
New York City Department of  
Health and Mental Hygiene  
Queens, NY

New York's highest court, the Court of Appeals, will decide whether the New York City Board of Health has the authority to limit the size of sugary beverages that the city's restaurants serve. In 2012, the Board adopted a rule prohibiting food service establishments from serving sodas and other sugary beverages in cups and containers that hold more than sixteen fluid ounces. In March 2013, just before the rule was to go into effect, a lower court found that the Board had violated the separation of powers clause in the New York State Constitution and struck the rule down. See 2013 NY Misc LEXIS 1216.

An intermediate appellate court agreed, finding on July 30, 2013 that the Board of Health only has the authority to make rules that protect the public from inherently harmful and inimical matters affecting the health of the City. See *NY Statewide Coalition of Hispanic Chambers of Commerce, et al. v. DOHMH*, 110 AD3d 1 (1st Dep't 2013). The Court of Appeals has granted leave and will likely hear the case early this year.

Other action is being taken elsewhere regarding sugary beverages. Both Mexico City and San Francisco are pursuing taxes. Mexico City is also looking at portion caps.

#### REMINDER:

ABA Health Law Section members can access past issues of *The Health Lawyer* on the Section's website. To access back issues and *The Health Lawyer's* full index, go to [www.americanbar.org/publications/health\\_lawyer\\_home.html](http://www.americanbar.org/publications/health_lawyer_home.html).



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February 6, 2014  
False Claims Act Fundamentals  
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February 26-March 1, 2014  
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March 6, 2014  
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Fundamentals  
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March 20, 2014  
Medical Staff – Hospital Relationships:  
Diagnosis, Treatment, and  
Practicing Wellness  
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Chicago, IL  
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