Hospital Summit on Risk Management
Friday, Sept. 25, 2015
Double Tree by Hilton Hotel Seattle Airport Seattle, WA
8:00 AM - 5:15 PM

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Agenda

Hospital Summit 2015 | September 25, 2015

8:00  REGISTRATION & BREAKFAST

9:00  Leslie Moore, RN, JD, CPHRM | Director, Healthcare Entity Risk Management, Physicians Insurance A Mutual Company
      Welcome Remarks

9:15  John J. Nance, JD | Author
      Flight Plan to Survival

10:00 BREAK

10:15 Leilani Schweitzer | Patient Liaison, Stanford University Hospital
      Disclosure and Compassion after Medical Errors

11:15 LUNCH

12:30 Doug Jaquez, MHA | Corporate Director, Risk Management Department, Swedish Health Services
      Jane Uhlir, MD | Executive Director, Insytu
      The Benefit of Simulation in Managing Risk

1:30  David McClellan, MD | Emergency Medicine
      Issues of Small Rural Hospitals

2:30 BREAK

2:45 Liz Leedom, JD | Bennett Bigelow & Leedom, PS
      Legal Update and Practice Tips

3:45 Eric J. Neiman, JD | Lewis Brisbois Bisgaard & Smith LLP
      Psychiatric Boarding and Other Hot Topics in Behavioral Health

4:45 Q & A

5:00 Leslie Moore, RN, JD, CPHRM | Director, Healthcare Entity Risk Management, Physicians Insurance A Mutual Company
      Closing Remarks

5:15 ADJOURN
Stanford’s PEARL
Disclosure & Compassion after Medical Errors

PEARL:
A Hybrid Values & Claims Centric Model
PEARL is based on the fundamentals of communication, transparency, and integrity.

Smart Business Practice
Patient Centered
Value & Principle Based

400,000+ deaths
2,100,000+ injuries
every year in the US.

doi:10.1097/PTS.0b013e318294b9ea
Recording of this session via any media type is strictly prohibited.

Early Rs
- Early Recognition
- Early Response
- Early Review
- Early Resolution

Claims Specialist (internal) + Patient Liaison (external) = PEARL
Recording of this session via any media type is strictly prohibited.

Patients Want

Three Things.
- an explanation
- an apology
- improvements
Patients Want Three Things
- an explanation
- an apology
- improvements

Hospitals Want Three Things
- to know what happened
- accountability
- improvements

Ecosystem of Medical Errors

I am one of the lucky ones.
Peer Support for Adverse Events

Studies show physicians involved in critical incidents experience:

- increased anxiety about future errors
- loss of confidence
- difficulty sleeping
- reduced job satisfaction
Physicians involved in a PEARL or critical incident.

- **Contact**: Physicians in a PEARL or critical incident are contacted by a support team member.
- **Guidance and Education**: Support team offers support, guidance and educates physician on PEARL process.
- **Additional Resources**: If more than support is required, physician directed through available programs offered by GME and EAP.

This program is not intended to be mental health support.

### TRA Results

<table>
<thead>
<tr>
<th>Metric</th>
<th>Desired Result</th>
<th>Observed Result</th>
<th>Basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lawsuit Frequency</td>
<td>Lower</td>
<td>Lower</td>
<td>Pre vs Post PEARL</td>
</tr>
<tr>
<td>Average Claim Severity</td>
<td>Lower</td>
<td>Lower (inconclusive in 2013)</td>
<td>Pre vs Post PEARL</td>
</tr>
<tr>
<td>Average Defense Costs (ALAE) Severity</td>
<td>Lower</td>
<td>Lower</td>
<td>Pre vs Post PEARL</td>
</tr>
<tr>
<td>Closing Pattern</td>
<td>Faster</td>
<td>Unchanged</td>
<td>Pre vs Post PEARL</td>
</tr>
</tbody>
</table>

**Notes:**
- Pre PEARL period includes FY 2003 to 2008
- Post PEARL period includes FY 2009 to 2014
TRA Results

Average Claim Cost Pre vs Post PEARL

- Indemnity
- Defense Cost

In addition, defense cost on PEARL cases are 20% lower than non-PEARL cases.

TRA Results

Frequency Rate of Lawsuits

PEARL implemented in 2008

First 3.5 years of PEARL

Claim frequency down 36%
Saving $3.2 million/year

Unintended Errors & Deliberate, Intended Responses
Thank you.

LSchweitzer@theriskauthority.com
The Benefit of Simulation in Managing Risk | Jane Uhlir, MD & Doug Jaquez, MHA

The Benefit of Simulation in Managing Risk

Jane Uhlir, MD
Doug Jaquez

Disclosure

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Disclosure

- The authors have no financial disclosures that would impact the content of this presentation

Jane Uhlir, MD
Doug Jaquez, MHA
Dale P. Reisner, MD
Cynthia Irwin, MN, RNC-OB
Rosalee Zingheim, RN, MN

Risk Management Benefit of Simulation

- New facility testing
- High risk/Low frequency
- Claims/RCA action plan
- Outbrief interface
- Litigation illustrative support

New Facility Testing

- Facility layout
- Systems testing
- Process flow
- Equipment/Supply testing
- Caregiver comfort/Confidence
High Risk/Low Frequency (examples)

• Practice emergent situation before they happen!
• OB
  – Fetal heart monitoring – Decision to incision
  – Shoulder dystocia
  – Emergent c-section
  – Post partum hemorrhage
• ED
  – Emergent delivery
  – Pediatric
  – Headache/Abdominal Pain/Chest Pain/Fever

Claims/RCA Action Plan

• Utilizing simulation for formal action plans
• Claims history
  – Trends?
• Root Cause Analysis (RCA)
  – Determine if isolated versus systemic issue
  – Allows for objective observation of improvements

Outbrief Interface

• Risk Manager attends post simulation outbrief
• Available for immediate consultation
• Ability to determine risks needing follow-up
  – Regulatory review
  – Policy and procedure
  – Education
• Helps support risk management exposure and credibility
Litigation Illustrative Support

- Ability to utilize manikins to provide a visual illustration of care defending
- Illustration can be videotaped or conducted live

In Situ Shoulder Dystocia Simulation Programs Resulted in Fewer Adverse Neonatal Outcomes and Improved Team Responses to This Emergency

Jane Uhlir, MD, Executive Director, InSytu

Background

- Shoulder dystocia complicates 1.5 – 2.5% of vaginal deliveries.
- Any given practitioner will not experience these very often.
- It’s estimated about half of these can not be anticipated.
- Neonatal adverse outcomes include brachial plexus injuries, humerus and clavicular fractures, NICU admissions, hypoxic ischemic encephalopathy or death.
Impetus for Shoulder Dystocia Simulation Program

• Prompted by Risk Management due to a historical cluster of adverse neonatal outcomes from shoulder dystocias.

• We designed a quality improvement program for in situ shoulder dystocia simulations. This was sequentially instituted at each of the four hospitals with Obstetrical Services in the Swedish Health System between 2012 – 2014.

Why Simulation for Shoulder Dystocia?

• Current ob-gyn, family medicine, and midwifery training programs teach techniques for managing shoulder dystocia, often using simulators in a classroom or a lab to demonstrate techniques.

• In situ simulation can refine technical aspects of management plus standardize the unit’s approach to this emergency, while enhancing safe teamwork & communication in their own L&D environment.

Objectives for the Simulation Program

1. Develop common definition of shoulder dystocia.

2. Have a standardized team approach to this emergency across the system.

3. Describe the main maneuvers for managing shoulder dystocia.

4. Know the important information to be recorded in the medical record after a shoulder dystocia and **ALWAYS** use the EMR Dystocia template.
Simulation Format for Dystocia

- Learning module sent out to participants in advance.
- Simulations are done during non-clinical time; each registers electronically in their appropriate role.
- Simulations carried out in a L&D room, within each individual hospital.
- Short pre-brief: Review of approach & maneuvers.
- Hybrid mannequin.
- Debrief as we go.
  - For muscle memory.
  - Scripting & refining tactful communication.

Simulations Used this Standardized Approach

**State the problem:** LIP – “Shoulder dystocia, stop pushing”
Remain calm – keeps the room calm.

**Discourage pushing / Coach breathing!** Then call for help: 1st RN – “Shoulder dystocia” (get repeat back from unit secretary who answers the call; this triggers “pages” for OB back-up team and Neo team responders).

**Cumulative Time:** When a 2nd RN enters, they become the documenter & call out every 30 seconds (30, 60, 120…).

**Initiate maneuvers:** Consider posterior arm first or after McRoberts or Gaskin (all four) if no epidural; follow with other maneuvers as needed, calling them out while attempting.

**KEY:** No maternal pushing or practitioners downward guidance until dystocia has resolved.

Documentation – Key in Decreasing Liability

**Always Use Template**

<table>
<thead>
<tr>
<th>Shoulder Dystocia</th>
<th>Completed by Provider: Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time started:</td>
<td></td>
</tr>
<tr>
<td>Time finished:</td>
<td></td>
</tr>
<tr>
<td>Maternal position:</td>
<td></td>
</tr>
<tr>
<td>Neonatal position:</td>
<td></td>
</tr>
<tr>
<td>Maternal pushing:</td>
<td></td>
</tr>
</tbody>
</table>

RN completes times, Apgars, guidances. Should only enter: “Shoulder dystocia, see provider’s note” (no separate RN delivery note).
LIP completes green area plus a detailed delivery note.
Data Assessment Pre- and Post-Simulation

- Standardized approach for emergency response
- Maneuvers
- Documentation
- Adverse neonatal outcomes:
  Defined as Apgar <7 at 5 min., NICU admission, brachial plexus palsy, humerus or clavicle fracture, hypoxic ischemic encephalopathy with or without cool cap therapy or neonatal death

Results

<table>
<thead>
<tr>
<th></th>
<th>12 mo PRE-SIMULATION</th>
<th>12 mo POST SIMULATION</th>
</tr>
</thead>
<tbody>
<tr>
<td># Vaginal Deliveries</td>
<td>5784</td>
<td>6121</td>
</tr>
<tr>
<td># Shoulder Dystocias</td>
<td>153 (2.6%)</td>
<td>189 (3%)</td>
</tr>
<tr>
<td>Documented Time</td>
<td>155 (75%)</td>
<td>169 (89%)</td>
</tr>
<tr>
<td>Posterior Arm Attempted</td>
<td>46 (40%)</td>
<td>124 (66%)</td>
</tr>
<tr>
<td>Pertinent Negatives: No Pushing/No Fundal P.</td>
<td>90 (38%)</td>
<td>151 (80%)</td>
</tr>
<tr>
<td>Adverse Neonatal Outcomes</td>
<td>24 (55%)</td>
<td>15 (8%)</td>
</tr>
</tbody>
</table>

Conclusions

In situ simulation programs with a standardized team approach to managing shoulder dystocia resulted in:

- Identified communication, systems, and process improvement opportunities, which were addressed
- Follow-up data show improved response to "Shoulder Dystocia" as a quickly identified emergency, resulting in improved neonatal outcomes and better documentation.
- Teams have developed greater confidence in their ability to manage shoulder dystocia.
- Avoiding adverse neonatal outcomes also has medico-legal and financial benefits.
Thank you!
CASE LAW UPDATE

Hyde v. UW Medical Center
Pre-suit notice requirement

- Facts:
  - UW Medical Center, State of Washington, and UWP sued for alleged medical negligence of physician practicing at UW Medical Center
  - Physician was member of UWP; all UWP members are UW School of Medicine faculty members (UWSM); UWP exclusively provides physician services to UWMC

- Procedural Background:
  - Defendants move for summary judgment for Hyde's failure to meet pre-suit requirements of RCW 4.92.100 and .110
  - Summary judgment granted for all defendants except UWP
  - UWP appeals, contending it is "arm of the state" and pre-suit requirements apply

- Court of Appeals REVERSES:
  - UWP effectively a "functional arm of the state" and subject to pre-suit requirements
    - UWP operated and managed by UW
    - UWP physician salaries set by state-funded UWSM
    - UWP activities expose state funds to liability

Statute of Limitations in Wrongful Death

• Facts:
  – Fasts sue for personal injuries of Mrs. Fast and wrongful death of their son due to medical negligence.
  – Serve defendants with request for mediation.
  – File suit more than 3 years after death of son.

• Procedural Background:
  – Defendants’ MSJ granted on grounds that healthcare statute does not apply to wrongful death cases; therefore filing was untimely.
  – Limitations statute applicable to a wrongful death action is the general tort limitations statute, RCW 4.16.080.

• Court of Appeals AFFIRMS:
  – General tort 3-year statute, not healthcare statute of limitations, applies to wrongful death claims based on medical negligence.
  – Therefore, no tolling with mediation requests in wrongful death.

Volk v. DeMeerleer

Mental healthcare professionals’ duty to protect third-party victims from harm

Facts:
• Bipolar patient killed his former girlfriend, her child, and himself.
• History of suicide and homicide ideation.
• Patient last seen by psychiatrist 3 months prior to incident:
  – Noted to have unstable mood; reported suicidal thoughts, but no plans to act. Homicide ideation apparently neither reported nor assessed.
• In months and days leading up to homicide, family and friends saw no indication of plans to commit homicide/suicide.

• Procedural Background:
  – Defendants’ MSJ granted
  – Doctor had no duty to victims because they were not identified by patient.

Volk v. DeMeerleer (cont’d)

Court of Appeals REVERSEs

• Trial court erred in dismissing negligence claim re failure to properly assess for homicide ideation and warn victims:
  – Patient’s victims were reasonably foreseeable here.
  – Issue of fact as to whether doctor violated duty owed to victims.
• Duty of mental healthcare providers:
  A) Involuntary commitment of patient:
    - Duty only to protect victims identified by patient.
  B) Outpatient treatment:
    - Duty to protect all reasonably foreseeable victims.

*Employees may be liable for employee health care practitioners’ failure to provide adequate protections to these third parties.

*Threats conveyed to outpatient or inpatient staff should be immediately reported to the patient’s mental health care provider.
Grove v. PeaceHealth
“team negligence”
Facts: • Raymond Grove develops compartment syndrome after heart surgery.
Procedural Background: • Plaintiff’s trial theory: The “team” that treated him after surgery was negligent; plaintiff relies on testimony from treating physicians as to “team” approach.
• Plaintiff experts testify that team leader was negligent, and negligence “continued” with subsequent providers. Opine that team leader ultimately responsible.
• Plaintiff verdict.
Judge grants hospital’s judgment as a matter of law: Where a hospital operates with team treatment provided only by the hospital employees will always be liable under respondeat superior where an employee is negligent within the scope of their employment. But a plaintiff is still required to prove negligence on the part of the particular employee.

Grove v. PeaceHealth (cont’d.)
Court of Appeals AFFIRMS:
• A “team” of healthcare providers is not a healthcare provider and does not belong to a profession or class.
• By not implicating a particular individual, Grove failed to prove the standard of care for the relevant healthcare provider.
Supreme Court REVERSES:
• Expert testimony was sufficient to support verdict.
• Experts identified leading surgeon as individually negligent and “ultimately responsible,” and testified that negligence continued with transfer of care to two other physicians.
• In dicta: “Hospital medical team...could constitute yet another type of ‘entity’.”
  Opens the door for hospital liability for “team negligence” claims and physician liability as “team leader” for negligence of other care providers.

Medical Malpractice Verdicts and Settlements Report
• 2014: – 32 reported verdicts/settlements
  • 17 defense verdicts
  • 12 settlements
  • 3 plaintiff verdicts
• 2015: – 10 reported verdicts/settlements
  • 9 defense verdicts
  • 1 settlement for $2M (failure to diagnose)
PRACTICE TIPS

Defense Strategy with Multiple Providers

- Wherever possible, it is important to present a united defense.
- This is best achieved by cooperation of counsel, sharing of information where appropriate, and adequate communication/prep work with treatment providers involved in the matter.
- The goal is to have:
  - Uniform understanding and presentation of the incident and care provided.
  - Consistent provider testimony.
  - Consistent, comprehensive, non-duplicative expert testimony.

EMTALA and Urgent Care

- Hospital-owned urgent care on hospital campus with dedicated ER – does EMTALA apply?
  - Yes. Applies to patients seeking emergency care anywhere on the hospital campus, including parking lot (excluding private offices/nonmedical shops or entities participating separately under Medicare). See definitions at 42 CFR 489.24 (b).
- Movement within the hospital, including from on-campus urgent care to ER, is not a “transfer.”
  - However, intra-hospital movement of emergency patients should be done consistently (for the same medical conditions) and regardless of patient’s ability to pay. Qualified medical personnel need to accompany the patient from urgent care to ER.
Physician Use of Hospital Equipment

  - Product liability suit regarding complications following robotically assisted prostatectomy. Plaintiff alleged that device maker owed a duty to warn both surgeon and hospital of potential complications. Trial court and Court of Appeals disagreed with plaintiff.

- Holding: Manufacturers of "unavoidably unsafe products" only have a duty to warn to a physician. No duty to warn the hospital (despite the fact that it is the purchaser/owner of the equipment).
  - Hospital is not a "learned intermediary" to which duty to warn attaches under WPLA.

- Hospital Practice Tips:
  - Understand the relative risks associated with new equipment.
  - Be diligent in keeping up to date on manufacturer warnings and training materials for all equipment.

Breach Definition Under HIPAA HITECH

- An impermissible use or disclosure of PHI is presumed to be a breach unless entity can show a low probability that the PHI has been compromised, based upon a risk assessment of at least the following factors:
  - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification,
  - The unauthorized person who used the PHI or to whom the disclosure was made,
  - Whether the PHI was actually acquired or viewed, and
  - The extent to which the risk to the PHI has been mitigated.

- Burden on entity to prove, with documentation, that PHI disclosure did not amount to a breach.

Breach Notification Under HIPAA HITECH

- Notice to Individuals – Mandatory
  - Regardless of the number of individuals affected.
  - Generally via first-class mail, or e-mail if patient agreed to e-mail notice.
  - Without reasonable delay and no later than 60 days after discovery.

- Notice to Secretary – Mandatory
  - 500+ individuals: must notify without reasonable delay and no later than 60 days after discovery.
  - Fewer than 500 individuals: must notify no later than 60 days after the end of calendar year in which breaches are discovered.

- Notice to Media – Mandatory with More than 500 Individuals
  - Must be without reasonable delay and no later than 60 days after discovery.
Breaches are EXPENSIVE.

- Mandatory civil penalties, calculated based upon the level of culpability.
- Notwithstanding civil penalties, breaches are extremely costly:
  - In the US healthcare industry, the average cost is $398 per patient.
  - Across all regulated industries, average per capita cost is $17.
  - In 2015, companies with data breaches involving fewer than 10,000 records spent an average of $4.7M, and those with loss/theft of more than 50,000 spent an average of $11.9M.


Examples of Recent HIPAA Breach Settlements

- June 23, 2014 – Settlement of $800,000
  - Entity employee left 71 boxes of medical records (5,000 – 8,000 patients) unattended in the driveway of a physician’s home.
- May 7, 2014 – Settlement of $4,800,000
  - ePHI of 6,800 individuals inadvertently made accessible on Internet search engines.
- April 22, 2014 – Settlement of $1,725,220
  - Unencrypted laptop with patient information stolen.
- March 7, 2014 – Settlement of $215,000
  - ePHI of 1,581 individuals inadvertently moved to publicly accessible server.
- August 14, 2013 – Settlement of $1,215,780
  - ePHI of up to 344,579 individuals disclosed when photocopiers with stored data were returned to photocopier leasing agency.
- July 11, 2013 – Settlement of $1,700,000
  - ePHI of 612,402 individuals accessible to unauthorized individuals over the Internet.

Pharmacy Quality Assurance Commission

Hospital Compliance and Investigation Issues

- PQAC governs hospital pharmacies.
- At present, hospitals may dispense 48 – 96 hours of pre-packaged emergency medications to patients discharged from the ER if no other pharmacy is open or available to the patient.
- The hospital pharmacy license can include hospital-owned clinics.
  - In the wake of the 2012 Massachusetts compounding deaths, PQAC has taken steps to increase the oversight and regulation of compounding in hospital pharmacies.
    - PQAC is specifically taking an aggressive approach with respect to compounding in hospital pharmacies.
    - This includes investigating a pharmacist’s personal license when a hospital pharmacy’s policies and procedures are evaluated for compliance.
- Practice tips:
  - Keep policies and procedures up to date and make sure they reflect current WACs.
  - Keep documents organized and readily available for surprise inspections.
Takeaways from 2014-2015 Cases


Pre-suit notice requirements (RCW 4.92.100 and .110) apply to both the State and “functional arms of the State,” such as Harborview and UWP. Ask whether a suit against a particular entity is effectively a suit against the State. If so, pre-suit notice requirements likely apply.


The general tort three-year statute of limitations applies to wrongful death cases, including those based in medical negligence. Mediation requests do not toll the statute.


RCW 71.05.120 does not apply outside of the context of involuntary commitment. The duties of mental healthcare providers to third party victims are: (1) in the involuntary commitment context, mental healthcare providers have a duty to protect only those victims identified by the patient; (2) in the outpatient context, mental healthcare providers have a duty to protect all reasonably foreseeable victims.


Sufficient evidence to support a plaintiff’s verdict found in this case where plaintiff’s experts testified that negligence started with the “team leader,” “continued thereafter” with other providers, and that team leader was “ultimately responsible.” Plaintiffs may attempt to use this case to support a theory of negligence against a singular “team” entity. This may also lead to claims that a “team leader” is responsible for the care provided by subsequent individual providers and care provided outside of a so-called team leader’s presence.


Admission of past collateral payments pursuant to RCW 7.70.080 is permissible, and does not violate any separation of powers principles. Separation of powers principles are implicated where a statute conflicts with a formal court rule. The common law collateral source doctrine, however, is not a formal court rule, and therefore, admitting collateral source payments pursuant to RCW 7.70.080 is no violation of separation of powers principles.
Practice Tips

A. EMTALA and Urgent Care

- Hospital-owned urgent care on hospital campus with dedicated ER – does EMTALA apply?
  - Yes. Applies to patients seeking emergency care anywhere on the hospital campus, including parking lot (excluding private offices/nonmedical shops or entities participating separately under Medicare) See definitions at 42 CFR 489.24 (b).

- Movement within the hospital, including from on-campus urgent care to ER, is not a “transfer.”
  - However, intra-hospital movement of emergency patients should be done consistently (for the same medical conditions) and regardless or patient’s ability to pay. Qualified medical personnel need to accompany the patient from urgent care to ER.

B. HIPAA HITECH – Breach & Notification

- Breach presumed with disclosure of PHI unless it is determined that there is a low probability that PHI has been compromised upon completion of a risk assessment and consideration of at least the following:
  - The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
  - The unauthorized person who used the PHI or to whom the disclosure was made;
  - Whether the PHI was actually acquired or viewed;
  - The extent to which the risk to the PHI has been mitigated.

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    - Fewer than 500 individuals: must notify no later than 60 days after the end of calendar year in which breaches were discovered.
  - Notice to Media – Mandatory with More than 500 Individuals
    - Without reasonable delay and no later than 60 days after discovery.
Aside from civil penalties, breaches are extremely costly. The average cost in responding to a breach is $398 per individual exposed.

C. Physician Use of Hospital Equipment

Manufacturers of “unavoidably unsafe products” (includes many medical devices) only have a duty to warn/train the physician. No duty to warn the hospital, despite the fact that it is the purchaser/owner of the equipment. See Taylor v. Intuitive Surgical Inc. (Wash. Ct. App. July 7, 2015).

- Hospital is not a “learned intermediary” to which duty to warn attaches under WPLA.

- Hospital Practice Tips:
  - Understand the relative risks associated with new equipment/devices.
  - Be diligent in keeping up to date on manufacturer warnings and training materials for all equipment.

D. Pharmacy Quality Assurance Commission – Compliance and Investigations Issues

- PQAC has recently shifted focus to the heavy regulation of hospital pharmacies.
  - Specifically, PQAC is taking an aggressive approach with respect to regulation of compounding in hospital pharmacies. This includes investigating the head pharmacist’s personal license when a hospital pharmacy’s policies and procedures are evaluated for compliance.

- Hospital/Pharmacy Practice Tips:
  - Keep policies and procedures up to date and make sure they reflect current WACs.
  - Keep documents organized and readily available for surprise inspections.
Psychiatric Boarding & Other Hot Topics in Behavioral Health

Eric J. Neiman
Lewis Brisbois Bisgaard & Smith | Portland, OR
September 25, 2015

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The Friday Night Patient
The Friday Night Patient
- A 30-year-old patient has been brought in by family.
- She is psychotic and threatening to kill her mother.
- Her behavior is escalating; security is present.
- She is refusing medications and wants to leave.

The Friday Night Patient
- There are no psychiatric treatment beds available in the community.
- The court commitment investigator has been called but has not arrived to assess the patient.

The Friday Night Patient
- Can you
  - Hold the patient?
  - If so, on what authority?
  - Involuntarily medicate?
  - Restrain?
Increasing Need/Decreasing Funding
United States 1955 – 2005

US Population
+64%

State and County Psychiatric Beds
-91%

US Psychiatric Beds per 100,000
1955 – 2005

130
340
50
150
250
350
450
1955
2005

Increasing Need/Decreasing Funding
United States 2005 – 2010

US Population
+4.7%

State Psychiatric Beds
-14%

Thirteen states closed 25% or more of their total state hospital beds
2009 – 2012: Mental Health Spending Cut

- $4.35 billion
- Trend expected to continue

National Association of State Mental Health Program Directors, Congressional briefing, March 22, 2014

Psychiatric and Medical Patients Use the Same Space and Staff

TRIAGE

Physician Evaluation

Psychiatric Condition

Medial Condition

Psych Social Worker or Under Arrangement

Admit to Hospital or Transfer to Hospital

The EMTALA impact

- “In the case of psychiatric emergencies, if an individual expressing suicidal or homicidal thoughts or gestures, if determined dangerous to self or others, would be considered to have an EMC.”
- “Psychiatric patients are considered stable when they are protected and prevented from injuring or harming him/herself or others.”
- EMTALA Interpretive Guidelines, § 489.24(d)(1)(i), Appendix V of State Operations Manual

“Psychiatric boarding”

“The phenomenon of persons with mental disorders remaining in the hospital emergency rooms while waiting for mental health services to become available.”


“Boarding” mentally ill becoming epidemic in state

TIMES WATCHDOG: Far more involuntarily detained patients are stuck in chaotic hospital EDs and ill-equipped medical rooms. They wait days, even months, for treatment. The practice traumatizes thousands of mentally ill residents, wreaks havoc on hospitals, and wastes millions of taxpayer dollars.

by Dennis L. Fowler
Seattle Times staff reporter

Matthew Jones stripped off his clothes, kicked over a trash can and ran into Kihlman's Juiceteria

All Stacked Up And No Place To Go

Psychiatric patients are being overwhelmed in Portland's emergency rooms in growing numbers.
The Friday Night Patient

- Can you
  - Hold the patient?
  - If so, on what authority?
  - Involuntarily medicate?
  - Restrain?
In the Matter of the Detention of DW

“We affirm the trial judge’s ruling that the ITA does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.”

Detention of D.W. v. The Department of Social & Health Services, 181 Wash. 2d 201, 332, p. 3d, 423 (2014)

Immunity Under Civil Commitment Laws

• No liability for acts in good faith and supported by probable cause pursuant to civil commitment laws

• ORS 426.335 – Oregon Revised Statutes

• RCW 71.05.120 – Revised Code of Washington

Duty to Protect Individuals and Public

• Threat to specific individuals

• Tarasoff v. Regents of the University of California

• Laws in some states require warning
Duty to Protect Individuals and Public

- Washington Court of Appeals
- Mental health provider can be liable to victims of violence by patient—even if patient did not make specific threat to harm victims

Other Hot Topics

- Legislation
- Reimbursement
- New facilities
- Provider shortage
- Federal enforcement

Behavioral Health and Other Rumblings From JPMorgan 2015

"After conversations with numerous health care private equity funds and lenders at the JPMorgan Healthcare Conference, we can report that the behavioral health sector continues to generate a great deal of buzz. In addition to some of the widely reported multifacility large investments, there is much more interest from funds in serial acquisitions of discrete facilities or operations," say attorneys with McGuireWoods LLP.

Other Hot Topics

- Consent and surrogate decision making
- Telepsychiatry
- Children’s mental health
- Geropsych
- Corrections mental health

More Questions?

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Thank you!
ONLINE COURSES

- Balancing Risk with the Noncompliant Patient: Tools and Techniques to Promote Accountability and Improve Documentation
- Current Issues in Health Care Risk Management
- Dangers of the EMR for Urologists: Increasing Patient Safety and Lowering Liability
- Don't Leave Me Standing Here Alone: Making the Case for Peer Support
- HIPAA Maintenance: Daily Habits for the Health Care Team
- HIPAA Maintenance: Document Control and Quality Improvement
- How Risky is Your EHR? Improving Patient Safety
- Images of Liability: Risk Management in Radiology
- Informed Consent: More Than Just a Form
- Language and Cross-Cultural Communication: Overcoming the Barriers
- Managing Category II Fetal Heart Rate Patterns: A Standardized Approach
- Patient Complaints and Service Recovery: Strategies for Successfully Handling Customer Satisfaction Issues
- Prescription Monitoring: Time-saving Strategies for Using a Life-saving Resource
- Recapturing the Basics: Risk Management Essentials for Medical Practices
- Recognizing and Responding to Addiction During Chronic Pain Treatment with Opioids
- Risk Analysis of PHI Related to Stage II Meaningful Use
- Risk Management Essentials for the Laboratory
- Risk Management Tips for EMR
- Safeguarding Your Practice: Understanding the Final HIPAA-HITECH Rules
- Shared Decision Making in Chronic Pain Management: Achieving Goals and Positive Health Outcomes
- Social Media: Patient Engagement and Professional Risk
- Sports Concussions: Where Are We Now?
- TeamSTEPPS: Tools and Strategies for the Emergency Department
- Teamwork, Communication, and Patient Safety in the Emergency Department: Case Studies
- Transitioning Care in the Face of Painkiller Addiction or Abuse
- The Medical Quality Assurance Commission Pain Rules: What Washington State Physicians Need to Know... and All Prescribing Physicians Will Benefit From
- VBAC Revisited: Avoiding the Swinging Pendulum

LIVE SEMINARS

- Apology and Disclosure Coach Training
- AVERT: AdVerse Event Response Training
- Leading Well™: Promoting Clinician Resilience and Patient Safety through Provider Support
- Medicine and the Courtroom: The Reality of Medical Care and Malpractice
- The Coach Approach: Transform Your Practice Through Lasting Behavior Change
- Tools for Your Team: Equipping Your Staff to Improve the Patient Experience (Not certified for Category 1 credit)
Not on our watch

You may know first hand that cyber crime is real. And when it hits health care, it is not just about theft of financial data, but also about identity, insurance information, personal health records, HIPAA violations, and more. To protect this sensitive data, you are in an ongoing race to stay ahead of the bad guys.

Learn from the experts when you join us for a half-day seminar on the growing risks of cyber crime as it relates to health care security. Featuring Tim Wallach, supervisory special agent for the FBI assigned to lead the Cyber Task Force in Seattle, this event is suitable for clinicians, IT professionals, and administrators responsible for patient privacy. It will conclude with a panel of experts responding to your questions and sharing information about insuring against breaches.

CyberWatch for Health Care Organizations
October 22, 2015
Talaris Conference Center
Seattle, WA 98105
8:00 AM - 11:30 AM

FREE REGISTRATION:
This is a free educational event for the local medical community, suitable for those responsible for the data security of their medical office or hospital. To register, visit www.phyins.com/CyberWatch