Washington Healthcare News®

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Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 6, ISSUE 11

NOVEMBER 2011

Double Trouble – Disruptive Physicians and Hostile Work Environments

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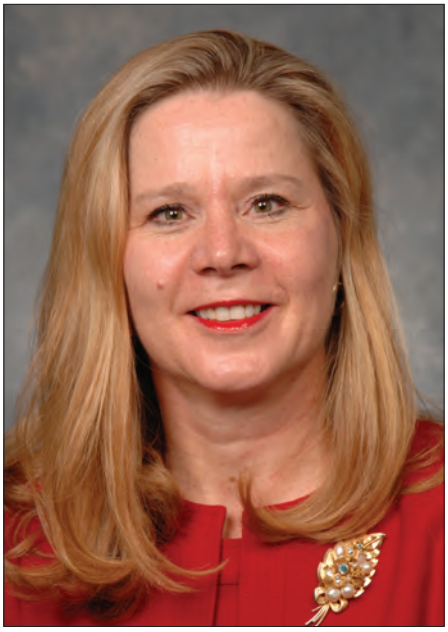

The First Circuit's August 29, 2011 decision in *Tuli v. Brigham & Women's Hospital* depicts the harsh financial consequences that may arise when a hospital fails to investigate and reign in a disruptive physician. The jury awards against the Hospital of $600,000 for retaliation and $1,000,000 for hostile work environment underscore the need for hospitals to promptly address and respond to complaints of disruptive behavior, including discriminatory or retaliatory conduct.

In 2002, the Hospital hired Dr. Tuli, a female, as an associate surgeon in its neurosurgery department, and Dr. Day, a male, as vice-chairman of the department.

In 2002-2003, Tuli became the departments' representative to the Hospital's quality assurance committee and had to investigate some of Day's cases. She was critical of Day's care and some of his cases were reported to the state licensing board.

In 2004, after two colleagues left and Tuli was the only spine surgeon, she, unlike previous male counterparts, was not promoted to the position of Director of Spine.

Between 2005 and 2007, Tuli reported concerns about Day's inappropriate and demeaning behavior to the Hospital's chief medical officer, Dr. Whittemore. No investigation was conducted and no actions were taken to eliminate the offensive behavior.

In 2007, Day was appointed de-

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partment chair and became Tuli's supervisor. When Tuli's credentials came up for review, Day presented Tuli's case to the credentials committee, stating that Tuli had mood swings, that various operating room staff did not want to work with her, and that she needed anger management training. The committee then conditioned Tuli's reappointment upon obtaining a psychological evaluation and counseling by an outside agency.

When concerns were raised about the lack of specificity in Day's presentation about Tuli, the credentials committee requested a second presentation. Whittemore provided a more balanced presentation, but still relied upon and presented unverified information from Day. Whittemore also failed to report Tuli's prior complaints against Day. The committee upheld its earlier decision.

Tuli then sued the Hospital for, among others, gender discrimination, hostile work environment and retaliation. Tuli was awarded $1,000,000 for hostile work environment, $600,000 for retaliation, and $1,352,525.94 in attorneys' fees.

On appeal, the First Circuit affirmed the judgment.

Hostile Work Environment.

The First Circuit found ample evidence to support the jury's verdict as to hostile work environment, based upon the conduct of Day, as well as another physician, Dr. Kim. The conduct the court found sufficient included (1) Day's multiple references to Tuli as a "little girl", questioning whether "girls can do spine surgery" or "big operations", barring Tuli from spine oncology research because he had "a guy in mind," frequent demeaning interruptions of Tuli's lectures; and giving Tuli prolonged hugs; (2) Day's and Kim's requests that Tuli table dance or belly dance; (3) Kim's frequent sexual comments to Tuli, about her being "hot," imagining her naked, and wanting "the opportunity to sexually harass" her; and (4) Tuli being assigned residents less-experienced and unhelpful residents, including one who threw her into the scrub sink and then the garbage.

The First Circuit noted that: "The accumulated effect of incidents of humiliating, offensive comments directed at women and work-sabotaging pranks, taken together, can constitute a hostile work environment." Further noting that Tuli

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made repeated complaints about these acts, but the Hospital did nothing to prevent them from continuing, the court concluded that the jury was entitled to find that the Hospital was liable for tolerating a hostile workplace.

The First Circuit rejected the Hospital's claim that Tuli's lawsuit should have been dismissed because she failed to seek corrective action by filing a formal complaint, finding that Whittemore had discouraged Tuli from filing a formal complaint, and had conceded his knowledge of Tuli's reasonable fear of retaliation. The court also rejected the Hospital's claim that acts occurring more than 300 days before Tuli filed her complaint with the Massachusetts Commission Against Discrimination should not have been considered, finding that the cumulative acts of Day and Kim, including those occurring outside the 300-day window, constituted a continuing violation and a single hostile environment claim.

The First Circuit also rejected the Hospital's claim of erroneous admission of evidence bearing on the hostile workplace claim. The court found that comments attributed to Day and Kim, and testimony about Day having a penis statue and a cookie jar with underpants in his office, and downloading sexual drawings on another female employee's Palm Pilot were admissible to show "notice to the Hospital and toleration of a general climate of offensive remarks and displays."

Retaliation

On Tuli's retaliation claim, the First Circuit rejected the Hospital's claim that it was entitled to judgment as a matter of law. The Hospital admitted that the complaints Tuli had made about Day were "protected conduct," but disputed that Tuli had suffered "an adverse employment action" or that "a causal connection existed between the protected conduct and the adverse action."

The court found that the jury could deem the consequences of the obligatory counseling ordered by the credentials committee – "invasion of privacy, potential stigma, and possible impact on employment and licensing elsewhere" – sufficient to constitute "adverse action." The court also found that, even though there was no evidence that those involved with the credentials committee, other than Day, harbored any re-

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taliatory motive, and the hospital was required to respond to complaints about Tuli to safeguard patients, there was evidence that the Hospital failed to do so in an unbiased manner. That Day, in making his presentation about Tuli, failed to advise the committee that Tuli had complained about his conduct and had issued adverse reviews of his patient care was sufficient to allow a jury to conclude that he misled the committee. The jury was not bound to find the causal chain broken when Whittemore gave the second presentation, because Whittemore relied on unverified information from Day and also failed to advise the committee of Tuli's complaints about Day. Two committee members testified that knowledge of Tuli's complaints against Day would have been "important information."

Lessons to Be Learned

Hospitals, as part of their peer review processes for members of the medical staff and as employers, must have policies and procedures in place that they routinely follow to deal with disruptive, discriminatory, harassing, or retaliatory conduct. As employers, hospitals are precluded from tolerating a hostile work environment and must take prompt action to dismantle a hostile work environment if one is found to exist. As *Tuli* illustrates, complaints of discrimination and hostile work environment require immediate investigation and remediation. Had the Hospital in *Tuli* complied with its internal policies protecting employees against discrimination, retaliation and hostile work environment, Tuli may not have had a legal basis on which to proceed.

Hospitals, who frequently have both employed and non-employed physicians on their medical staff, should make sure that both the policies and procedures developed by the medical staff and those developed by Human Resources for dealing with disruptive conduct and hostile work environment issues are consistent with each other. Especially in the case of employed physicians engaging in improper behavior, both the medical staff and Human Resources may be involved in investigating and taking appropriate action to eliminate the bad behavior. Hospitals should have appropriate mechanisms in place for Human Resources and the medical staff to promptly share complaints regarding disruptive physician behavior with each other and to assure that the appropriate committee or department promptly investigates.

Honesty and Transparency Above All

Hospital peer review committees must exercise care to make sure that presentations made about a physician whose credentials or quality of care are being evaluated are scrutinized for bias and completeness. As *Tuli* demonstrates, hidden personal agendas have no place in presentations to such committees. Day clearly had a personal agenda against Tuli, and failed to disclose that Tuli had previously been critical of his care and had lodged complaints about his conduct. Whittemore then compounded the problem by also failing to disclose his knowledge of Tuli's adverse reviews of Day's cases, or her complaints about Day's conduct and fear of retaliation. Committee decisions adverse to a physician that are based on incomplete and misleading information may prove not only unsustainable but also incorrect, very detrimental to the physician, and very costly to the hospital.

Professional Collaboration is Encouraged

Medical Staff Peer Review Committee members may be well versed in the medical staff bylaws and medical staff policies, but may not be as conversant with the legal standards that govern a hospital workplace. When complaints about physician behavior arise in the workplace setting, consultation with Human Resources and/or outside employment counsel is encouraged.

Kim Baker and Mary Spillane are members in the Seattle office of Williams Kastner. Kim's practice emphasizes health care and employment law. Kim advises health care clients on risk management, credentialing, quality assurance, and employment issues, including terminations and investigations into discrimination complaints and EEOC charges. Mary's practice emphasizes health care law, state and federal appeals, medical malpractice and products liability defense litigation. Mary has chaired both the firm's Health Care Practice Group and Appellate Practice Group since their inception.

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Rush Commercial Develops Franciscan's Bonney Lake Medical Pavilion

By Nora Haile
Contributing Editor
Washington Healthcare News

There's a new "go to" center for health coming to Pierce County. Franciscan Health System has partnered with Rush Commercial to develop a 3.2-acre lot at SR 410 and 184th Street. The 45,000 sf medical office building, dubbed Franciscan Medical Pavilion-Bonney Lake, is one of the most recent Franciscan Health System projects in the area. Rush Commercial of Gig Harbor is the project developer as well as a building owner. "Franciscan is excited to be partnering once again with Rush Commercial," states Jeff Harrison, DO, Division Chief of Primary Care for Franciscan Medical Group, about the Bonney Lake project.

Matt Smith, President of Rush Commercial, says that this is a business model that has worked well in the past. "Cash flow in the industry has been tight. We help navigate financial options for healthcare project funding with the ability to leverage great long-term interest rates, as well as seek equity investors. It's all about relationships, and we've built many

Artist's Rendering of Bonnie Lake Medical Pavilion

over the years through our real estate development, construction and management companies."

Smith went on to share that their role in this project is as a developer only, rather than the combination of general contractor and developer roles they've often held. "The developer position of oversight for the other key roles means that every time we come to the table, it's as the owner's representative," he said. "Our development manager has to ask the tough questions and be highly knowledgeable about the process."

That means helping navigate not only financial paths, but also any code or design issues that may arise during the permitting process. For instance, Rush has worked closely with the City of Bonney Lake, ironing out any concerns that arise around off-site improvements, such as traffic impact to nearby intersections. As Smith says, "We work toward melding our vision and their vision."

Franciscan's vision is smart and strategic, as the Bonney Lake location positions the facility between St. Elizabeth Hospital in nearby Enumclaw and St. Joseph's Regional Medical Center in Tacoma. Franciscan's patients can be easily referred to either facility, depending on their needs. The facility is slated to offer primary care, a prompt care (urgent care) for minor illnesses and injuries, as well as including a laboratory, diagnostic imaging and other ancillary outpatient services.

Service delivery being the primary focus, Franciscan turned to the 3P Lean design process to come up with a highly efficient workflow and patient flow. The organization is excited about the process, believing it will take them to a new level in high quality, patient-centric design. Jeff Harrison, DO, Division Chief of Primary Care for Franciscan Medical Group, describes the effort. "A group of more than 60 Franciscan employees, along with some of our patients and strategic partners, spent a week focusing their efforts on the design of the new Franciscan Medical Pavilion. Our goal is to create a Lean and Collaborative design that will function efficiently and create a unified Franciscan presence for our future patients."

The project team has also integrated sustainable practices in their approach, and is incorporating a Pacific Northwest look and feel in the elements used. On the technol-

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Too Much Care? Stepped Up Medical Necessity Fraud Litigation Against Hospitals

By David B. Robbins
Shareholder
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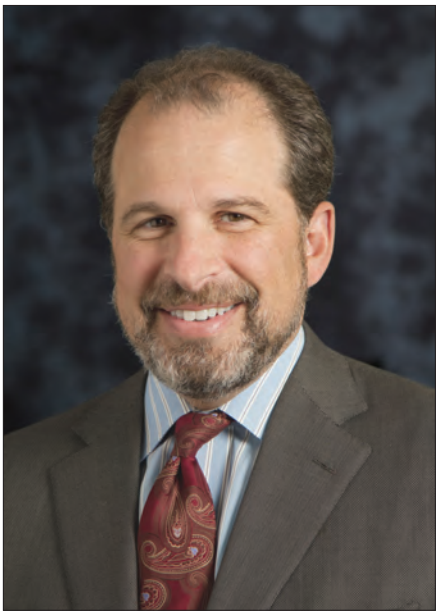

By Anastasia Anderson
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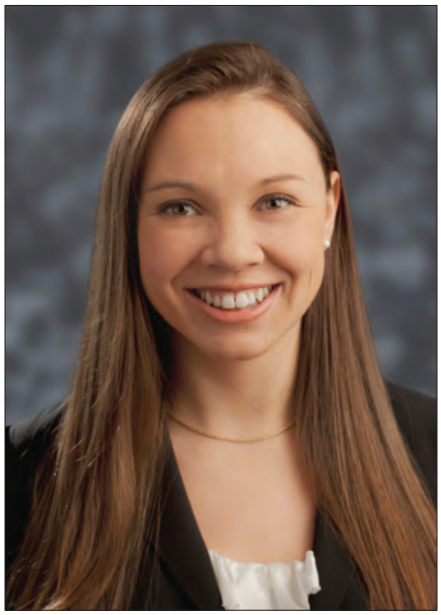

The view of fraud prosecution's new frontier is becoming clearer with the announcement of substantial new enforcement actions and settlements focusing on the hospital's role in the performance of allegedly unnecessary procedures. These cases should cause providers to take a fresh look at the intersection of risk management, peer review and billing where medical procedures are alleged to have been unnecessary or in excess of the patient's needs. Hospitals should evaluate how alleged unnecessary services reported through quality assurance channels might create repayment obligations and fraud prosecution risk.

In August, the U.S. Department of Justice ("DOJ") reported that Peninsula Regional Medical Center of Salisbury, Maryland paid $1.8 million to settle allegations that the hospital knew of, but failed to remediate staff members' concerns regarding a cardiologist's improper stent procedures. The physician was criminally prosecuted and convicted in July of six health care fraud offenses involving the heart stents, including falsifying patient records, performing unnecessary operations, and billing private and public insurers for these procedures. The DOJ accused the hospital's senior medical staff of failing to fully investigate the reports, and therefore, the submission of false claims for the associated procedures. In addition to repaying the amounts billed for the cardiac procedures, the hospital signed a Corporate Integrity Agreement ("CIA") with the Department of Health and Human Services, Office of the Inspector General ("OIG"), which, notably, requires it to appoint a full-time "physician executive" to police hospital quality of care issues, and a board-certified cardiologist to direct the cath lab.

Cardiac stent insertion appears to be a hot issue in this realm. In December 2010, yet another Maryland hospital, St. Joseph's Medical Center, was the unwitting recipient of DOJ's attention where it self-reported to the government and to its patients that an employed cardiologist reportedly implanted unnecessary stents in 585 patients between January 2007 and May 2009. The DOJ settled with St. Joseph for $22 million. This settlement related to these allegations as well as those that St. Joseph's paid illegal kickbacks to the associated cardiology group by overpaying for their practice and artificially inflating physician salaries above fair market levels. St. Joseph's woes did not end there, as the allegedly victimized patients have filed multiple suits against the hospital, as has the allegedly profligate cardiologist,

who believes he has been defamed by the hospital's self-reporting.

Even self-examination raises thorny questions. Excela Health of Pennsylvania initiated audits of 100% of the stent procedures performed by two staff cardiologists after learning of suspected problems. The audit, which cost Excela approximately $500,000, revealed that about 10% of the coronary stents may have been unnecessary. In its June 2011 press release, Excela explained that the patients were notified and offered additional consultation services. The health system also plans to reimburse the insurers. As far as we are aware, the DOJ has not yet knocked on Excela's door.

The government has also initiated nationwide campaigns related to the medical necessity of performing certain procedures on an inpatient rather than outpatient basis, allegedly because the reimbursement for inpatient services is higher. In one such investigation, nine hospitals have agreed to pay more than $9.4 million to settle allegations that they improperly billed kyphoplasty procedures as inpatient procedures in order to increase Medicare reimbursement. Kyphoplasty, the government contends, is a minimally invasive procedure to treat spinal fractures that often can be performed safely as a less costly outpatient procedure. The government is staking out this position despite the fact that Medicare quality improvement organizations accepted the procedures performed on an inpatient basis, and InterQual admission criteria, among others, treated them as being performed on an "inpatient only" basis. Similarly, the DOJ is currently reviewing whether cardiac defibrillator implants were performed in a manner that comported with a Medicare national coverage determination policy. Medicare Recovery Audit Contractors are looking at these and similar procedures as well.

It has long been common wisdom that, because medical necessity cases usually devolve into a battle of experts, such cases are poor candidates for fraud prosecution. However, as hospitals' compliance departments have become more effective in dealing with the more prosaic coding and coverage issues, the government is paying more attention to medical necessity as a basis for not only coverage determinations, but also the imposition of penalties. Providers can take a number of steps to mitigate their risk with respect to billing for medically unnecessary procedures:

1. Educate physicians about proper medical record documentation. Such documentation is essential to supporting medical necessity decisions.

2. Conduct regular audits (either internal or external) and pay attention to high-cost procedures that generate significant government reimbursement, or identify physicians who may be outliers in the incidence of such procedures;

3. Promptly and thoroughly investigate complaints or reports of potentially improper procedures;

4. For employed physicians, periodically review whether compensation levels are consistent with fair market value, as overpayment may lead to an inference that the hospital is encouraging unnecessary care; and

5. Implement policies requiring disclosure of financial relationships between physicians and pharmacy and device vendors. The pending implementation of the Payment Sunshine Act (§6002 of the Accountable Care Act), will assist as manufacturers will be required to disclose to the government information about all but the most nominal payments made to physicians. Nevertheless, a hospital's affirmative knowledge of these relationships may enable it to identify suspicious procedures and/or billing practices before it is too late.

Medically unnecessary care in the hospital raises a host of legal and political issues, fraud being only one. Assistance from counsel to address those issues should be sought early and often.

David Robbins is a shareholder of Bennett Bigelow & Leedom, P.S. David has a national practice that focuses on representing health care clients in litigation involving regulatory compliance, including false claims, antitrust, anti-kickback and physician self-referral rules, Medicare and Medicaid reimbursement and licensing. His clients include academic medical centers, hospitals, physicians and other providers.

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The Importance of Screening Medical Patients for Behavioral Health Issues

By Jeremy Senske, PsyD
Psychologist
UBC, Inc.

People seeking medical treatment in hospitals, healthcare clinics and in primary care settings often have behavioral health needs that are inadequately addressed. Discussing behavioral health issues in medical settings can ensure that patients are receiving proper care that addresses psychological conditions which may be interfering with medical interventions and treatment. Proper screening of a patient's potential behavioral health needs may generate appropriate referrals to behavioral health specialists, such as psychologists, psychiatrists, and counselors, when necessary to ensure that all of their needs are being addressed in a more interdisciplinary fashion.

Behavioral health services are widely accepted and recommended as effective treatment for conditions such as depression, anxiety, interpersonal issues, and other psychological conditions. Many individuals with medical conditions or chronic illnesses, such as diabetes, cancer and chronic pain, often suffer from comorbid depression and anxiety. In fact, 25% of individuals with chronic or severe medical illness will develop Major Depressive Disorder in their lifetime (American Psychiatric Association, 2000). Gender is often also a factor, for example twice as many women with diabetes have symptoms of anxiety or depression compared to their male counterparts (Grigsby, Anderson, Freedland, Clouse, & Lustman, 2002). A study done by Strine, Champman, Balluz and Mokdad (2010) found that inadequate emotional and social support is a major risk factor for adverse health behaviors and disability. Emotional health has also been associated with positive stress management and overall physical health (Richards, Campania & Muse-Burke, 2010). It is imperative that initial medical assessments address emotional and behavioral health issues in order to provide appropriate referrals for successful treatment.

UBC, Inc. (United Backcare) offers comprehensive behavioral health services to the community and also provides them as an integral part of interdisciplinary care for the management of chronic pain. Behavioral health services often encompass a wide variety of interventions, evaluations and assessments. Pre-surgical psychological assessments can help identify patients who may have psychological or psychosocial conditions that can impact compliance with the surgical procedure and/or follow up care. Opioid dependency screening and treatment can assist individuals in tapering off of narcotic medications, while also adjusting to lifestyle changes. Personality, cognitive and neuropsychological assessments can identify factors that may impact an individual's psychological, social, interpersonal, or occupational functioning in order to provide appropriate interventions and recommendations for further treatment. Telehealth services can provide psychological treatment to those who cannot make it to traditional office appointments or reside in remote areas. Behavioral health consultations with other clinicians and care providers facilitate ongoing dialogue between members of different disciplines in order to provide comprehensive and interdisciplinary treatment. Social and interpersonal factors must also be

taken into consideration, as many medical conditions are chronic, invisible and unpredictable, making support groups for chronic medical conditions beneficial. As psychological treatments continue to advance and become more specialized in the healthcare field, ongoing psychosocial research is also essential to behavioral health services. Internships, practicum and fellowships also provide opportunities for future psychologists, counselors, and clinicians to obtain experience providing psychological services within a multidisciplinary setting.

Adequate behavioral health screening and treatment also provides a number of financial benefits to the individual and society overall. Behavioral health treatment has been associated with reduced medical costs for some populations, as well as leading to an overall reduction in subsequent medical service use (Anderson & Estee, 2002). Pallak, Cummings, Dorken & Henke (1994) found that the use of managed mental health treatment was associated with a 20% decline in medical costs for those clients who received it. These managed mental health clients used the emergency room less, spent less time in the hospital, and received fewer controlled drug prescriptions. Many counties in Washington State have implemented mental health programs, such as PACT (Program for Assertive Community Treatment), which provide comprehensive and collaborative mental health services to the community. Results of these programs reveal substantial reductions in community and state hospital days (Anderson & Estee, 2002).

As we continue to advance medical science in theory, practice and treatment, it becomes increasingly important that we also utilize the availability of behavioral health services for these reasons. Behavioral health services are a necessary part of interdisciplinary care and can lead to increased health and quality of life in patients, reduce the burden of care to the medical community, and lead to comprehensive and cost-effective treatment for society as a whole.

Dr. Senske is a licensed psychologist in Washington State. His background includes working with individuals with psychosis, unipolar and bipolar depression, anxiety, chronic pain, as well as experience working with individuals in acute crisis situations. He is also an adjunct professor for Argosy University's counseling program.

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ogy side, they are using the popular building information modeling (BIM) tool. It provides a digital representation of the building process, facilitating the conceptual estimating phase and general project presentation and planning.

Chris DeWald, Rush Commercial's Vice President of Construction and Development, shares, "The BIM model becomes more critical as we get into mechanical drawings, and designing critical systems. We intend to use it for coordination throughout construction of the facility." Development manager for the project, DeWald went on to explain that the 3D model allows the various trades' plans to be viewed in overlay. BIM helps the team identify potential problems before building or fabricating, minimizing conflicts and rework in the field. "BIM allows for early design coordination and assists accuracy," he said. "It helps us build it once the right way, and expedite on the front end."

Doing things the right way requires tight teaming and well-matched capabilities, which the Rush and Franciscan partnership continues to demonstrate. Franciscan Health System brings a commitment to community, quality and efficiency in care delivery. Rush brings vertically integrated strength to the project with their experience as a developer, contractor, property management and investment company. With over a million square feet of professional office space under their management, Rush clearly knows the business and is committed to being the "go to" partner for their clients. As Smith states, "Clients like Franciscan can come to one entity for help with all the different facets. We're the only arrow they need in their quiver."

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Chief Human Resources Officer
(Wenatchee, WA)

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