

Health Law ADVISORY

Current legal insights for health care executives

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Julie A. Knutson, Editor

Despite Controversy, Hospitals Must Be Ready For Safe Haven Incident

It may or may not be what Nebraska lawmakers intended, but Nebraska's Safe Haven law has been heavily utilized since its effective date with children of all ages being surrendered to the custody of hospital personnel. Despite the controversial brevity and ambiguity of Nebraska's new statute and the polarizing opinions it evokes, hospitals in this State must safely, effectively and carefully respond to an incident of a child being left at the hospital under the safety net of this new law. Regardless of one's opinion of the law, hospitals must be ready. There are some important considerations as you prepare to respond at your facility to a safe haven incident.

Child Not Necessarily a Patient. The Nebraska Hospital Association distributed a model policy for assisting hospitals with implementing procedures to respond to safe haven incidents. Some of you have asked about the policy provision that states:

“For purposes of confidentiality, record creation, and other applicable Hospital policies, a child accepted into the Hospital's custody pursuant to this policy shall be handled as if the child is a patient of the Hospital.”

Importantly, this provision does not state that the child becomes a patient; rather, this provision says that the child should be handled as if they were a patient. This provision is merely intended to invoke a body of existing policies that hospital personnel are trained in and comfortable with, such as confidentiality of the encounter and documentation of the actions taken with respect to the child. The identity of the child and the person surrendering custody should be kept as confidential as someone's protected health information under HIPAA. And creating a thorough record of the hospital's actions in following the policy will be critical if later challenged that the hospital did not use reasonable care with respect to the child. Thus, even though the child may not become a patient of the hospital, these known procedures should be followed just as if the child were a patient. Where existing procedures can be invoked, staff will have fewer questions when presented with an incident.

Application of EMTALA. The model policy also contains important language designed to protect the hospital from self-imposing broader EMTALA application with respect to the child than EMTALA would otherwise require. Unless a prudent layperson observer would

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believe that the child required examination or treatment for an emergency medical condition, a medical screening examination is not required under EMTALA. As you tailor the model policy to your organization, be careful not to state your policy in such a way as to implicate EMTALA in every safe haven incident.

Test Your Procedures. If your hospital is faced with a safe haven incident, there is likely to be heightened anxiety and emotional reaction by hospital personnel involved. Working with local law enforcement, consider staging one or more mock safe haven incidents to prepare hospital personnel to appropriately respond to the incident without causing unnecessary alarm or stress. If the community learns of the incident, how will media inquiries be handled? Test your procedures in advance to ensure there are no gaps in the chain of command for reporting the incident to appropriate authorities within the hospital and externally consistent with the policy. Practicing your procedures now will go a long way in setting the stage for a safe, secure and confidential process should your hospital become the next safe haven for a child.

Vickie Brady Ahlers

Revised Hospice CoPs Issued by CMS and DHHS

Final rules revising the Medicare Hospice Conditions of Participation were published June 5, 2008 to be effective December 2, 2008. (73 Fed. Reg. 32088.) The changes are substantial, and several will require changes to existing agreements. The summary indicated that the rule “focuses

on the care delivered to patients and their families by hospices and the outcome of that care. The final requirements continue to reflect the unique interdisciplinary view of patient care and allows hospices flexibility in meeting quality standards.”

The final rule includes changes necessary to incorporate in the CoPs the statutory changes of the Balanced Budget Act of 1997 that permitted hospices to provide all physician services, including medical director services, under contract and that allowed rural hospices to receive a waiver of the requirement that PT, OT, speech-language pathology and dietary counseling services be available on a 24-hour basis. The BBA also permits a waiver to enable dietary therapy to be provided by hospice employees. The final rule reflects changes required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that permits a hospice to enter an arrangement with another hospice to provide core hospice services or highly specialized services of nurses under certain circumstances.

A large number of industry groups are conducting sessions with hospice provide to digest and plan implementation to the multiple changes that will become effective under the final rule including new patients’ rights and quality assessment standards. From a legal standpoint, the new CoPs include several changes which may require revision to existing agreements. A partial list includes:

- The revised standard governing “Coordination of services,” (42 CFR §418.56(e)), while not a new concept, is more specific in describing the communications required. The standard requires a “system of communication and integration,” to assure that the hospice, through the interdisciplinary group, coordinates

From a legal standpoint, the new CoPs include several changes which may require revision to existing agreements.

and supervises all care and services provided by both hospice and non-hospice providers. It is advisable that contracted providers agree to follow procedures adopted by hospice to accomplish this coordination and communication.

- Licensed professionals providing services of hospice under arrangements are required to participate in the hospice's quality assessment and performance improvement program. (42 CFR §418.62(c))
- Physicians providing services to hospice patients must function under the supervision of the hospice medical director. (42 CFR §418.64(a)(1))
- The new standards include heightened requirements for skill assessment of individuals providing care to hospice patients, including contracted services. (42 CFR §418.100(g)(3)) Contractual arrangements must be made to assure the contracting parties cooperate in such assessments of employees and subcontractors.
- The revised standard for inpatient care provided under arrangements (42 CFR §418.108(c)) includes specific requirements for assuring that contractual standards are met through a liaison appointed by the hospital and verification of training of hospital staff. The hospital needs to agree to cooperate with the hospice in meeting these requirements.
- The provisions of 42 CFR §418.112(c) setting out the requirements for hospices that provide hospice care to the residents of a SNF/NF or ICF/MR includes a revised standard for written agreements with NFs. This standard includes a number of specific additional

requirements that will need to be added to NF agreements with hospices.

- Contracts with DME suppliers are required to have additional language set out at 42 CFR §418.106(f)

The revised CoPs for hospice providers will require operational, clinical and legal adjustments for compliance including revisions to several categories of hospice agreements.

Julie A. Knutson

HIPAA and Disclosures of Protected Health Information to Law Enforcement

Law enforcement officers frequently request protected health information of health care providers. The challenge is that HIPAA's detailed, yet limited, exceptions related to disclosing protected health information to law enforcement are less than clear at times, and in most cases require a parallel State law before disclosure can be made. In this article, we present two common requests by law enforcement that are not permitted under HIPAA or state law:

"Police Hold" Cases – Law enforcement

HIPAA's detailed, yet limited, exceptions related to disclosing protected health information to law enforcement are less than clear at times...

officers bring a patient to the hospital under what is referred to as “police hold.” The patient is left at the hospital for treatment without any law enforcement supervision. The officer requests that the hospital notify the officer when preparing to discharge the patient on the premise that the officer will return to arrest or resume custody of the patient once discharged. Law enforcement will “unarrest” an individual prior to taking such individual to the hospital to avoid paying for the treatment rendered or the necessity of providing a guard during treatment. Unless the individual is *under arrest*, and therefore in the lawful custody of law enforcement, HIPAA does not provide for any authority to notify law enforcement officers when a particular patient is discharged under the law enforcement exceptions to HIPAA. While law enforcement officials tend to believe that their access to protected health information is unlimited, these provisions are drafted quite narrowly and only a small subset of actual requests from law enforcement will fit within these exceptions. In exceptional cases where there is an imminent threat to health or safety, we may look to other exceptions to provide authority for disclosure, but the typical “police hold” patient that is “unarrested” at the hospital door does not usually fall into this exceptional “imminent harm” category.

Newborn Cases – Law enforcement officers (or Child Protective Services) request that the hospital notify them when a specified pregnant woman presents to the hospital for delivery of a baby. The premise is that the woman is under investigation for abuse/neglect of another child and the law enforcement officer suggests that the hospital has a duty to report the impending birth in connection with the abuse investigation. There typically are no specific allegations of abuse of the fetus; the abuse is anticipated following the delivery.

Unless a state law provides the authority for notifying law enforcement when the woman presents for delivery, HIPAA does not authorize the disclosure, absent exceptional circumstances where imminent and serious harm to the newborn is likely. Both Iowa and Nebraska child abuse reporting statutes describe the reporting obligation as arising when the reporter reasonably believes a child has been abused. Likewise, the statutes do not provide specific authority to disclose information related to the mother’s health care or another child (or unborn child) in connection with the investigation of a current child abuse report or to provide information pertinent to a child abuse/neglect investigation reported by someone other than the hospital.

Requests for protected health information from law enforcement officers present challenges to hospital/health care staff. The exceptions and rules under HIPAA and state law are detailed and do not cover a number of circumstances. In addition, the requests are typically presented under color of authority with a high degree of urgency. When the answer to the request is “no,” the requesting party should be reminded that the information may be available upon presentation of a proper request, *e.g.*, a subpoena.

Vickie Brady Ahlers

Requests for protected health information from law enforcement officers present challenges to hospital/health care staff.

Save the Date for the 20th Annual Baird Holm Health Law Forum - November 21, 2008

The Forum will be held on November 21 at the Marriott Regency Omaha featuring sessions on the latest updates affecting your industry. Check-in and continental breakfast begin at 8:00 a.m. followed by the welcome and introduction at 8:15. The forum concludes at 3:30 p.m. followed immediately by a cocktail and hors d'oeuvres reception. Topics for this year's Forum include:

- *The Changing Landscape of Hospital-Physician Ventures* by Kelly Clarke and Andy Kloeckner
- *Stark: Are You Ready for a Compliance Audit?* Presented by Barbara Person with a panel of hospital compliance officers
- *New Challenges in Physician Recruitment* by John Holdenried and Barbara Person
- *The OIG Self-Disclosure Protocol Unwrapped* by Julie Knutson
- *Latest Word-* A rapid-fire review of significant legal development affecting our health care clients presented by a panel of Baird Holm health care attorneys
- *Why You Should be Worried About HIPAA Privacy and Security Enforcement* by Vickie Brady Ahlers

- *Medical Identity Theft, the Red Flag Regulations and You* presented by Vickie Brady Ahlers and Gray Derrick

Watch for the 2008 Baird Holm Health Law Forum flyer in your mailbox later this month. We hope to see you on November 21st!

Upcoming Speaking Engagements

Barbara Person and Nancy Ruzicka of Iowa Health System, October 24, 2008, "Twenty Years of EMTALA – Where Are We Now?" Sponsored by the Iowa Hospital Association. (8:30 a.m. to 3:30 p.m.) Des Moines, Iowa

Where in the World is Vickie Brady?

For those of you who may have had trouble locating Vickie Brady lately, she's alive and well and practicing law at Baird Holm as Vickie Brady Ahlers. Vickie and Dave Ahlers were married in Omaha, Nebraska on August 9, 2008. Vickie's updated e-mail address is vahlers@bairdholm.com.

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