AHLA

VOLUME 21 ISSUE 1 March 2019

Hospitals & Health Systems Rx

A Publication of the American Health Lawyers Association
Hospitals and Health Systems Practice Group

Table of Contents

Emergency Care, Urgent Care, and Walk-In Care: Drawing Distinctions Among Care Settings

Christine Burke Worthen
Northern Light Health

Since the passage of the Affordable Care Act, much attention has been paid to the shift to value-based reimbursement. The concept of value-based reimbursement focuses on the cost and quality of health care services. Low-cost, high-quality services are the ideal; low-quality services and high health care costs coupled with a proliferation of high deductible plans are motivators for change. As part of the transformation, many payers and providers are educating health care consumers about the cost variances that come into play when seeking care. Encouraging health care consumers to get care at the right place has sparked a rise in urgent care centers and walk-in clinics, as well as an educational push to help consumers understand the high costs associated with care in an emergency department.[1] As hospitals and health systems look to encompass patient care across the continuum, many have reshaped their service lines to add, for example, extended primary care office hours and urgent care facilities. In doing so, providers must differentiate among the various care settings as they look to reduce unnecessary emergency department visits and promote access to care in the "right" setting. It is also vital that providers stay educated on legal obligations and reimbursement nuances related to these different care settings.

Hospital emergency departments have traditionally been the destination for patients needing care for an injury or an illness that is life threatening or for an issue that is not life threatening, but they have nowhere else to go. Hospital emergency departments are notorious for being high-cost care settings. They are subject to strict regulations, including Medicare Conditions of Participation[2] and the Emergency Medical Treatment and Labor Act (EMTALA).[3] EMTALA requires anyone coming to an emergency department to be stabilized and treated regardless of insurance status or ability to pay.[4] As more and more patients purchase high deductible health plans, the proliferation of bad debt from emergency department care continues to grow. Hospitals and health systems alike have taken note, and many have embarked on a path to provide access to services for patients who are not in need of emergency department-level care but might otherwise have still gone to the emergency department. Such paths include extended hours for primary care, urgent care, and walk-in care.

Extended hours for primary care is the simplest concept to grasp as it merely takes an existing service line and extends its hours or open days. While the concept may be simple, reimbursement for office visits can vary depending on the payer. For hospitals and health systems with a provider-based status, Medicare pays a professional fee and a technical fee for the visit, as the patient is considered an outpatient of the hospital. The professional fee reimburses the hospital for the services of the physician, while the technical component reimburses the hospital for the facility overhead. The combined total is generally higher than if the service was furnished in a freestanding physician office. Some commercial payers have sought to eliminate this discrepancy by requiring hospitals that acquire physician practices that have provider-based status for Medicare purposes to bill the office visits as if they were freestanding physician offices. This is generally done via a policy requiring office visits to be globally billed on the Centers for Medicare & Medicaid Services (CMS) 1500 form rather than being split billed. While there may be variances in the reimbursement and patient cost sharing for these visits, access to extended primary care office hours is much more cost effective than a visit to the emergency department.

In addition to extended hours for primary care, many hospitals and health systems have opened urgent care centers. Urgent care centers provide the opportunity to alleviate crowded emergency departments while offering consumers a lower-cost alternative to their care needs when their primary care provider's office is not an option or they need services not provided onsite at that office (e.g. onsite x-rays or laboratory services). For many hospitals and health systems, urgent care is not meant to rise to the level of emergency department care. Nevertheless, careful attention must be paid to EMTALA when structuring an urgent care center model as the EMTALA regulations define "hospital with an emergency department" to mean a hospital with a dedicated emergency department.[5] In turn, the regulations define "dedicated emergency department" as any department or facility of a hospital that either (1) is licensed by the state as an emergency department; (2) is held out to the public as providing treatment for emergency medical conditions; or (3) in the preceding calendar year actually provided treatment for emergency medical conditions on an urgent basis on one-third of the visits to the department.[6] Further, one federal court found that EMTALA covered a hospital-owned urgent care center as it noted that a person driving by needing emergency care would not check the website first and based on the signage would not distinguish "urgent" care from an emergency medical condition.[7] The court found that the urgent care center was a dedicated emergency department for EMTALA purposes since individuals would conclude that it was an appropriate destination for emergency care.[8] Before using the name "urgent care" to define/market a service line, hospitals and health systems should examine the services that will be offered, the branding and marketing of those services, and the potential public perception to make an informed decision regarding EMTALA's applicability. Moreover, commercial payer contracts and policies should be reviewed to determine the expectations around billing and whether services will be bundled. For Medicare and many commercial payers, urgent care is billed with a place of service 20. However, we have seen instances where a payer treats urgent care as an office visit with a place of service 11.

Some hospitals and health systems also are embracing the concept of walk-in care to ensure access. For some providers, walk-in care is simply akin to extended physician hours; for others, walk-in care provides services that would be expected in an urgent care setting. Walk-in care also can describe care provided in retail clinics. Again, careful attention should be paid to the service provided and the expectations of payers that reimburse for the services.

The evolution in care settings coupled with changing reimbursement, more patient financial responsibility, and the advent of consumerism in health care continues. As hospitals and health systems look to redesign their service lines and promote access to care, they must decide on the service-level offerings and consider the regulatory and reimbursement impact as they launch and market those offerings. Moving the less acute patients out of the emergency department will, of course, free up spots for the more acute patients, but it also will serve to provide patients and providers the opportunity for care delivery in a less expensive, less intrusive manner, which should in turn improve the patient experience.

---

1 Brian Zimmerman, *The Rise of Urgent Care: 5 Findings and Statistics,* Beckers Hosp. Rev., Mar. 7, 2016, https://www.beckershospitalreview.com/quality/the-rise-of-urgent-care-5-findings-and-statistics.html.
2 Program Integrity: Medicaid, 42 C.F.R. § 455.
3 42 U.S.C. §§1395dd.
4 *See id.*
5 42 C.F.R. § 489.24(b).
6 *See Id.*
7 *Friedrich v. South County Hosp. Healthcare*, 221 F. Supp. 3d 240 (D.R.I. 2016).
8 *See id.*

Consent for Treatment in Pediatric Health Care

Rachel J. Freyman
Kutak Rock LLP

It is generally well known that consent to provide medical treatment must be obtained for all patients, and a provider who renders nonurgent medical care to a patient without proper consent may be exposed to significant professional and legal claims. It is also well known that typically consent of a minor's parent or legal guardian is usually required before rendering nonurgent medical care to a minor (an individual under the age of 18 years old). However, minors in need of medical care often present alone or with someone other than the minor's custodial parent or legal guardian, causing confusion and uncertainty regarding whether appropriate consent has been obtained. When navigating these types of scenarios, three questions help provide a general framework for determining whether proper consent to treat has been or can be obtained for a minor patient.

First, can treatment be rendered without parental consent based on the status of the minor or treatment being sought? Consider the status of the minor. Many states afford minors with a particular status the ability to consent to all medical care on behalf of themselves. For example, in many states married minors and those legally emancipated may consent based on their status as married or emancipated.[1] If the status of the minor does not allow the minor to consent to all treatment, consider what specific treatment is being sought. There are particular types of services that do not require parental consent in many states, such as treatment rendered in connection with pregnancy, sexually transmitted disease, contraceptives, or sexual abuse.[2] In addition, minors who can understand and appreciate the consequences of a proposed treatment can consent to certain medical care in many states.[3]

Second, if parental consent is required, has parental consent already been obtained or can it practically be obtained? Consider whether prior authorization has been obtained. If the minor's parent or legal guardian has signed a consent form authorizing treatment to be rendered by the provider without the parent or legal guardian being present, additional parental consent may not be required before rendering care to the minor. If no prior authorization has been obtained, consider whether consent from the parent or legal guardian can be obtained by a means other than being physically present, such as by telephone. In these instances, all attempts to contact, and all discussions with, a minor's parent or legal guardian regarding consent should be documented in the minor's medical record. A copy of any consents executed by the minor's parent or legal guardian also should be kept in the minor's medical record.

Finally, if parental consent has not previously been or cannot presently be obtained, is there an individual present with the minor who can legally consent on behalf of the minor? The law in many states allows certain individuals other than the minor's parent or legal guardian to consent for the minor, including persons standing *in loco parentis*, adult siblings, and grandparents, under certain circumstances.[4] In this case, rendering treatment may be appropriate once proper consent is obtained from the individual with authority. However, reasonable steps should be taken to verify the relationship of the individual to the minor, such as dated signature and photo identification. Documentation verifying the authority of the individual to consent for the minor's treatment also should be required and placed in the minor's medical record.

Though this general framework is helpful for determining whether proper consent to treat has been or can be obtained for a minor patient, ultimately, if there is any doubt, the provider should consider delaying nonurgent medical care until appropriate consent can be obtained from the minor's parent or legal guardian at a later time.

---

1 *See e.g.*, 410 Ill. Comp. Stat. 210/1; Ark. Code Ann. § 20-9-602.
2 *See e.g.*, Wis. Stat. § 252.11(1m); Ky. Stat. § 214.185.
3 *See e.g.*, 410 Ill. Comp. Stat. 210/1.5; Ark. Code Ann. § 20-9-602; Kan. Stat. Ann. § 38-123(b).
4 *See e.g.*, Ga. Code Ann. § 31-9-2; Fla. Stat. § 743.0645.

Physician Codes of Conduct—Creating a Culture of Safety?

Robert Fielder
Resolution Resources, LLC

Gary R. Clayton
Negotiate.Pro

Over ten years ago, The Joint Commission (TJC) called for a "Culture of Safety" with the release of their Sentinel Event Alert, Issue 40[1] and the 2009 Leadership Standards.[2] A key element of TJC's directive was the elimination of undesirable disruptive behavior (UDB). The result has been the proliferation of professional Codes of Conduct (COC) that define UDB as well as processes for management of UDB, usually delegated to a committee of the medical staff (Committee). With ten years of experience, now is a good time to assess the effectiveness of these COCs in fostering a culture of safety by reducing the incidence of UDB.

Making an assessment is challenged by a paucity of empirical data. Confidentiality has prevented the disclosure of the Committees' deliberations;[3] not even de-identified statistics on the number of complaints or interventions are available. This assessment of COC effectiveness is made based on media reports and anecdotes from conversations with chief medical officers, chief nursing officers (CNO), Committee leadership and membership, as well as front line doctors and nurses. Findings reveal that the adoption and enforcement of COCs has done little to reduce the incidence of UDB.

Individuals filing complaints, most often nurses,[4] are excluded from the UDB management process. They are not privy to the Committees' deliberations or evaluation of their complaints. Complainants are not told about actions, if any, taken by the Committee, and not asked about the suitability of any remedy proposed by the Committee. Many nurses reported that the only real feedback they received following the filing of a complaint came when the doctor they complained about confronted them. This lack of transparency can destroy trust and can lead to the degradation of confidence in the organization.[5] In many locations, nurses have ceased filing COC violation complaints. In other places, reports of COC violations continue unabated but the complaints cite repeated behaviors by the same physicians. CNOs interviewed believe this latent and simmering frustration will not stay hidden much longer. They insist that health care is just a tweet away from finding itself exposed to the #MeToo movement. An outcome many insist will severely impact the reputations of the country's health care executives and hospitals.[6] These findings suggest that TJC's call for a *culture of safety* is not being realized.

Nurse advocates want medical staffs and Committees to intervene with aggressive disciplinary action (e.g. quicker resort to suspensions and terminations of staff privileges).[7] In contrast, physician supporters argue that the stresses associated with the COC complaint process are adding to the unsustainable demands placed on already overburdened practitioners. They point to burnout among physicians,[8] growing shortages in critical specialties,[9] and question how patient care and safety can possibly be improved by forcing more doctors into early retirement. Given these competing pressures, it is urgent that management of UDB become more effective.

Why Are COCs Not Working?

The limitations of COCs, specifically the ineffectiveness of bans on unwanted behavior or actions, were suspected before TJC mandated them in 2009. In a 2002 survey of 142 hospitals, 90% reported having COCs, "but less than 50 percent felt they were effective."[10] Prior to 2009, medical errors, like UDB, were thought to be the fault of the health care professional.[11] A change in attitude came when TJC acknowledged that "to err is human,"[12] referring to the November 1999 Institute of Medicine report, *To Err is Human: Building a Safer Healthcare System*.[13] This realization noted that approaches and methods for making processes in health care safe are highly dependent on fallible humans. These approaches require "systems thinking" to compensate for the errors that are likely to be made.[14] "Rather than punishing the 'who', [for medical errors] the question has become what processes, or lack thereof, in the hospital, caused or enabled the human error."[15] Committee intervention predicated solely on COCs means we are still just asking who rather than also looking for what caused or contributed to the UDB.

What Can Be Done?

The COC complaint process can be characterized as "*peace keeping without peace making*."[16] Peace making requires an organizational dispute resolution system[17] (DRS) that would *prevent, recognize, and quickly recover*[18] from disruptive events. A DRS would include more elements than just a COC. To be more effective, the COC complaint process needs a wider array of interventions for dealing with UDB. Currently, Committees have only a few interventions to wit: referrals to Professional/Problem-Based Ethics (PROBE) courses,[19] psychological or psychiatric evaluations, and anger therapy. Some Committees designate member(s) of the Committee to counsel or coach the offending physician. Lack of training has limited the effectiveness of this approach; consequently, professional coaches are now being deployed more readily and can be an effective intervention.

Other intervention ideas can be gleaned from the list of adverse consequences from UDB in Sentinel Event Alert 40.[20] Damage to communication is on that list but it is much more than a consequence of UDB, it is the means by which all other adverse outcomes are realized. Restoring communication needs to become a priority; it is essential to get the offended and offender talking about the disruptive event and how their relationship can be restored.[21] Properly facilitated, these sessions can have a powerful impact on restoring team relationships and performance.

One example of intervention that successfully incorporates many of these concepts comes from a director of an intensive care unit (ICU). After hearing of a UDB event, the director conducts an investigation of the incident. Her investigation includes an effort to identify what *triggered* the physician's purported offensive behavior.[22] The search for a trigger should be included in any

DRS but too often triggers are not thoroughly examined out of concern that doing so is finding excuses for bad behavior, or worse yet, blaming the victim. By considering the trigger, the ICU director can look for performance or process deficiencies with personnel or procedures. The director then engages the offending physician, making it clear that the physician's behavior is unacceptable regardless of the circumstance or situation that might have preceded the outburst. The director offers the physician an opportunity to make amends by conducting in-service training for the ICU staff to address the specific situation that triggered the behavior.[23] Ideally, formalizing the ICU director's intervention strategy could become a type of *community service* intervention available to the Committee.

The doctors and nurse also can talk one-on-one. This should be done in a controlled setting best accomplished with the aid of a trained and neutral third party—yes, mediation.[24] Not the hard-nosed, distributive bargaining evaluative mediation many health care professionals have experienced in medical malpractice related cases. Rather, these situations call for facilitative or transformative mediation[25] designed to aid the parties in coming to an agreement while improving communication and preserving their working relationship.

What Is Preventing Improvement to COC Complaint Processes?

There is no sense of urgency; TJC's acceptance of the mere *presence* of a COC Policy as compliance with the Leadership Standard is one explanation for lack of improvement in COC complaint processes. "A second more disturbing barrier is that of tolerance and acceptance [of purported disruptive behavior]."[26] Hospital leadership has relied on the volunteer and part-time efforts of Committee members working behind closed doors to address complex workplace issues that could undermine factors critical to the hospital's success and survival (e.g., employee morale, nurse/physician recruitment/retention, physician engagement, and patient experience).[27]

Conclusion

The costs and consequences of UDB are rising. Nurses have lost faith in the process and medical staffs are losing patience. To reverse these trends, leadership must lend tangible support to the Committees. Counsels must lead in making the management of UDB proceedings more transparent to restore trust in the COC complaint process. Committees must deploy additional interventions to reduce UDB and promote communication. If not, it seems certain that growing unmet frustrations with the COC complaint process will result in a host of legal challenges and workplace issues (e.g., wrongful termination, hostile workplace, etc.) and TJC's "Culture of Safety" may never be fully realized.

---

1 TJC, *Behaviors That Undermine a Culture of Safety*, Sentinel Event Alert, no. 40, at 1 (July 2008).

2 Comprehensive Accreditation Manual for Hospitals: The Official Handbook; camh. Joint Commission on Accreditation of Healthcare Organizations (2009).

3 Alan H. Rosenstein, *Physician Disruptive Behavior; Five-year Progress Report*, World J. Clinical Studies 2 (Nov. 16, 2015).

4 Rick Gessler, RN, Alan Rosenstein, MD, MBA, and Liz Ferron, MSW, LICSW, *How to Handle Disruptive Physician Behaviors*, 7 Am. Nurse Today (Nov. 2012), http://www.physiciandisruptivebehavior.com/admin/articles/32.pdf.

5 Frank La Fasto and Carl Larson, When Teams Work Best: 6,000 Team Members and Leaders Tell What It Takes to Succeed (Thousand Oaks: Sage Publications, Inc. 2001).

6 Tara Bannow, *#MeToo Era Highlights Importance of Emergency CEO Succession Plans,* 48 Modern Healthcare 6 (Sept. 17, 2008); Rosenstein, *supra* note 3, at 4.

7 Karen Appold, *Tips for Working with Difficult Doctors*, The Hospitalist 5 (Dec. 2016).

8 Mike Drummond, *Physician Burnout: Its Origin, Symptoms, and Five Main Causes.* Family Practice Management 42 (Sept. 2015).

9 Elaine K. Howley, *What Can be Done about the Coming Shortage of Specialist Doctors?* US News & World Rep., May 2, 2018, https://health.usnews.com/health-care/patient-advice/articles/2018-05-02/what-can-be-done-about-the-coming-shortage-of-specialist-doctors.

10 Alan H. Rosenstein et al., *Disruptive Physician Behavior Contributes to Nursing Shortage Study Links Bad Behavior by Doctors to Nurses Leaving the Profession.*, 28 The Physician Exec. 8-11 (Nov. 2002).

11 Molia Sloanne Donaldson, PhD, MS, *Introduction to Chapter 3, An Overview of To Err is Human: Re-emphasizing the Message of Patient Safety, Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, Agency for Healthcare Res. and Quality (Apr. 2008).

12 Paul M. Schyve, M.D., *Leadership in Healthcare Organizations, A Guide to Joint Commission Leadership Standards, A Governance White Paper*, The Governance Inst. 4 (Winter 2009).

13 LT Kohn, JM Corrigan, MS Donaldson, *To Err is Human: Building a Safer Health System*, Committee on Quality of Health Care in America, Inst. of Med., Washington, DC (Nat'l Academies Press 2000), https://www.nap.edu/catalog/9728/to-err-is-human-building-a-safer-health-system.

14 Schyve, *supra* note 12, at 4.

15 *Id*. at 32.

16 Thomas Weber, *The Problems of Peace Making*, 1 Journal-Interdisciplinary Peace Res. no. 2 (1989).

17 Frank E.A. Sander and Robert C. Bordone, *Early Intervention: How to Minimize the Cost of Conflict, Negotiation—Decision-Making and Communication Strategies That Delivery Results*, A Newsletter from Harvard Business School Publishing and the Program on Negotiation at Harvard Law School (2005); Etty Liberman, Yael Foux Levy and Peretz Segal, *Designing an Internal Organizational System for Conflict Management Based on Needs Assessment*, Dispute Resolution J. (May/June 2009).

18 Molia Sloanne Donaldson, PhD, MS, *An Overview of To Err is Human: Re-emphasizing the Message of Patient Safety, Patient Safety and Quality: An Evidence-Based Handbook for Nurses, Chapter 3,* Agency for Healthcare Res. and Quality (Apr. 2008).

19 Catherine V. Caldicott and Joseph d'Oronzio, *Ethics, Remediation, Rehabilitation, and Recommitment to Medical Professionalism: A Programmatic Approach*, Ethics & Behavior (Oct. 2014), https://www.tandfonline.com/doi/full/10.1080/10508422.2014.930687.

20 *See supra* note 1, at 1.

21 Michael Redler, MD, *8 Tips on How to Deal with a Difficult Physician*, #5, Beckers Hosp. Rev., Mar. 28, 2011, https://www.beckershospitalreview.com/asc-turnarounds/8-tips-on-how-to-deal-with-a-difficult-physician.html.

22 Gerry Vassar and Diane Wagenhals. *Do You Know Your Anger Triggers*?, Lakeside, Lakeside Therapeutic School, Mar. 1, 2011, https://lakesidelink.com/blog/lakeside/do-you-know-your-anger-triggers/.

23 *See* Redler, *supra* note 21, at #7.

24 *Conflict Resolution: Mediation—How do We Mediate a 'Cease Fire Between Two Employees?* Soc'y for Human Resource Management (Aug. 20, 2013).

25 Jessica Katz Jameson, Andrea M. Bodtker, and Tim Linker, *Facilitating Conflict Transformation: Mediator Strategies for Eliciting Emotional Communication in a Workplace Conflict*, Negotiation J. 26 (Jan. 2010); Jim Hanley, *Transformative Mediation—Allow disputing parties to air grievances and come to their own solution*, Soc'y for Human Resource Management (Apr. 1, 2010).

26 Rosenstein, *supra* note 3, at 3.

27 J. Fortune, and D. White, 24 *Framing of Project Critical Success Factors by a Systems Model*, 24 Int'l J. Project Management 53-65 (2006).

Disaster Preparedness and Response: Five Focus Areas for Hospital and Health System Counsel

Miglisa Capo
Metro Pavia Health System, *Puerto Rico*

Charles E. Engeman
Ogletree Deakins PC, *U.S. Virigin Islands*

Andrea Ferrari
HealthCare Appraisers, Inc., *Florida*

Lynn Gordon
New Hanover Regional Medical Center, *North Carolina*

Emily Grey
Breazeale Sachse & Wilson LLP, *Louisiana*

Delphine O'Rourke
Duane Morris LLP, *Pennsylvania*

Gena Peyton
Sutter Health, *California*

Montrece McNeill Ransom*
Centers for Disease Control and Prevention, *Georgia*

Sarah Swank
Vermont

David Weil
Quorum Health, *Tennessee*

There are regular reminders that disaster situations pose special challenges for health care providers and, by extension, for their legal advisers. This article provides an overview of the types of questions that hospital and health system counsel may need to address in disaster situations. To learn more about these topics, please register for the Disaster Preparedness and Response Webinar Series at https://distancelearning.healthlawyers.org/products/disaster-preparedness-and-response-webinar-series-all-parts.

1. Decisions to Shelter-in-Place, Evacuate, and Repopulate

Although many states grant authority to the local government to order hospitals to evacuate, a hospital usually has a choice to evacuate.[1] Historically, voluntary hospital evacuations were rare occurrences.[2] Perhaps partly due to the lessons and litigation that followed Hurricane Katrina,[3] and perhaps partly due to the recent increase in frequency of potentially catastrophic and unmitigable disasters such as wildfires, voluntary hospital evacuations have become relatively common in recent years.[4] Sutter Health recently evacuated two of its facilities in northern California when faced with risks from the Tubbs Fire and Mendocino Complex Fire, respectively. Eight hospitals in the Florida panhandle were partially or fully evacuated in October 2018 based on damage assessments in the wake of Hurricane Michael.[5] Most recently, in November 2018, news reports were filled with harrowing images of patients being evacuated from Adventist Feather River Hospital in Paradise, CA, as smoke and flames enveloped the community around it.[6]

Some hospital counsel who have recently been involved in evacuation decisions have reported being surprised by the complexity of the legal considerations and implications that accompany these decisions. They've faced a cascade of questions relating to issues such as pharmaceutical handling, radiation safety, biohazard management, workplace and patient safety, and public health. State and local licensing and public safety regulations set certain standards that the facility must meet to continue or restore its operations, and may even set standards that it must meet if evacuated, since certain hazards, and personnel to monitor those hazards, will remain in the facility after patients are gone.

Occupational Safety and Health Administration (OSHA) regulations require that workplaces have emergency action plans that include, at a minimum: procedures to be followed by employees who remain to operate critical plant operations before they evacuate; procedures to account for all employees after evacuation; procedures to be followed by employees performing rescue or medical duties; and the name or job title of every employee who may be contacted by employees who need more information about the emergency action plan or their duties under the emergency action plan.[7] The newer Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Rule,[8] which was implemented in November 2017, echoes many requirements of the OSHA Emergency Action Plan Rule, but in some cases is more restrictive and applies more broadly with obligations to contractors and patients as well as employees.[9] Given that rules change over time and that disaster situations are relatively rare, familiarity with these rules may be limited and it may be a duty of counsel to ensure that applicable regulations are appropriately understood and implemented in the event of a decision related to evacuation.

Likewise, counsel may be called upon to negotiate and draft transfer and take-back agreements for the patients who will be evacuated; to negotiate and draft emergency supply, equipment, or staff leasing agreements to keep all or a part of the facility operating; and to prepare or interpret policies and procedures for assisting staff and discharged patients with medical and non-medical needs arising in the context of the extenuating circumstances created by the disaster and/or evacuation. Many of these asks will be time-sensitive and allow little opportunity for due diligence.

Thankfully, there are resources to assist counsel in preparing themselves for these types of duties and requests, including from The Joint Commission,[10] the Centers for Disease Control and Prevention,[11] CMS,[12] and state and local public health agencies.[13] There probably isn't a "one-size-fits-all" resource for questions related to evacuation, shelter-in-place, and repopulation, but there are common questions and considerations that counsel may anticipate, some of which are summarized in the following tables:

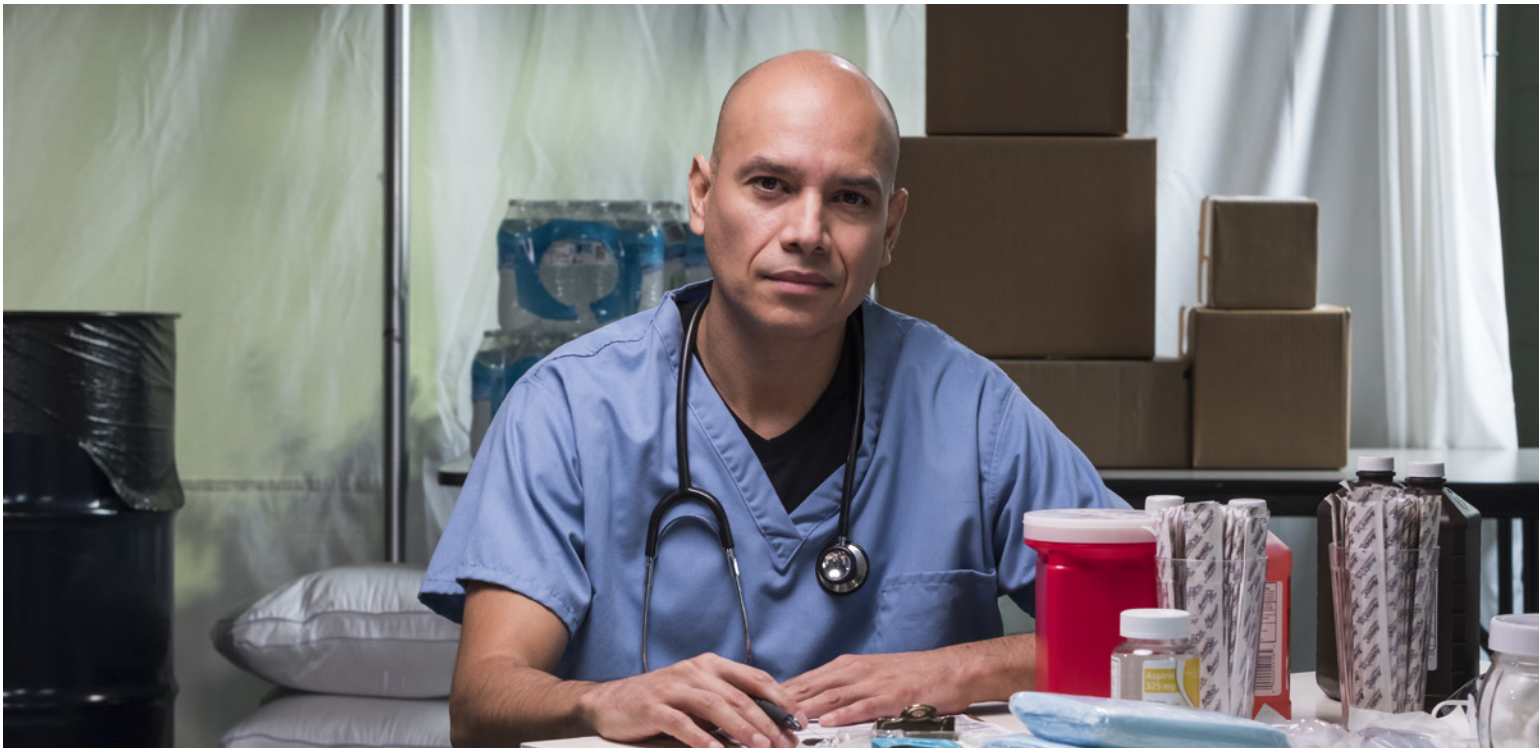
Legal Considerations in Voluntary Health Care Facility Evacuations:

- Will sheltering-in-place be detrimental to or cause unacceptable risks for patients, staff, workers, or visitors? Do these risks rise to the level of a breach of the hospital's duty of care?
- Do the timelines and resources support full evacuation or only partial evacuation? Consider:
  - Communication and existing arrangements with county/municipal EMS and law enforcement
  - State and local requirements for transport and accommodation of patients
  - Federal and state laws and regulations governing the actions and safety of staff and providers involved in evacuation activities
- If sheltering-in-place or repopulating after evacuation, what waivers or approvals are needed? Consider:
  - Section 1135 waivers for Medicare requirements[14]
  - Requirements of the CMS Emergency Preparedness Rule at 42 C.F.R. § 482.15
  - State and local facility-licensing requirements, which vary by jurisdiction. Consider:
    - Requirements of state/local public health agencies
    - Pharmacy boards
    - Hospital/laboratory/radiologic licensing agencies

SSA § 1135 Waivers

- Require Presidential declaration of disaster and declaration of public emergency by Secretary of Health and Human Services (HHS)
- Are not automatic→ specific waivers are requested
- If granted, they do not waive state law requirements, which must be waived/addressed separately
- Are of limited duration→ end no later than the termination of the emergency period or 60 days from the date the waiver is first published, unless the Secretary of HHS extends the waiver by notice for additional periods up to 60 days
- Potential Section 1135 waivers include:
  - Medicare Conditions of Participation
  - Medicare program participation requirements
  - Requirements that physicians or other providers be licensed in the jurisdiction where providing services, if they have equivalent licensing in another state
  - EMTALA enforcement
  - Stark enforcement
  - Performance deadlines and timetables (may be adjusted but not waived)

Examples of SSA § 1135 waivers are available here: https://www.phe.gov/emergency/news/healthactions/section1135/Pages/default.aspx



CMS Emergency Preparedness Rule: 42 C.F.R. § 482.15—Excerpts

(b) Policies and procedures.

(1) The provision of subsistence needs for staff and patients, whether they evacuate or shelter-in-place, include, but are not limited to, the following:
(i) Food, water, medical, and pharmaceutical supplies.

(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.

(B) Emergency lighting.

(C) Fire detection, extinguishing, and alarm systems.

(D) Sewage and waste disposal.

(2) A system to track the location of on-duty staff and sheltered patients in the hospital's care during an emergency.

(3) Safe evacuation from the hospital, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

(4) A means to shelter in place for patients, staff, and volunteers who remain in the facility.

(5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

(6) The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(7) The development of arrangements with other hospitals and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to hospital patients.

2. Protecting and Managing the Health Care Client's Supply Chain and Access to Essential Goods and Services

Counsel's role may include serving as a key advisor and problem-solver for vendor management and contract challenges arising from force majeure clauses, exculpatory liability clauses, and other types of common contract provisions. In some cases, issues and concerns may be addressed with emergency temporary vendor agreements or temporary amendments to existing vendor agreements. In other cases, the situation may require contractual amendments or regulatory and judicial interventions.

As part of an emergency preparedness plan, counsel should consider creating an up-to-date inventory of vital vendor contracts and the provisions of those contracts. This inventory may include contracts that secure access to essential medical supplies and services, such as pharmaceuticals, oxygen, syringes and physician services, and also contracts for more mundane items such as food, linen/laundry, waste management, and security services. All these items and services may be critical needs after a disaster.

It may be helpful for counsel to undertake a refresher on state contract law and application of the Uniform Commercial Code, including the common construction and limits of force majeure and exculpatory clauses. Even if counsel cannot negotiate force majeure or exculpatory provisions out of contracts, they may be able to prevent detrimental effects of these provisions if, for example, they establish that under the applicable state law a particular force majeure clause lacks appropriate specificity, or the vendor had an obligation to mitigate the issues, failed to do so, and those issues are preventing performance.[15]

In an emergency situation, courts may be willing to issue injunctions or restraining orders, or to otherwise provide an immediate remedy for non-performance. However, judicial remedies, particularly when courts may not be accessible, might not be counsel's best initial plan of action.

Depending on the geographic scope of the disaster, counsel's professional relationships with other facilities' and vendors' counsel may play a critical role in successful and expedient resolution of crises related to critical services and supplies, since temporary agreements and workarounds may be the only viable course.

3. Managing Employee and Workforce Issues

During and after a disaster, counsel may be presented with many questions related to worker needs, welfare, and compensation. Workers may experience difficulty with housing, transportation, hygiene, work schedules, and working conditions. Counsel may be asked to assess and advise their client about when and under what conditions accommodations for these difficulties are reasonably appropriate and when they implicate and are outweighed by legal concerns.

There may be questions for counsel about payment of wages, including the ever-important questions of how and when workers and employee benefits providers can and must be paid if bank accounts are difficult to access. These questions become more complicated when certain client facilities are closed and certain workers are not able to report to the facility, or, conversely, when the client's operations are compromised but certain workers are told to report to and/or remain at the facility regardless. Generally, these will be questions of state or local law and the answers will vary according to the locality of jurisdiction. For certain employers and certain circumstances, the answers may be influenced by the application of federal laws such as the Fair Labor Standards Act (FLSA),[16] the Employee Retirement Income

and Security Act (ERISA),[17] the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA),[18] or the National Labor Relations Act (NLRB).[19]

Similarly, counsel may be asked to provide advice, or draft agreements or emergency policies regarding worker financial assistance, including for establishing and distributing emergency assistance funds or other types of financial benefits that exceed normal wages. Although sanctions under the Stark Law[20] may be subject to Section 1135 waiver in the event of a disaster, this type of waiver is not automatic or guaranteed and, even if granted, will not be unlimited or indefinite.[21] Also, some laws that may be implicated by financial assistance, including the federal Anti-Kickback Statute[22] and a state or territory's own physician self-referral or anti-kickback laws, may not be subject to waiver at all. Therefore, counsel should ask and consider the nature, amount, recipients and duration of the emergency assistance to determine how best to navigate the applicable laws and regulations.

4. Securing Revenue and Reestablishing Solvency

Counsel may have a central role in maintaining or reestablishing essential revenue streams during and following a disaster. This role may include managing insurance claims; advising on, ensuring, and restoring proper billing procedures in accordance with regulatory requirements; and securing contractual payments against legal challenges.

Aside from disaster situations, it is unlikely that most health care lawyers have given thought to the typical limits and construction of "valuable paper" insurance contracts. Yet, counsel's guidance and advice on this issue may be pivotal to a health care provider being able to address medical record damage that may otherwise threaten the provider's ability to be paid for its services, defend itself in the event of a lawsuit, or provide quality patient care.

Even for a client that is financially challenged from disaster damage, retaining counsel who specializes in disaster recovery may be a prudent investment to restore solvency. Likewise, engagement of valuation professionals to establish the fair market value and/or replacement value of lost assets and capabilities may be an important and valuable investment. The likelihood of successfully challenging denied or underpaid insurance claims may increase with assistance from experienced, reputable, and trusted experts.

Clients that are governmental or private not-for-profit entities may be eligible under the Stafford Act[23] for federal grant assistance to aid recovery efforts.[24] These grant funds may be used for repair, reconstruction, or replacement of infrastructure or facilities; emergency protective measures; emergency communications; and replacement of lost revenue.[25] Clients that are for-profit entities do not currently qualify for such assistance, but there has been at least one instance when a private, for-profit health system was provided government assistance under the Stafford Act through an act of special legislation. In 2001, after Tropical Storm Alison caused severe flooding and damage to the 13 hospitals of the Texas Medical Center (TMC), Congress passed an omnibus appropriations statute declaring TMC eligible for assistance under the Stafford Act.[26] This type of legislative assistance is not routine or common, but is evidence that there may be options for seeking exceptions to legal restrictions that might otherwise impede the ability of a health care provider to continue to serve the community.[27]

5. Managing Information and Media Relations

The role of counsel may include identifying and advising the client regarding laws and regulations prohibiting, restricting, or requiring transfer of information regarding patients, staff, and facilities, and on what to do when information is incorrectly reported.

Counsel should be prepared to address questions, or seek advice from other experts, regarding the scope and limits of privacy standards under the Health Insurance Portability and Accountability Act (HIPAA), as well as under any applicable state confidentiality laws. Counsel also should assess and understand the risks of sharing—or conversely, not sharing—certain types of information that, even if sharing is permitted or required by law, may create legal risk for the client because of the nature of the information or the method by which it is shared.

Appointment of a spokesperson or communications firm that has an expert understanding of the implications of and usual restrictions on information sharing can be an assistance to counsel but should not be assumed to supplant the role of counsel as a legal advisor. In some cases, the client must comply with the duty to report information timely and accurately, and that duty may not be delegated without independent monitoring by the client.

CMS Emergency Preparedness Rule: 42 C.F.R. § 482.15—Excerpts

(c) Communication plan. The communication plan must include all of the following:

(1) Names and contact information for the following:
- (i) Staff.
- (ii) Entities providing services under arrangement.
- (iii) Patients' physicians.
- (iv) Other hospitals and CAHs.
- (v) Volunteers.

(2) Contact information for the following:
- (i) Federal, State, tribal, regional, and local emergency preparedness staff.
- (ii) Other sources of assistance.

(3) Primary and alternate means for communicating with the following:
- (i) Hospital's staff.
- (ii) Federal, State, tribal, regional, and local emergency management agencies.

continued from page 9

(4) A method for sharing information and medical documentation for patients under the hospital's care, as necessary, with other health care providers to maintain the continuity of care.

(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii).

(6) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

(7) A means of providing information about the hospital's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Conclusion

In a disaster situation, counsel may serve as a crisis-time negotiator, a knowledgeable advisor, or a point of contact for regulatory assistance. They will be called on to address diverse legal, compliance, and risk management issues, and sometimes to make quick decisions. Although counsel are not direct caregivers, undoubtedly, their role may put them in a position to save or change lives, just as their clients do.

**The findings and conclusions in this newsletter are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention (CDC). AHLA's copyright does not extend to the portion of the article (Decisions to Shelter-in-Place, Evacuate, and Repopulate) authored by Montrece McNeill Ransom, a CDC employee.*

The authors would like to thank Ellie Bane (Catholic Health Initiatives, Texas) for serving as an editor of this article.

1 *See* Meghan D. McGinty et al., *Legal Preparedness for Hurricane Sandy: Authority to Order Hospital Evacuation or Shelter-in-Place in the Mid-Atlantic Region*, 14 Health Security 2, 78-85 (2016).

2 This assertion is based on interviews with emergency preparedness directors of several state hospital associations. It is supported by a variety of published statements and statistics. For example, the Florida Department of Health's "Hospital Evacuation Toolkit" states, "In the past, a hospital evacuation had been considered a remote possibility for most hospitals; however, recent hurricane seasons demonstrated that a full-scale hospital evacuation is not only a possibility, but also a grim reality."

3 *See, e.g.,* Sherry Fink, *The Deadly Choices at Memorial*, N.Y. Times, Aug. 25, 2009 (chronicling the criminal and civil trials following the deaths of patients at Memorial Medical Center in New Orleans after failed evacuation attempts during Hurricane Katrina).

4 *See supra* note 2 for references.

5 *See* Tara Bannow, *Eight Hospitals Evacuate Patients in Wake of Hurricane Michael*, Modern Healthcare, Oct. 12, 2108.

6 *See, e.g.,* Steve Schoonover and Tang Lor, *Fast Moving Flames Make Hospital Evacuation Harrowing*, Chico-Enterprise Record, Nov. 8, 2018.

7 29 C.F.R. § 1910.38(c).

8 81 Fed. Reg. 63860 (Sept. 16, 2016).

9 *See* 42 C.F.R. § 482.15(b)-(d).

10 *See, e.g.,* https://www.jointcommission.org/emergency_management.aspx.

11 *See, e.g.,* https://emergency.cdc.gov/planning/index.asp (includes resources specific to health care facilities and legal professionals).

12 *See, e.g.,* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/index.html (certain resources are organized by type of disaster—e.g., earthquakes, hurricanes, wildfires/fires, flooding, homeland security threats).

13 *See, e.g.,* http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/healthcare-system-preparedness/discharge-planning/_documents/%20evac-toolkit.pdf.

14 29 C.F.R. § 1910.38(c).

15 *See Castor Petroleum Ltd. v. Petroterminal De Panama, S.A.*, No. 600243/08, 2012 WL 4844458 (N.Y. Sup. Ct. Sept. 27, 2012) (Force majeure clauses will be narrowly construed, even if drafted broadly).

16 29 U.S.C. 8 § 201 et seq.

17 29 U.S.C. § 1001 et seq.

18 29 U.S.C. § 1161.

19 29 U.S.C. § 151 et seq.

20 42 U.S.C. § 1395nn, with regulations at 42 C.F.R. § 411.350 et seq. (strict liability statute preventing an entity from presenting a claim or billing for any designated health services, including inpatient and outpatient hospital services that are the result of a referral from a physician with which the entity has a financial relationship, unless one of a specifically enumerated list of exceptions applies; transfers of value to a physician generally constitute a "financial relationship" and an exception will require that the transfer be part of a fair market value compensation arrangement that is commercially reasonable).

21 Waivers under Section 1135 of the Social Security Act need to be requested and granted to be effective and typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published, unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days. Additional information regarding the waivers and waiver process is available at-a-glance from CMS at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf.

22 42 U.S.C. § 1320a-7b with regulations at 42 C.F.R. § 1001.952 et seq. (statute with criminal and civil provisions that prohibits knowingly and willfully soliciting or receiving any remuneration directly or indirectly, overtly or covertly, in cash or in kind, as an incentive for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program; although providing support to a physician or other provider in the event of a disaster is not per se a violation, arrangements providing cash or items or services of value to providers who are in a position to refer can lead to scrutiny under the Anti-Kickback Statute if those arrangements are not carefully considered and documented.).

23 42 U.S.C. 68 § 5121 to 5208.

24 42 U.S.C. 68 § 5172(1)(B).

25 *Id.*

26 Pub. L. No. 108-7, 117 Stat. 514.

27 Even without special legislation, a for-profit entity may be eligible for Stafford Act assistance indirectly if its services are contracted by an eligible entity, or through loans by the Small Business Administration (SBA). For additional information *see, e.g.,* http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/disaster-response-resources/esf8/_documents/healthcare-facility-reimburse.pdf.

Resource Corner

Are You a Member of these Affinity Groups?

Fair Market Value Affinity Group
Public Health System Affinity Group
Real Estate Affinity Group

To join any or all of these Affinity Groups, please contact AHLA's Member Satisfaction Center at msc@healthlawyers.org or (202) 833-1100, #2.

Membership in these Affinity Groups is free to all members of the Hospitals and Health Systems Practice Group as well as government, academic, and student members, and those that have paid for all-PGs access (PG 15). Please note that you must be a member of one of these groups to join.

New Webinar Series!

Disaster Preparedness and Response Webinar Series

With various types of disasters seemingly becoming increasingly common across the United States and the world, health care providers have many reasons to be considering whether they are prepared for a disaster event. Community disasters pose special challenges for hospitals and other health care facilities given the functions they serve in communities. Counsel to providers with recent real-life experiences addressing these challenges have stories and insights to share, based on what they learned and what they wish they had known. This webinar series will provide current, real-life, "from the trenches" examples and analysis of the unexpected and challenging legal questions that arise for hospitals and other essential health care providers in preparation and response to disasters.

Learn more and register at https://distancelearning.healthlawyers.org/products/disaster-preparedness-and-response-webinar-series-all-parts.

HOSPITALS AND HEALTH SYSTEMS PRACTICE GROUP LEADERSHIP

Emily B. Grey, Chair
Breazeale Sachse & Wilson LLP
Baton Rouge, LA
(225) 381-8011
emily.grey@bswllp.com

Gregory D. Anderson, Vice Chair – Publications
HORNE LLP
Hattiesburg, MS
(601) 620-5101
greg.anderson@hornellp.com

Ritu Kaur Cooper, Vice Chair – Strategic Planning and Special Projects
Hall Render Killian Heath & Lyman PC
Washington, DC
(202) 370-9584
rcooper@hallrender.com

Nicole F. DiMaria, Vice Chair – Membership
Chiesa Shahinian & Giantomasi PC
West Orange, NJ
(973) 530-2111
ndimaria@csglaw.com

Neerja Razdan, Social Media Coordinator
University of Maryland Medical System
Baltimore, MD
nrazdan2@gmail.com

Kimberly S. Ruark, Vice Chair—Research & Website
BakerHostetler
Atlanta, GA
(404) 256-6699
kruark@bakerlaw.com

Julia K. Tamulis, Vice Chair—Educational Programs
Bass Berry & Sims PLC
Washington, DC
(202) 827-2999
jtamulis@bassberry.com

PUBLISHING STAFF

Cynthia Conner
Vice President of Publishing
(202) 833-0755
cconner@healthlawyers.org

Bianca Bishop
Senior Managing Editor
(202) 833-0757
bbishop@healthlawyers.org

Lisa Salerno
Senior Legal Editor
(703) 489-8426
lsalerno@healthlawyers.org

Matt Ausloos
Manager of Publishing
(202) 833-6952
mausloos@healthlawyers.org

DESIGN STAFF

Mary Boutsikaris
Creative Director
(202) 833-0764
mboutsik@healthlawyers.org

Jen Smith
Graphic Designer/ Administrator
(202) 833-0781
jsmith@healthlawyers.org

AHLA

VOLUNTEER

Find your role at AHLA.

www.healthlawyers.org/volunteer

Hospitals & Health Systems Rx

AHLA

American Health Lawyers Association
1620 Eye Street, NW, 6th Floor • Washington, DC 20006-4010
(202) 833-1100 • Fax (202) 833-1105 • www.healthlawyers.org