CCH Healthcare Compliance LETTER

Volume 7, Issue 2 www.cchgroup.com January 26, 2004

Tenet whistleblowers receive $8.1 million award

by Sharon Sofinski

Father John Corapi and Joseph Zerga will receive $8.1 million under the False Claims Act for their whistleblower complaint alleging unnecessary cardiac surgeries were performed at Tenet Healthcare Corporation's Redding Medical Center.

After Corapi, a Catholic priest, underwent a cardiac catheterization at Redding Medical Center, the Redding physician recommended that he have an immediate, multiple-vessel heart bypass surgery. Believing the surgery was not necessary, Corapi went to physicians at a different hospital seeking a second opinion. Those physicians confirmed that he did not need the surgery. Corapi reported the unnecessary procedure recommendation to Redding officials. He then decided, along with Zenga, to report the fraud to the FBI in July 2002, and the FBI launched an investigation.

Senator Chuck Grassley, chairman of the Senate Committee on Finance and author of the 1986 *qui tam* whistleblower amendments to the False Claims Act, praised the two whistleblowers. "Fortunately, there are still courageous whistleblowers who care enough to expend their time, energy and resources, often at great personal cost, to see that the right thing gets done." Without the complaint by Corapi and Zenga, he added, "the public might never have heard the very serious charge of widespread, unnecessary cardiac surgery at Tenet's Redding Medical Center." Senator Grassley's hope is that this award will encourage others to come forward and report such fraud and abuse.

The $8.1 million award is fifteen percent of the record $54 million the United States recovered in the civil case. That amount is generally the minimum amount for which whistleblowers are eligible under the False Claims Act. The FBI, Department of Health and Human Services, and the Defense Criminal Investigative Service are participating in the Tenet investigation, which continues. (See "Tenet urged to comply with Senate document request; Investigation widening," *CCH Healthcare Compliance Letter,* Vol. 6, Issue 23, November 24, 2003.) Criminal charges have not yet been filed in the case.

In December 2003, Tenet Healthcare Corporation announced that it was seeking a buyer for Redding Medical Center. The sale is expected to be complete by mid-2004. Tenet decided to sell Redding as part of an agreement with the Office of Inspector General (OIG) in the U.S. Department of Health and Human Services. The OIG had initiated proceedings to exclude Redding Medical Center from federal health care programs based on the allegations of unnecessary cardiac services provided to patients. (For more details, see http://oig.hhs.gov/publications/docs/press/2003/121103release.pdf.). ■

CCH Chicago Bureau, January 12, 2004

Boards need to take active role in compliance

by Catherine Hubbard, MA, Contributing Editor

Health care Boards of Directors need to take a more active role in their organization's compliance programs. "Boards of Directors shouldn't just sit back and wait until they hear about something bad that happened," according to Lois Cornell, senior compliance officer and associate general counsel with Tufts Health Plan, Waltham, Massachusetts. The board needs to make sure management is running and overseeing a compliance program that's effective, and they need to stay informed on a regular basis, she said.

"Boards have an affirmative duty to monitor compliance," said Cornell. "In turn, the organizations must have reporting systems that enable their boards to reach informed decisions," she added. "At the end of the day, the board needs to receive information about the organization's compliance program and monitor and oversee it," said Anne Doyle, compliance and privacy officer with Tufts Health Plan. She noted that she and Cornell meet with the Board Audit and Compliance committee three times per year, in addition to ongoing communications.

Following enactment of the Sarbanes-Oxley Act of 2002 (P.L. 107-204), health care entities have found they need to improve compliance program oversight by their boards. Although the law doesn't directly apply to private companies, it's imposing a heightened standard on all organizations, said Cornell. Before the high-profile corporate scandals and ensuing enactment of the law, she observed, "Some boards were not actively overseeing both the internal financial and the compliance standards within the organization." It is important for boards to be aware of new laws and regulations impacting their company, compliance concerns identified and/or reported, and the steps being taken to address those situations, she added.

"The 1996 *Caremark* decision made it clear that boards have an affirmative obligation to ensure the organization has an effective compliance program and that it has an adequate information and reporting system to allow management and the Board to reach informed judgments," said Cornell.

Doyle emphasized that a board also must probe and ask questions during meetings. "A quiet board meeting (when the compliance team makes a presentation) is not a good thing," she said. "You want interaction, you want questions, you want discourse, so that you can strengthen the compliance progam," she said. The feedback on the compliance program from the board is just as important as feedback from the departments, she added.

Doyle also provided tips for creating a sound compliance program. She said it is crucial to have an organizational culture that encourages an effective commitment to compliance. "Organizations need to create a robust program, not just have policies and procedures and a code that are dead documents," she said.

An important component of a robust compliance program is a company-wide comprehensive risk assessment approach, noted Doyle. The compliance team should work closely with internal audit to thoroughly assess areas of potential compliance risks and identify and prioritize those risks, she suggested. "From a potentially long list of compliance topics, the Compliance Officer can then focus resources and time and energy," she added.

Components of the risk assessment include conducting interviews, reviewing results of external and internal audits, reviewing day-to-day business operations and checking compliance with policies and procedures, Doyle said.

To determine its particular set of compliance needs, an entity should create feedback mechanisms to gather comments from people close to the day-to-day operations. Armed with this information, a compliance team can tweak its policies and procedures and redirect resources if needed, she said.

Despite a company's best efforts, violations still can occur. Yet a corporate compliance program will help the organization correct any problems that do occur and enable it to get back on course more efficiently and effectively, Cornell said.

Cornell and Doyle emphasized that the key message for health care Boards of Directors is to play an active compliance role: monitor and oversee the company's compliance activities so that if a violation does occur, the board is assured that accountable people and processes are in place to address these matters quickly and effectively. ■

CCH Washington Bureau, January 15, 2004

CCH Healthcare Compliance Letter

Managing Editor
Yvonne Kanak

Coordinating Editors
Angela Fanelli, J.D.
Sharon Sofinski

CCH Washington Bureau
Paula Cruickshank
DOJ, FTC–John Scorza
SEC–Peter Feltman
Health Law–Catherine Hubbard
Tax–Jeff Carlson, David Hansen

Designer
Craig L. Arritola

Comments from readers are welcome and should be directed to Sharon Sofinski at SOFINSKS@CCH.COM, Tel. 847-267-7860, Fax 847-267-2514. Customer service inquiries should be directed to 800-449-9525.

CCH Healthcare Compliance Letter is published 24 times a year by CCH INCORPORATED, 4025 W. Peterson Avenue, Chicago, IL, 60646. Subscription rate is $305 per year. First-class postage paid at Chicago, Illinois, and at additional mailing offices. POSTMASTER: SEND ADDRESS CHANGES TO *CCH Healthcare Compliance Letter*, 4025 W. PETERSON AVENUE, CHICAGO, IL 60646. Printed in U.S.A.

Evidence of prior regulatory warnings allowed to refute physician's mistake defense

by Richard C. Sarhaddi, Esq., Contributing Editor

The Fifth Circuit recently found that the district court did not abuse its discretion when it allowed materials from the Texas State Board of Medical Examiners (Medical Board) concerning the physician's prior regulatory violations and affirmed the physician's conviction for health care fraud and aiding and abetting. The physician, James T. Parsons, was convicted of defrauding Medicare and Medicaid by submitting numerous claims for office visits that never occurred and echocardiogram services that were never performed.

Fraud scheme. In support of the allegations of health care fraud and aiding and abetting, twelve government witnesses testified that Parsons obtained their social security numbers fraudulently by bringing baked goods to the assisted living facility where they lived, and locating the numbers, which he later used to fraudulently bill Medicare and Medicaid for services he did not provide. The government also attempted to use evidence concerning Parsons' prior regulatory violations obtained from the Medical Board, pursuant to Federal Rule of Evidence 404(b), to prove that Parsons had motive, knowledge, a plan and the like to commit the fraud. Parsons, however, obtained a motion *in limine* to exclude this information from being introduced into evidence.

Medical Board evidence. The government, however, would later have the opportunity to introduce the Medical Board evidence after one of Parsons' witnesses stated that she did not have any heart problems, and did not recall Parsons ever performing an echocardiogram on her. On cross-examination, the government introduced evidence that Parsons had billed Medicare for six echocardiograms on that witness over a period of two years. During his testimony, Parsons claimed that the bills were a result of staff mistakes and lack of office organization. Parsons' testimony opened the door for the government to challenge his defense of mistake or accident by introducing evidence from the Medical Board showing that he had been warned by the Board that he needed to adequately supervise his employees and that his files were substandard. During closing arguments, the government again referenced the Board's warnings to refute Parsons' accident/mistake defense.

"...the district court did not equate the Medical Board regulatory violations with evidence of the alleged crimes."

On appeal, Parsons claimed that the district court abused its discretion by allowing the Medical Board evidence to be introduced against him, asserting that the evidence was more prejudicial than probative. The Fifth Circuit stated that, "when Parsons raised the defense of mistake, he made evidence regarding his intent relevant." Therefore, the evidence of Parsons' prior warnings from the Medical Board showed that he had knowledge of his duty to adequately supervise his staff "to make sure they were not violating the law," and this evidence was relevant to rebut Parsons' mistake defense. In addition, the district court did not equate the Medical Board regulatory violations with evidence of the alleged crimes. Instead, the court appropriately limited the evidence concerning the Medical Board's warnings only to show that Parsons was on notice and to refute his mistake defense. Accordingly, the Fifth Circuit found that the district court did not abuse its discretion and affirmed the judgement against Parsons. ■

U.S. v. Parsons, ¶102,108

Letters to the Editor

The CCH Healthcare Compliance team welcomes comments or questions regarding articles published in the CCH Healthcare Compliance Letter. Send comments to Sharon Sofinski, Coordinating Editor, at sofinsks@cch.com. For more information about the CCH Healthcare Compliance Portfolio visit our online store at http://health.cch.com.

What you should know about screening for excluded individuals and entities

by Louis Feuerstein and Deborah Joslyn

Over the past five years, the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) has averaged over 3,000 exclusions per year. In total, over 15,000 individuals and entities have been temporarily or permanently barred from participation in any federal or state health-related programs. And it is important to know that the OIG has the authority to assess penalties against individuals and entities that bill for any services or items furnished by these excluded parties.

Herein lies the problem. Where do you think these bright and well-trained health care professionals are working? If you are not careful, there is a good chance that they might be working in your health care organization.

So let's begin by considering the following:

Do your employment and medical staff applications include the following questions?

- Have you ever been convicted of any criminal violation of law, or are you now under pending investigation or charges of violation of criminal law? If yes, explain.
- Have you been the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency? If yes, explain.
- Have you ever been or are you now the subject of any adverse action(s) by any duly authorized sanctioning or disciplinary agency for either conduct-based or performance-based actions? If yes, explain. For example, are you now or have you ever been excluded or debarred from participation with Medicare, Medicaid, or any other governmental contract program or service?

Do your applications and employment agreements also include the following statement?

- All employees and volunteers are obligated to notify their supervisor or Human Resources Department if they have been convicted of a criminal offense or have been excluded/debarred from a federally-funded healthcare program (examples: Medicare and Medicaid) during your employment.

These questions and statements are not only necessary to help ensure that excluded individuals are not unwittingly employed by your organization but can often give you a legal basis upon which to act in those cases where an employee may not have been truthful in completing an employment application or agreement.

What Are Some of the Rules and Requirements?

Section 1128 of the Social Security Act (42 U.S.C. §1320a-7) details the exclusion authority provided to the OIG of the DHHS. This exclusion authority was originally provided just to Medicare and Medicaid, but was expanded to include all federal health care programs by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We will have more on HIPAA later in this article.

The United States Sentencing Commission Guidelines require, among other things, that an organization exercise "due care not to delegate substantial discretionary authority to individuals, whom the organization **knew or should have known**, through the exercise of due diligence had a propensity to engage in illegal activities."

A Special Fraud Alert issued by the OIG in 1999 states that "Providers and contracting entities have an affirmative duty to check the program exclusion status of individuals and entities prior to entering into employment or contractual relationships, or run the risk of CMP [Civil Monetary Penalty] liability if they fail to do so."

Thus, health care organizations have a proactive responsibility to ensure that they are not employing or doing business with an excluded individual or entity. And the best time for an organization to determine this is prior to employment and prior to entering into a business arrangement or clinical relationship with another individual or entity.

Where Do We Check for Excluded Individuals and Entities?

There are several well-known websites, as well as some new websites, available through the Internet, free of charge, that are available to check for exclusions.

Currently, most organizations refer to the National Practitioner Data Bank (http://www.npdb-hipdb.com) as part of the medical privileges process. This data bank contains physi-

cian licensing and malpractice information and is an absolute "must check" before credentialing any physician.

Two of the most often used websites for screening are the OIG Cumulative Sanctions Report Exclusions Database (http://oig.hhs.gov/fraud/exclusions.html) and the General Services Administration (GSA) Excluded Parties Listing (http://epls.arnet.gov). Whereas the OIG website reflects the status of individuals and entities that have been excluded from participation in the Medicare and Medicaid programs, the GSA listing includes individuals, entities and contractors excluded from government-wide federal procurement, sales programs and non-procurement programs. Both of these websites include searchable databases that are updated regularly.

Because the health care industry has one of the most mobile workforces, state and local law enforcement databases as well as regulatory or licensing agencies should also be considered. Often, actions taken at a state or local level are not reported or are not reported on a timely basis to the federal government. Checking the OIG or GSA lists may not disclose that a home health aide has been sanctioned by a state or that a Registered Nurse lost his or her license due to patient abuse or other problems.

There are also two lesser-known but important listings to consider: the Office of Foreign Assets Control (OFAC) Specially Designated Nationals (SDN) and Blocked Persons and the Bureau of Industry and Security (BIS) Denied Persons List (DPL). The OFAC website (http://www.treas.gov/offices/eotffc/ofac/sdn/index.html) contains names of individuals and organizations that have had financial transactions and property blocked by the U.S. Department of Treasury. Established under an Executive Order signed by President Bush in September 2001, its purpose is to target and block financial transactions and assets of terrorists, narcotic traffickers and foreign countries that pose a threat to national security. OFAC has jurisdiction over all U.S. citizens, permanent residents and U.S. companies, including health care organizations. Transacting with individuals or organizations on the SDN List could result in criminal and civil actions.

The BIS DPL List (http://www.bxa.doc.gov/enforcement) is a listing of sanctions denying the export privileges of individuals and entities. BIS functions to prevent illegal exports. Although there are fines and penalties for corporations and individuals that do business with a DPL listed party, health care organizations might only want to consider this website in connection with any international operations.

What Does HIPAA Have to Do with This?

President Clinton's signing of the Health Insurance Portability and Accountability Act (HIPAA) in August 1996 had significant and far-reaching effects on our health care system of today. Initially touted for giving employees the ability to carry their health care coverage from employer to employer, HIPAA also provided for the funding of hundreds of millions of dollars to fight health care fraud and abuse. Today, the Privacy and Security rules of HIPAA are in the forefront of the news. But HIPAA also included another lesser-known section that impacts our discussion here. Under HIPAA, in March 2000, a national data bank, the Healthcare Integrity and Protections Data Bank (HIPDB), was established. This federal data bank receives and discloses certain final adverse actions against health care providers, suppliers and practitioners. The OIG will use this data bank to ensure that health care organizations do not employ excluded individuals or entities. In effect, this gives the OIG the capability of matching Social Security Administration databases (such as from your payroll records) to the HIPDB listing. This listing is not available to the general public, although individual providers can check the listing for their own name. Thus, you can expect that the OIG will be screening your employees. It would be a good idea for you to do this before they do.

Answers to Some Typical Questions:

Whom should we screen?

Screening should be performed for:

- All employees
- Independent contractors
- Health care providers, including physicians, physician assistants, pharmacists, nurses, aides, therapists, social workers, lab techs, etc.
- Business partners
- Outside vendors, including durable medical equipment suppliers, other supply companies, group purchasing organizations and ancillary and contracting service organizations
- Board members

How often should we screen?

Most organizations screen at least annually. They also screen all new employees, new vendors, and new Board members. Most perform the screening prior to employment or establishing a relationship with the individual or entity. It is always much easier to use the results of the screening prior to hiring or establishing a relationship than after.

How do we document our screening procedures?

We all should be pretty familiar with the phrase "if it isn't documented, it didn't happen." Yet so often, organizations do not do a good job of documenting their screening efforts. Reports, printouts, memos, CDs and floppies, as applicable, should all be saved and archived to document your screening efforts.

What do we do if we think we employ an excluded individual?

continued on page 6

Just like when we cross the street, we were taught to "stop, look and listen." This advice applies here as well. First, you must positively verify that the name on the exclusion list is in fact your employee. This often requires some due diligence on your part and typically requires a phone call to the regulatory authority to confirm identity and to understand the details and current status of the action. If positive identification is made, you should consult with your legal counsel to thoroughly understand your rights and responsibilities as well as the rights of the employee in question. It is often a good idea to consult with the Human Resources people in your organization to determine what your policies and procedures require in these matters. And perhaps most importantly, with the advice of counsel, determine if self-disclosure or repayment may be necessary.

What are the penalties for employing or doing business with an excluded individual or entity?

Penalties for billing for services or items furnished by excluded parties can be significant. They include:

- Denial or repayment of paid claims
- Civil monetary penalties
- Exclusion from participation in federal programs
- Negative public relations and public embarrassment
- Loss of customer and patient confidence

What should be your first step?

Develop a formal, written sanction and screening policy and procedure. Among other things, the policy should include how often screening will take place, what screening methods and databases will be utilized and who will be responsible for the performance and oversight of the process. Key stakeholders should be identified and typically include representatives from human resources, purchasing, and the medical staff. Individuals responsible for screening should be trained on the policy and procedure. An ongoing monitoring and auditing of compliance with the policy and procedure should also be performed on a regular basis.

Just do it!

Our experience in working with the health care industry seems to indicate that the sanction and exclusion screening process is not consistently and adequately performed by many organizations. Remember, in order to get credit for your compliance program, sanction screening must be a built-in core element of your program. In other words, not screening for excluded parties could be described as driving your car without insurance. Sure you can do it, but the price of getting caught is just not worth it.

Lou Feuerstein *directs Ernst & Young's Corporate Compliance Practice on a national level. He has over 30 years of experience with Ernst & Young and the health care industry. He has extensive experience with all types of health care providers, including hospitals, nursing homes, continuing care retirement centers, home health agencies, health maintenance organizations, and physician group practices. To date, Lou has assisted over 100 health care organizations with their corporate compliance program initiatives.*

Lou joined Ernst & Young in 1972 after receiving his B.S. degree in accounting from Fairleigh Dickinson University. He is a Certified Public Accountant and a member of the Health Care Financial Management Association, as well as the American Institute of Certified Public Accountants. He served as Chairman of the Health Care Committee of the New Jersey State Society of CPA's from 1993 to 1995. Lou is also a member of the Health Care Compliance Association.

Deborah Joslyn *is a Senior Manager with Ernst & Young in the Health Sciences Advisory Services Regulatory and Compliance Practice. She has been assisting clients with their compliance program effectiveness measures since the inception of the Health Insurance Portability and Accountability Act, focusing on the accountability (compliance) aspects as well as the administrative simplification components (privacy). She has managed the implementation of corporate compliance programs within health plans, hospitals, biotechnology and provider practices. Working with over 50 clients, she has conducted assessments, developed policies and Codes of Conduct, developed and led training programs, and implemented auditing and monitoring systems. Deborah also supports Ernst & Young's auditing and monitoring tool, ComplianceSaver, on a national basis.*

Deborah has over 18 years progressive industry experience managing a diverse array of health care activities. Deborah has a B.A. degree from the University of Pennsylvania and did graduate work at Baruch College in Health Care Administration. Deborah is the author of "Look for Compliance Risks Hiding in the Registration Form," published by the Physician Practice Compliance Report and also "Evidencing Effectiveness of Your Compliance Program," published by The Compliance Officer. ■

Trends

Health spending climbs to $1.6 trillion in 2002, prompted by Rx drugs

by Catherine Hubbard, MA, Contributing Editor

For the second year in a row, health care spending rose faster than GDP in 2002, reaching $1.6 trillion, according to a Jan. 8 article in the journal Health Affairs. "We've had two successive years of rather dramatic increases in the share of the GDP going to health care," said report co-author Katharine Levit, director of the National Health Statistics Group in the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary. "This continued acceleration injects pressure into the health care system, and everyone—from businesses, to government, to consumers—is affected," she said in a release.

In another article, CMS economist Cynthia Smith said the health care spending growth is caused largely by spending on new prescription drugs. "Recent rapid spending growth for retail drugs has largely arisen from

continued on page 7

increased use of new drugs, rather than from increasing prices of existing drugs," she said. A large shift in the payment from consumers to third parties has also contributed to faster growth, she added.

The CMS economists report that U.S. health care spending grew 9.3 percent in 2002, up from an 8.5 percent growth rate in 2001, and more than twice the rate of growth of GDP (3.6 percent in 2002). As a result, the share of GDP devoted to health spending rose from 13.3 percent in 2000 to 14.9 percent in 2002—about four times the average annual percentage point increase. Hospital spending is the largest share of overall health care spending and a major driver of increased costs, Levit, Smith and other CMS authors said in the article, "Health Spending Rebound Continues In 2002."

Growth in health spending may have pressured employers to reduce jobs, reduce benefits or pass on more of the cost onto consumers. Meanwhile, state and federal governments face the same dilemma of costs rising more rapidly than revenues. As a result, governors will be forced to "scrutinize discretionary Medicaid benefits as the number eligible for coverage continues to grow," the authors said.

Yet factors fueling the growth in health care spending are showing "signs of dissipating in 2003," the report concludes. Hospital employment growth has eased and wage growth in the health care sector is decelerating. In addition, Medicare policies that temporarily boosted payments to various providers have expired and states are starting to curb Medicaid spending growth, said the authors.

The report also concludes:

- Consumers increasingly are facing higher out-of-pocket payments, particularly for prescription drug benefits.
- Hospital spending reached $486.5 billion—a 9.5 percent increase from 2001, and the fourth year of accelerated growth. This growth was driven primarily by a rising demand for services, increased wages and liability costs, a loosening of managed care controls and hospitals' increased ability to negotiate higher rates from payers.
- Drug spending decelerated slightly for the third year in a row, increasing 15.3 percent in 2002. This followed growth of 15.9 percent in 2001, 16.4 percent in 2000 and 19.7 percent in 1999. Among state Medicaid programs, spending growth was dampened through greater use of preferred drug lists, increased copayments, or required use of generic drugs. Smith said the deceleration in the growth of retail drug spending is partly linked to fewer new drugs entering the market. Only 17 new drugs entered in 2002, compared with an average of 25 per year in 2000 and 2001 and 35 in 1999.
- The federal Medicare program accounted for $267 billion of the health care bill in 2002. Over the past 30 years, Medicare spending growth per enrollee has grown slower than private health insurance spending. In 2002, the authors estimate that Medicare spending grew 8.4 percent—2.5 percentage points slower than private health insurance spending.
- Medicaid spending is rapidly approaching the level of Medicare spending. Faced with growing demands amid a weak labor market, federal/state Medicaid spending rose 11.7 percent in 2002, to $249 billion. The share of health care spending paid through Medicaid (16 percent) nearly matched that of Medicare (17 percent), together paying for one-third of all health care. Medicaid's share has increased slowly over time, by one-half of one percentage point each year since 1989, as the program covered more people. ■

CCH Washington Bureau, January 8, 2004

Human Resources

Clara Barton Hospital settles EEOC sexual harassment lawsuit

by Robyn McCain, JD, Contributing Editor

The EEOC has settled its lawsuit against Clara Barton Hospital in Hoisington, Kansas for a payment of $43,500 to a former female employee and an agreement to provide sexual harassment training to all managers, employees, and Board members of the hospital. The settlement was announced on January 7, 2004.

In March 2003, the EEOC filed suit (No. 03-1107-MLB) claiming that the hospital violated Title VII by subjecting Nita Brack to sexual harassment and retaliation. The EEOC filed suit after exhausting its conciliation efforts to reach a voluntary pre-litigation settlement.

The hospital hired Brack in April 2000 to work as a Human Resources/ Administrative Secretary. In its lawsuit filed in the District of Kansas in Wichita, the EEOC claimed that the hospital administrator sexually harassed Brack and put her on probation and demoted her when she told him that she did not like his conduct. When Brack filed an internal grievance and told the hospital's Board of Directors about the harassment, it took no action. Instead, it affirmed her demotion and placed her on ninety days probation in her new job. On March 12, 2001, the administrator discharged Brack for insubordination.

Under the proposed consent decree, now pending approval before US District Judge Monte Belot, Clara Barton Hospital agreed to pay Brack $43,500 in backpay and damages for emotional distress. In addition, the hospital agreed to issue a new sexual harassment policy and to provide training in the policy to its workforce. The hospital also agreed to retain an outside consultant to provide training in sexual harassment, sex discrimination, and retaliation to all employees and to members of the Board of Directors. The

continued on page 8

hospital will also report complaints of sexual harassment to the EEOC for a two-year period as well as actions taken to address the complaints. ■

CCH Chicago Bureau, January 9, 2004

OSHA releases guidelines for preventing workplace violence

by Sharon Sofinski

The Occupational Safety and Health Administration (OSHA) has issued "Guidelines for Preventing Workplace Violence for Health Care and Social Service Workers," a 29-page booklet intended to help healthcare employers establish effective workplace violence programs adapted to their specific worksites.

OSHA defines workplace violence as "violent acts (including physical assaults and threats of assaults) directed toward persons at work or on duty." Healthcare workers have faced job-related violence for a number of years. Most of these violent incidents tend to be non-fatal assaults, but according to the Bureau of Labor Statistics (BLS), from 1996 to 2000 there were 69 homicides in healthcare settings. In 2000, 48 percent of all occupational assaults and violent acts occurred in healthcare and social services, with nurses aides, orderlies and attendants suffering the most non-fatal assaults. While these numbers are alarming, OSHA states that "the actual number of incidents is probably much higher" because violent incidents often are considered "part of the job" and therefore are not reported.

The Guidelines outline the risk factors for work-related assaults, which include:

- the prevalence of weapons among patients and their families and friends;
- the criminal justice system's use of hospitals for criminal holds and the care of acutely disturbed and violent patients;
- growing numbers of acute and chronically mentally ill patients released from hospitals without proper follow-up care;
- availability of drugs and money at hospitals, clinics and pharmacies; and
- low staffing levels, and lack of staff training in recognizing and managing hostile behavior.

The goal of the Guidelines is to "eliminate or reduce worker exposure to conditions that lead to death or injury from violence by implementing effective security devices and administrative work practices, among other controls." In the booklet, OSHA discusses:

- the elements of an effective violence prevention program;
- management commitment and employee involvement in an effective safety and health program;
- the value of a worksite analysis;
- safety and health training;
- hazard prevention and control;
- how an employer should respond to incidents of violence;
- recordkeeping and program evaluation; and
- sources of assistance.

Several workplace violence checklists, as well as sample violence incident report forms, are also included. A copy of the Guidelines can be found at http://www.osha.gov/Publications/osha3148.pdf.

OSHA notes that several states (including California, New Jersey, and Washington) as well as healthcare organizations (JCAHO and the American Nurses Association, for example) have also developed recommendations for preventing violence in the healthcare workplace. ■

CCH Chicago Bureau, January 13, 2004

HealthSouth strengthens corporate governance practices

HealthSouth Corporation has announced that it has revised its Corporate Governance Guidelines and hired a new Senior Vice President and Chief Compliance Officer, John Markus, who will manage its regulatory compliance and internal audit programs.

The new guidelines meet Sarbanes-Oxley Act requirements, as well as the recently revised listing standards of the New York Stock Exchange.

Under the new guidelines, three-fourths of the members of HealthSouth's Board of Directors must be independent; independent directors' qualifications have been strengthened to reflect best practices standards; the number of outside directorships board members may hold is limited; terms limits are imposed; and strict policies are in effect for related-party transactions.

The revised Corporate Governance Guidelines will be posted on HealthSouth's website at www.Healthsouth.com.