



Letter from the Section Chair

## The Far Reach of Healthcare Reform Legislation

Healthcare reform legislation signed into law in March, 2010 by President Obama promises to bring sweeping changes to the healthcare system, and we as health lawyers will undoubtedly be called upon by our clients to help them navigate those changes. It is certainly going to impact my radiologist and diagnostic imaging clients and all of us as attorneys for health care entities.

**Short Term:** Signed into law were the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Together, they seek to expand access to health insurance (including subsidies, mandates, and market reforms); reduce health care spending (primarily through cuts to providers in the Medicare program, including payments my own diagnostic imaging clients' services) and institute a variety of other health policy reforms.

**Long Term:** The Patient Protection and Affordable Care Act has not immediately produced a systematic restructuring of the fee-for-service health care delivery system, but elements of the legislation could produce truly transformative change.

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The creation of programs for Medicare payments to accountable care organizations and demonstration projects for bundled payments could escalate a move to more vertical integration of health care providers. The obvious question in the future is whether hospitals will be the initial recipient and dispenser of the payments for hospital-based radiologists' services. Also, the reform law creates a new Independent Payment Advisory Board that is empowered to make recommendations for Medicare spending cuts that would go into effect automatically unless Congress votes to block them, potentially affecting all providers of Medicare services. The new law also embraces value-based purchasing and comparative effectiveness-research, both of which suggest the potential for Medicare payment based on quality outcomes.

It is also interesting to speculate how the increased population of insured patients will impact the practice of my radiologist clients who practice in tertiary hospitals and are burdened with a heavy population of indigent patients. Beginning in 2014, individuals with income up to 133% of the federal poverty level will qualify for Medicaid. The legislation mandates the purchase of insurance. And those individuals with income below 400% of the federal poverty level will qualify for subsidies to purchase health insurance coverage on newly-created state insurance exchanges.

In today's world, many of my radiology group clients currently bear a large load of uncollectable debt. The elimination of bad debt could be a significant plus to many hospital-based radiologists. With the potential elimination of charity care, there is even speculation that the death of charity care could threaten the tax-exempt status - or at least the exemption from local real estate taxation - of many 501(c)(3) charitable hospitals. Time will tell.

In short, the health care legislation certainly has known short-term impacts on imaging providers. But it's the potential for transformational - and currently unknown - changes that could be the lasting legacy of this legislation.

Sincerely yours,

*Tom*

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# Healthcare Reform and Other Recent Developments in Diagnostic Imaging

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This past year has produced some significant regulatory developments impacting radiologists and other providers of diagnostic imaging services.

## HEALTH CARE REFORM LEGISLATION

Cuts to diagnostic imaging payments. It is no surprise that diagnostic imaging has been a target for more than its share of the cuts. The strategy to cut spending for imaging services has been to decrease payments for the technical component of certain non-hospital advanced imaging services. Historically, CMS assumed that imaging equipment was used 25 hours per week (50% of the time) in applying practice expense RVS values to payments for imaging services. If this utilization factor were to be increased, the cost of the equipment (and thus the payments) would spread over more units of service, thus lowering the payments-per-procedure.

The 2010 Medicare Physician Fee Schedule final rule had adopted a 90% utilization rate for certain imaging equipment valued at more than \$1 million that CMS stated included CT and MR services. The higher rate was to be phased in over a 4-year period.

The Patient Protection and Affordable Care Act adopted a 75% utilization rate for CT, MR, nuclear medicine and PET equipment phased in over a 4-year period. The Reconciliation Act, however, set the final policy: a 75% utilization rate, effective 2011, applicable to the same modalities as defined in the 2010 Medicare Physician Fee Schedule final rule that CMS stated used imaging equipment priced at \$1 million or more: non-hospital technical component CT and MR services. Nuclear medicine and PET services appear to have avoided a payment cut.

Greater discounts for same-day studies. The Patient Protection and Affordable Care Act also increases the discount for the technical component of additional imaging studies performed on the same Medicare patient, the same day, from 25% to 50%. Many may recall that CMS had proposed to do this beginning in 2009, but decided against it based on data from the ACR showing that there were not efficiencies that warranted this multiple procedure discount. Congress nevertheless decided to implement the increased reduction for multiple procedures in its quest for savings.

## PROVISIONS AIMED AT SELF-REFERRAL

Disclosure. Physicians who order tests for their own patients in reliance on the Stark in-office ancillary services exception for MR, CT and PET services are required to inform their patients in writing that the services can be obtained elsewhere and provide the patient with a list of suppliers of the imaging services in the area where the individual resides.

Appropriateness criteria demonstration project. The Secretary of HHS may consider a project to study the impact of varying the payment to physicians who order advanced imaging services (MR, CT, nuclear medicine and PET) in accordance with the physicians' adherence to appropriateness criteria.

## OTHER DEVELOPMENTS

Place of Service/Date of Service Transmittal. On February 5, 2010 CMS gave notice that it was rescinding Change Request (CR) 6375 titled, "Place of Service (POS) and Date of Service (DOS) Instructions for the Interpretation (Professional Component) and Technical Component of Diagnostic Tests." This transmittal would have required split-billing of the PC and TC of diagnostic tests if the place of service codes or the dates of service for the two components were not identical. Despite efforts by organizations, including ACR, RBMA, HBMA and MGMA to have CMS withdraw the transmittal, CMS announced last December that it would delay only the date of service portion of the original transmittal. The industry continued to seek a delay of the POS instructions to carriers. CMS declined to do that - until February 5, 2010.

The POS instructions were very controversial and the guidance from carriers on how to implement POS coding varied widely. The rescission announcement has been met with widespread approval from the industry. CMS is expected to revisit the issue in the coming year.

Anti-Markup Test Manual Instructions. On Jan. 15, CMS issued an update to the Medicare Claims Processing Manual (Change Request 6733) addressing "Payment to Physician or Other Supplier for Diagnostic Tests Subject to the Anti-Markup Payment Limitation." The transmittal contains an action that may prove to be a major setback for many teleradiology arrangements that operate across state lines.

Most of this transmittal is not surprising, it's just putting Medicare's anti-markup requirements in place. But the issuance has set back a practical and commonsense billing technique that has been permitted by CMS since 2005. For the last five years, an independent diagnostic testing facility (IDTF) or radiologist-owned imaging center that had tests ordered by physicians who had no financial interest in the imaging center could contract for independent contractor interpretation services regardless of location of the interpreting physician and bill the center's local Medicare carrier (Medicare Administrative Contractor). The only requirement was that the imaging center denote the zip code of the interpreting radiologist so that the claim for the interpretation service would be paid based the correct Medicare geographic practice cost index.

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Effective March 15, CMS has replaced its rules permitting zip code billing for what were called "purchased interpretations" with a rule that will permit zip code billing for only those tests "subject to the anti-markup payment limitation." Only those out-of-state interpretation services subject to the anti-markup payment limitation can be billed to a local Medicare Administrative Contractor (MAC). Only referring physician groups that bill for interpretation services by physicians who do not share their practice can now use this efficient billing zip code billing methodology.

IDTFs and radiology groups that have imaging centers will now be required to take reassignment from the out-of-state radiologists and enroll with and submit their claims to the out-of-state MAC (carrier)-or have the out-of-state interpreting radiologist bill separately. Formerly, IDTFs and radiology groups that have imaging centers could report the zip code of the out-of-jurisdiction interpreting physician when submitting the 1500 claim form to their local MAC. Now, since most of them don't perform anti-markup tests, they must take reassignment and bill the MAC in the jurisdiction where the interpreting physician performed the service.

Supervision of Medicare Hospital Outpatients. The 2010 HOPPS Final Rule standardizes the supervision requirements for all hospital outpatient diagnostic tests. Beginning January 1, 2010, all diagnostic tests provided (directly or "under arrangements") by a hospital (1) in the main buildings of a hospital, (2) in a provider-based department of a hospital or (3) in a non-hospital location must be performed in accordance with the physician supervision requirements described in the MPFS Relative Value File, which indicates whether the supervision of a particular test must be general, direct or personal.

The 2010 MPFS Rule also gives specific context to how direct supervision is accomplished in the various settings.

- In the case of diagnostic services furnished on-campus, direct supervision is accomplished when the supervising physician is present on the same campus and immediately available to furnish assistance and direction throughout the performance of the procedure.
- In the case of diagnostic services furnished off-campus, direct supervision is accomplished when the supervising physician is present in the off-campus provider-based department of the hospital and immediately available to furnish assistance and direction throughout the performance of the procedure.
- In the case of diagnostic services furnished in non-hospital location (i.e. services provided "under arrangements" to the hospital in a freestanding diagnostic imaging center or a physician office), direct supervision means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

CMS confirmed in the final HOPPS Rule that non-physician practitioners, like nurse practitioners and physician assistants, cannot supervise diagnostic tests. Only physicians can supervise these tests

On May 28, 2010 CMS issued Transmittal 128 that appears to have gone far beyond the final rule and the rule's preamble statements regarding the qualifications of physicians who must supervise diagnostic tests for Medicare outpatients. The transmittal makes more restrictive than the final rule the proximity of the supervising physician. Here is the key new language:

*Immediate availability requires the immediate physical presence of the physician. CMS has not specifically defined the word "immediate" in terms of time or distance; however, an example of a lack of immediate availability would be situations where the supervisory physician is performing another procedure or service that he or she could not interrupt. Also, for services furnished on-campus, the supervisory physician may not be so physically far away on-campus from the location where hospital outpatient services are being furnished that he or she could not intervene right away.*

*The supervisory physician must have, within his or her State scope of practice and hospital-granted privileges, the knowledge, skills, ability, and privileges to perform the service or procedure. Specially trained ancillary staff and technicians are the primary operators of some specialized diagnostic testing equipment, and while in such cases CMS does not expect the supervisory physician to operate this equipment instead of a technician, the physician that supervises the provision of the diagnostic service must be knowledgeable about the test and clinically appropriate to furnish the test.*

New Requirements for Documenting Orders of Imaging Services. CMS published an interim final rule with comment period on May 5th implementing several changes to the Medicare and Medicaid programs mandated by the Patient Protection and Affordable Care Act. In the interim final rule, CMS exercised its discretion to expand the requirements of the Affordable Care Act in ways significant to imaging centers and radiology practices across the country. Notably, the rule places new burdens on maintaining written orders for imaging services and identifying the legal name and National Provider Identifier or "NPI" of the ordering physician or practitioner on the claim.

The interim final rule represents one of the first efforts by CMS to issue rules implementing the requirements of the Affordable Care Act. In this effort, CMS addressed three separate issues. First, the new rule requires both the furnishing and ordering provider or supplier of Medicare Part B services to maintain documentation of the order or referral for 7 years. Second, it requires providers and suppliers to include their NPI on all Medicare enrollment applications, as well as all claims submitted to the Medicare and Medicaid programs. Third, the rule requires physicians and other eligible professionals who order services for Medicare beneficiaries to be enrolled in the Medicare program or to maintain a valid opt-out record.

Accreditation of Advanced Imaging Services. Section 135(a) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires all non-hospital suppliers of advanced imaging services be accredited by organizations designated by the Secretary of HHS by January 1, 2012, to qualify to provide services to Medicare beneficiaries. In January 2010, CMS published a Federal Register notice announcing its approval of the following three national accreditation organizations to accredit suppliers seeking to furnish the technical component of advanced diagnostic imaging services (MR, CT and PET) under the Medicare program: the American College of Radiology, the International Accreditation Commission, and The Joint Commission.

# Biting the Hand that Feeds?

## JCAHO Mandates Healthcare Organizations Get Tough with Disruptive Practitioners



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*Enraged by the hospital's nursing shortage and a two-hour wait for lab results, Dr. A vented his frustration by yelling profanities at the charge nurse in a crowded waiting room and then threw a magazine in the air for added emphasis.*

While inappropriate behaviors are not exclusive to healthcare settings, they have long been tolerated due to hospital administrators' reluctance to antagonize physicians who bring patient admissions to the organization's revenue stream. Physicians themselves were equally reluctant to counsel their peers on behavioral issues, lest they become the next "victim."

But healthcare organizations may no longer tolerate disorderly behavior from physicians and staff. A JCAHO standard made effective Jan. 1, 2009 requires JCAHO accredited providers—including hospitals, nursing homes, ambulatory surgery centers and home health agencies—have policies in place that define acceptable, disruptive and inappropriate behaviors. In addition, procedures must be implemented to review complaints, impose sanctions and protect against retaliation.

Personal conduct was tackled because the JCAHO views disruptive behaviors as a serious threat to patient safety and the overall quality of care. Threats, assault and criminal actions are behaviors easy to identify, and are certainly targets of Leadership standard LD.03.01.01. But targets also include non-constructive criticism leveled in a way to intimidate or imply stupidity; placing demands on staff that having nothing to do with improving patient care; and making rude or derogatory comments to patients or visitors.

The JCAHO has provided a list of suggested actions to guide a facility's compliance. As expected, physician and staff training is recommended to educate the healthcare team on the organization's code of conduct, as well as a review of basic business etiquette, phone skills and people skills. While this requirement seems reasonable, the

challenge is to ensure equitable treatment among all staff, especially with regard to non-employed physicians.

Zero tolerance clauses are typically found in administrative policies, and now must be incorporated into medical staff bylaws and employment agreements. Non-retaliation clauses should also be considered, and organizations may wish to include a requirement that any report is made in good faith and without malicious intent.

According to the JCAHO, compliance also requires an organization's plan include suitable responses to patients, families and visitors who witness disruptive behavior. Acceptable responses could include empathy for their concern and appreciation for sharing. If an apology is provided, it should only express benevolence, sorrow or sympathy, and nothing that could be reasonably construed as an admission of guilt or wrongdoing.

The JCAHO also recommends that an interventional ladder be established that starts with non-confrontational "cup of coffee" conversations with the disrupter. The focus at this stage is to address the conflict, overcome it and move forward on a base of trust, accountability and patient safety. These chats, while informal, should directly address the problem and move toward a detailed action plan if problems progress. If any statements from informal conversations may be used against the alleged disrupter, organizations should evaluate if appropriate due process protections are in place to pull the conversation under the peer review privilege and the Health Care Quality Improvement Act (HCQIA).

Disciplinary action will vary between employees and medical staff members in private practice, and should be approached cautiously. Counsel should review medical staff bylaws to ensure disciplinary actions are addressed and a process is clearly set forth, being heedful that in some instances disciplinary reports may need to be submitted to professional licensure bodies. In addition, counsel should review applicable state laws regarding peer review immunity and confidentiality protections to ensure that any medical staff bylaw revisions do not inadvertently fall outside of such protections.

Physician counsel should also consider a review of applicable state laws regarding peer review immunity and confidentiality protections to ensure any bylaw revisions do not fall outside protections. Counsel should also encourage physician clients to attend medical staff meetings that concern bylaw revisions. In addition, if applicable, counsel should review the terms of employment and service contracts to determine whether definitions of unacceptable, disruptive and inappropriate behaviors could conflict with bylaw revisions.

In addition to personal conduct, the Leadership standard also impacts executive committee functions, departmental leadership, credentialing and performance improvement processes.

The process of implementing the new Leadership Standard will not be easy. Hospital administrators and physicians will need to agree on such things as what constitutes "disruptive behavior." In the end, the process should benefit all concerned, especially patients, with better outcomes.

# Amendment to § 54.1-2413(E) of the Code of Virginia: HB 143 (2010)

The Health Law Section Council of the Virginia Bar Association successfully offered a legislative initiative addressing practitioner self-referral during the 2010 Session of the Virginia General Assembly. An amendment to § 54.1-2413(E) of the Code was offered to clarify this section that was adopted several years ago.

## BACKGROUND

42 U.S.C. § 1395nn is the Federal physician self-referral law, known as the "Stark Law." The Stark Law prohibits a physician from making referrals for certain "designated health services" ("DHS") payable by Medicare to an entity with which the physician (or immediate family member) has a financial relationship - either an ownership/investment interest or a compensation arrangement - unless an exception applies.

The Stark Law limits a physician's ability to profit from his own referrals for DHS. DHS consist of 10 categories of services, such as clinical laboratory services, imaging services (including MRI and CT), radiation therapy services, home health services, etc. Importantly, the Stark Law only applies to referrals for the limited set of specific health services that are DHS.

Virginia has its own version of the self-referral prohibition - the Practitioner Self-Referral Act, § 54.1-2410, et seq. (the "Act").

There are a number of significant differences between the Stark Law and the Act but, for the purposes of the legislation, the important differences are that:

- The Stark Law applies only to referrals for DHS, whereas the Act applies to referrals for any health services;
- The Stark Law applies to both compensation arrangements and ownership or investment interests between referring physicians and the entities to which they refer, whereas the Act applies only to physician ownership of the entities to which they refer; and
- The Stark Law applies only if Medicare is a source of payment, whereas the Act applies regardless of the source of payment.

## 2005 AMENDMENT TO THE ACT

Because of the differences between the Stark Law and the Act, a Virginia physician could structure an arrangement that complies with the Stark Law, but which violates the Act (and vice-versa). As a result, several years ago the Act was

amended to try to coordinate the two self-referral provisions. In 2005, § 54.1-2413 was amended to add subsection E, which provided:

E. Notwithstanding the provisions of this chapter, a referral to an entity with which the referring practitioner or his immediate family member has an arrangement that would qualify for an exception under federal practitioner self-referral law, 42 U.S.C. § 1395nn, as amended, or any regulations adopted pursuant thereto, permitting a practitioner or an immediate family member of a practitioner to maintain an ownership or investment interest in an entity that provides designated health services, shall not be in violation of this chapter, regardless of the type of health service provided or the source of payment for such service.

The goal of the 2005 amendment was to protect a Virginia physician's referrals if the referrals were protected by the Stark Law. The amendment sought to make the exceptions that are available under the Stark Law also available under the Act, regardless of whether the referrals involved DHS or whether the services were payable by Medicare.

Unfortunately, the language of the 2005 amendment could have been interpreted several different ways, some of which were never intended, and at least one interpretation would have resulted in an exception that swallowed the rule, effectively gutting the Act.

For example, former subsection (E) could have been interpreted so that:

- If a Virginia physician invested in an entity, and the physician referred a patient to the entity in which he invested, but the referral was for a health service that was not a Stark Law DHS, then the referral would always be excepted from the Act because the Stark Law would never apply to a referral where DHS was not involved.
- Similarly, if a Virginia physician invested in an entity, and the physician referred a patient to the entity in which he invested, but the referral was not for a service paid for by Medicare, then the referral would always be excepted from the Act because the Stark Law would never apply to a referral where Medicare was not the payor.



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Those results were never intended.

## 2010 CLARIFYING AMENDMENT TO THE ACT

The new amendment resolves the former ambiguities and clarifies the Act in accordance with the original intent of subsection (E). The amendment is as follows:

*E. Notwithstanding the provisions of this chapter, a referral to an entity in which the referring practitioner or his immediate family member is an investor shall not be in violation of this chapter if (i) the health service to be provided is a designated health service as defined in 42 U.S.C. § 1395nn(h)(6), as amended, and an exception authorized by 42 U.S.C. § 1395nn, as amended, or any regulations adopted pursuant thereto, applies, or (ii) the health service to be provided is not a designated health service as defined in 42 U.S.C. § 1395nn(h)(6), as amended, but would qualify for an exception authorized by 42 U.S.C. § 1395nn, as amended, or any regulations adopted pursuant thereto, if the health service were a designated health service.*

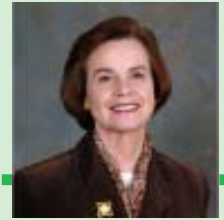
Essentially, the new amendment requires that, regardless of the health service that is being referred by a physician who has an investment interest in the entity to which he is referring, the health service is to be viewed as though it were subject to the Stark Law, and then a determination is to be made whether there is an exception under the Stark Law that would permit the arrangement. If the arrangement satisfies the requirements of a Stark Law exception, then the arrangement is also excepted from the Act. Conversely, subsection (E) does not apply if the arrangement does not come within a Stark Law exception.

Thus, the proposed amendment clarifies the Act's exception to accomplish the objective that was originally intended. It limits the scope of the Act's exception, and requires that investment/referral arrangements that are subject to the Act be tested against the Stark Law before they can be excepted from the Act's self-referral prohibitions.

The VBA gratefully acknowledges the efforts of Delegate John O'Bannon for his sponsorship of this legislation.

# Sensible Intervention to Manage Disruptive Behavior in Health Care Facilities and Avoid Fatal Distraction

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Compliance with The Joint Commission's Leadership Standard concerning Behaviors That Undermine A Culture of Safety, LD.03.01.01<sup>1</sup>, is a timely, important, but potentially troubling subject. Jon Joseph and Michael Guanzon have been doing an excellent job of presenting this subject to health lawyers. They presented their program once again in January 2010<sup>2</sup> with the addition of some discussion by this author about using informal process (conflict management and mediation) to manage disruptions effectively and where possible without unnecessary and damaging legal consequences for the players. This article will restate and expand upon some of the points made concerning use of informal processes.

To begin, it is worth noting the importance of the subject and the value of crafting useful tools to prevent repetition of incidents that could endanger safety and quality of health care. The stated purpose of the Leadership Standard is in fact to protect safety and quality of care. Most of us could agree that the flawed communications and behaviors common in some workplaces today are nonetheless just too risky or unhelpful in healthcare facilities.<sup>3</sup> But the broad language of the standard, and when read along with TJC's Suggested Actions, could lend itself to possible unintended and inappropriate consequences. A poorly crafted, understood or implemented policy, code of conduct and implementation process will be potentially damaging to all or any of the players. As an ounce of prevention, this article proposes use of conflict management and an informal "Step Back" process to assess and resolve situations involving conflict or communication issues before invoking a formal disruptive behavior incident process.<sup>4</sup>

It would make good sense for the disruptive behavior program to draw upon conflict management resources and capabilities existing within the accredited healthcare facility. After all, disruptive behavior scenarios can involve a lot of conflict. Representing clients in both medical staff credentialing disputes and Board of Medicine defense has shown that what may present as a "problem physician" can often be something else, once one looks below the surface. Precipitating complaints, or incidents or patterns are often the manifestation of underlying conflicts, competition, or really poor communications. Taking advantage of expertise, lessons learned and training opportunities existing elsewhere in the facility would avoid duplication of efforts.

Accredited healthcare facilities are required by TJC to have a conflict management policy and process that is implemented within the facility to minimize the damage of unresolved conflict that imperils the safety and quality of care (sound familiar?). Like the Disruptive Behavior Leadership Standard, this conflict management (CM) requirement became effective on January 1, 2009.<sup>5</sup> Accredited facilities are also required to manage conflicts between leadership groups to protect the quality and safety of care.<sup>6</sup>

Because of these CM requirements, healthcare facilities

that are in compliance will have their own unique versions (broad latitude is allowed) of policy and processes that must be implemented, and by individual(s) either on staff or from outside with skill in conflict management. The process must include meeting with individuals and groups involved in the conflict to gather information about the issues, and to help them try to resolve matters. Because of the relative lack of guidance from TJC about the CM Leadership Standards, The American Health Lawyers Association (AHLA) ADR Service published a Conflict Management Toolkit which offers a good amount of helpful information for facilities and their lawyers to come into effective compliance.<sup>7</sup>

Like its CM program, a hospital's disruptive behavior compliance program will consist of a policy (or code of conduct), clear processes with responsibilities for them identified, and should include orientation for all in the facility about the policy, what to expect from the processes, and how to use them appropriately. Applying conflict management concepts and skills to handling, even preventing, disruptive behaviors can begin with the development of the disruptive behavior policy and code of conduct. Getting the various departments within the organization to hammer out a policy for universal application - about what behavior is acceptable and unacceptable, what triggers which process, who gets to call the shots, who runs the process, who monitors its use - will call for, in some facilities if not most, a kind of facilitation or conflict management. The same will apply within departments.

Taking the time and trouble at the outset to work through some assumptions and age old conflicts to arrive at a policy and the bones of process can go a long way to building credibility for the program and a foundation for trust sufficient to encourage its use. There is a lot of "us" and "them" in medical politics, health institutions and their daily operations, as well as embedded prejudice between professions. Moreover, traditional roles and responsibilities have been undergoing radical changes, cultural and otherwise, but not always with clarification about the changes, accountability and liability keeping apace. Such negatives could be inadvertently perpetuated by a proforma compliance approach. A boilerplate code or process, or assigning responsibility for creating these to a chosen group that uses it as a chance to exercise power could doom the program to lackluster support.

Once the policy and code of conduct is clear, I urge that a preliminary step be created that is informal, without direct legal consequences, and that precedes decision to invoke formal investigation and process.<sup>8</sup> The idea is to allow people room to pause, and communicate with the goal in mind of resolving matters efficiently and effectively with

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respect for all involved. This initial response could be called a "Step Back" (a non-inflammatory term keyed to a communication skill that will be mentioned again later in this article). It would precede what might be treated as a formal complaint or grievance to any office or body within the hospital responsible for investigating incidents, complaints or grievances, and that allows for a heavy dose of problem-solving and prevention. A skilled individual would gather information about a particular situation neutrally, enlisting the participation and help from persons involved, help identify the issues, suggest what needs to happen next and present those involved with options, if they haven't figured things out already themselves. This is not dissimilar from what facilities should have in place to handle conflicts within the facility. With regard to medical staff, it is the proverbial cup of coffee but with a method and someone who knows how to make the method work to its best advantage.

"Step Back" could function like a triage system. It may be that the outburst or incident is a result of personal conflict or misunderstanding between individuals that would benefit from private facilitated (mediated) conflict resolution assisted by the hospital conflict management service, or that might be settled then and there by a conversation and a handshake. It may be that the assessment reveals misunderstanding of policies, or roles and responsibilities that require clarification. It may be that the behavior is so egregious, or appears to be a pattern of behavior that is disturbing the ability of others to do their jobs properly, or has disturbed patient care such that the intervener refers the matter to job counseling or performance review, medical staff review or EAPs, for investigation and handling.

The intervener or screener should not only be someone who is skilled (trained) but whose role is to function neutrally as between the parties involved, while nonetheless accountable to standards and policies of the hospital (much like a bioethics mediator is).<sup>9</sup> The intervener shows respect to all persons involved and sets a problem-solving tone from the beginning.

The program for handling possible disruptive behavior will benefit from use of core capabilities that empower everyone to communicate better. A few "truisms" support the point. Healthcare communications take place sometimes under stressful circumstances that are plainly not conducive to clear, effective or polite communication. Second, in situations of puzzling, inscrutable, or outrageous behavior, people observing it tend to freeze and don't know what to do or say. The "wrong thing" may then be said, or the matter is swept under the rug and nothing is done.<sup>10</sup> Health lawyers know that conflicts in hospitals can go from 0 to 60, perhaps unnecessarily in hindsight, in a very sudden moment with consequences that can be hard to avert or undo. This point is well made in examples of well intentioned but poor communication skills that played out with particularly awful consequences in the airline industry (as analyzed by Malcolm Gladwell in a chapter in his third book, *Outliers*, in which he writes about why airplanes crash.<sup>11</sup>). The parallels to communications in a hospital setting are striking.

There are consultants and products used in training about communications skills that may be helpful. As part of the "excitement" in non-legal literature for nursing, administration, and conflict resolution professionals, about the disruptive behavior standard,<sup>12</sup> there is advocacy for communications approaches, some of which are

trademarked. Whatever communications program or training is used, I think it is wise that the communications skills be developed and taught in the context of the behavior policy and code of conduct, and if possible in a shared manner. Different groups may respond better to different communications tools or lessons; training could be customized. But common reasons and goals of changed communications skills or protocols would go a long way toward their larger success.

The focus on communications would also be consistent with a well organized and implemented CM program. These observations about communications, gleaned from experience as a lawyer counseling and representing clients, and as a mediator and facilitator, might be helpful. Communications entails three parts: what the person communicating intends to get across, the actual communication (written, oral, action) and third, what the recipient of communication actually perceives. In situations where things have gone awry, where there is unresolved conflict, often it is because the three parts of the communication do not match. Untangling the web and undoing the damage done or perceived is part of the resolution process.<sup>13</sup> (Of course sometimes the disagreement is more substantive, involving genuine difference of opinion about the best or right way to do something. Skilled facilitation to resolve such differences of opinion can lead to new ideas that neither person or group saw previously).

Concrete examples of using conflict management and communications skills to good effect in healthcare facilities is to be found in a study conducted at the University of Ottawa Medical Center.<sup>14</sup> Medical faculty and residents were trained in a conflict management framework and basic communications skills. They were surveyed afterwards about what they thought they had learned. One year later, they were surveyed again to ask if they ever applied what they had learned, was the effort successful and what did they really learn? The communications framework for conflict management given the physicians was rather simple and included: making time and space for communication (the "Step Back"),<sup>15</sup> identifying and avoiding simple words and phrases that can be inflammatory, using words and phrases that open communication, listening well (this takes practice), seeking to discern and communicate interests, assessing thoughtfully what has been communicated. The survey responses were perhaps unsurprising that the trained physicians found they could avert problems more easily and diffuse lingering conflicts in daily health care delivery. Comments included the power they felt they acquired (to alter a situation) by finally understanding what was really bothering the other individuals. In some of the situations cited, a lawyer would have been able to supply a quick legal answer (some incidents actually did have black and white legal answers) but the negative interactions or their aftermath could have lingered absent the communications and problem solving that were employed to clear the air as well as identify solutions.

At all times, it will be important to remember that the jurisdiction or purpose of any disruptive behavior program (and thus the definition of disruptive behavior) is to prevent and address behavior that compromises the quality and safety of healthcare delivery. It is not to address personality issues, assuage hurt feelings or promote one person's concepts of what is politically correct behavior. Rather, in those kinds of situations, persons involved might choose to

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use a hospital CM service, or simply do their jobs and go home.

The Joseph-Guanzon program sets out the numerous issues health lawyers need consider in conjunction with implementation of the disruptive behavior standard. These legal concerns are beyond the scope of this article. But there are implications for health lawyers raised by this proposal for an informal pre-step, to be considered during development of the facility program and when advising clients about participation in the "Step Back" or screening phase. The "Step Back" discussion or other informal screening conversation should not be considered an "investigation" for purposes of whether an investigation has been launched that could trigger reporting requirements later on. It is more in the nature of a first response effort to pre screen whether a situation even merits formal investigation. Reference to or characterization of this preliminary informal step (which would not only apply to medical staff members) in Medical Staff Bylaws, if any at all, should be carefully and accurately worded.

Issues of confidentiality and privilege will be important to the lawyer representing an individual or the facility if a particular matter is revealed as a more serious one that escalates to investigation and formal action taken against an employee or an independent medical practitioner.

With respect to confidentiality, the informal process should include clarification about the extent of confidentiality of communications and records. Confidentiality is in general a good idea for the informal process. It would give the parties a greater comfort level to allow the process to work for them by setting a tone of mutual respect and limiting the chance for hurtful gossip. An important exception to confidentiality is likely some degree of reporting by the neutral/intervener (whether in-house or outside neutral) to administration or leadership so the facility can assess whether the program appears to work well in service of quality and safety of care, and to assure that state reporting requirements are not inadvertently ignored. The parties themselves can be expected to enter a mutual confidentiality agreement with regards to the informal process that spells out any other allowable exceptions. Lawyers advising the facility on the disruptive behavior program should advise concerning a form agreement (or provision included in the training about the program) and the neutral's reporting parameters. Confidentiality provisions in agreements to undertake mediation could be a helpful reference point.<sup>16</sup>

With respect to privilege of an informal process, such process could possibly fit within an ombudsman privilege if Virginia had one but alas, Virginia does not recognize such a privilege. When informal response in some situations moves deliberately into a conflict management phase, that phase of the process can be structured as a mediation within the definition of Virginia Code Section 8.01-581.22 to avail the process of a Virginia statutory confidentiality as far as impermissible disclosure in administrative or judicial proceedings (with exceptions). Otherwise, whether communications and records from different phases of the facility disruptive behavior program fall within the application of any privilege accorded hospital processes like peer review and quality assurance process will require a separate and fuller analysis.

The extent to which physicians and their legal counsel will be comfortable with the idea of an informal process will depend to some degree upon the reputation of the

facility's program (policy and process) for fair, neutral and competent administration. Becoming familiar with the disruptive behavior construct within the facility where your client works can assist you when counseling a client about productive use of an informal approach. Besides preventing serious incidents, use of conflict management and communications opportunities can help actors within the facility bring problems back down as fast as possible to a "can we talk?" level. It equips people to overcome the limitation identified earlier - our natural tendency (being conflict averse) to avoid dealing directly with awkward, unpleasant problems. Prevention is also advised by health lawyer Michael Jordan who counsels that physicians should be forewarned to cultivate cordial relations with nursing staff, and to recall that not all battles with administration can be won (or need be won, for that matter).<sup>17</sup>

In conclusion, alleged disruptive behavior incidents could sometimes be resolved or future ones prevented by good faith communications and conflict resolution process that is more affable than a disciplinary investigation and proceedings that can actually have the undesirable effect of transforming small problems into larger ones. While the disruptive behavior issue is often framed as the disruptive physician problem (which it sometimes is), the literature about this standard is beginning to reveal concern within nursing ranks that the problem is often their own.<sup>18</sup> Bullying and other negative group interactions, the acting out of prejudices, are not the property of anyone group. Further, disruptive behavior is not always the obvious incident or behavior but can be the subtle corrosive work of an uncooperative or manipulative individual. An honest approach within the facility to identify and deal with problems in a manner that is less threatening and more conducive to willing changes should be a respected part of the disruptive behavior program. Finding ways to help people stay on track or to get back on track seems a laudable goal. Undertaken in a positive spirit that strengthens morale and respects all individuals, the disruptive behavior program might become a more effective one.

## Notes

1) This Standard, effective January 1, 2009, and its Elements of Performance 4 and 5, require that accredited facilities address disruptive behaviors by creating a code of conduct defining acceptable and disruptive, inappropriate behaviors, and implementing a process created to manage the disruptive, inappropriate behaviors. The Joint Commission will be referred to as "TJC" through the remainder of this article.

2) The Program Disruptive Physicians: Tension, Dissension, Prevention and Intervention-Resolution Without Revolution, was presented on January 23, 2010 during the Virginia Bar Association's Annual Meeting.

3) Or, in airline cockpits for that matter to which certain parallels can be drawn. We can't have people hurling objects during surgery, providing healthcare and making decisions while impaired or working on their laptops while they should be focused elsewhere (since unnecessary multi-tasking could create a fatal distraction.) Even sustained bickering while actively engaged in testing and treatment is at least counter-productive.

4) There might be situations where the informal preliminary step would not be appropriate because the disruptive behavior involves actions that must be addressed in more immediate, formal, disciplinary or therapeutic ways.

5) LD.01.03.01

6) LD.02.04.01

7) The Conflict Management Toolkit, of which this author is also a co-author, was published in December 2008. It is available free of charge and can be downloaded from the AHLA website. (available at: [www.healthlawyers.org/adr](http://www.healthlawyers.org/adr)).

8) Suggested activity Number8 on TJC's list of "Other Suggested Actions" references a tiered approach to include an informal one.

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# The New SMFP: One Year Later... and More Changes Ahead?



**Jamie Baskerville Martin**  
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After more than 15 years with only minimal changes, Virginia's State Medical Facilities Plan ("SMFP") was revised in 2009 and is now on a path of regular review and revision. Participants in the Certificate of Public Need ("COPN") program should be aware of the process and substance of the SMFP revisions in order to identify COPN-related challenges and opportunities and to ensure effective participation in the regulatory process.

## Background

The State Medical Facilities Plan is the set of regulations implementing Virginia's COPN law. The COPN law mandates state authorization for endeavors defined as "projects" by the law. Projects include:

- establishment of a medical care facility
- an increase in the total number of beds or operating rooms in an existing medical care facility
- the establishment of certain high-acuity services such as organ transplant or open-heart surgery
- the introduction of certain diagnostic imaging services or equipment, including MRI and CT.

See VA. CODE ANN. § 32.1-102.1.

The SMFP sets forth the standards for the review of each project. For example, the SMFP for surgical services

establishes the formula by which the number of inpatient and outpatient operating rooms needed in a planning district shall be determined. This formula takes into account historical and projected utilization of a planning district's operating rooms, historical and projected population, and the average hours per general purpose operating room visit in the planning district. 12 VAC 5-230-500. Any decision to issue or approve the issuance of a certificate shall be consistent with the most recent applicable provisions of the State Medical Facilities Plan. VA. CODE ANN. § 32.1-102.3A; see also *Roanoke Mem'l. Hosps. v. Kenley*, 3 Va. App. 599, 352 S.E.2d 525, 529 (1987) (defining consistent as meaning, *inter alia*, "in harmony with" or "in general agreement with," and not "exactly alike" or "the same in every detail").

## A Long-Awaited Revision

The prior version of the SMFP was implemented in 1992. Application of the SMFP's standards proved increasingly difficult as advances in medical technology, among other changes, arguably made certain SMFP provisions outdated. In fact, the General Assembly anticipated such challenges and provided for a "set-aside" of the SMFP. Virginia Code Section 32.1-102.3A provides that the

Commissioner may approve COPN projects despite SMFP non-compliance if appropriate evidence is presented "that the provisions of [the SMFP] are not relevant to a rural locality's needs, inaccurate, outdated, inadequate or otherwise inapplicable." See also *Johnston-Willis, Ltd. v. Kenley*, 6 Va. App. 231, 369 S.E.2d 1 (1988). By 2006, more than half a dozen provisions of the SMFP had been set aside. Some set-asides recognized that the use of certain COPN-reviewable equipment had changed enough since the 1992 drafting of the SMFP to make the provisions inapplicable. For example, in recognition of the evolving nature of positron emission tomography ("PET") from a cardiac imaging technology to a cancer imaging tool, the Commissioner set aside the standard for the consideration of additional PET scanners in 2002. Other set-asides acknowledged arguments that utilization thresholds were inappropriate. For example, in 2003 the Commissioner set aside certain utilization standards relevant to proposals to replace acute care hospital beds off-site, while in 2006, the Commissioner set aside the standards for computing the need for medical/surgical beds, pediatric beds, and

*Continued page 11*

## Sensible Intervention Cont'd...

9) The limits of neutrality of a bioethics mediator, that is the necessity of presenting to disputants and enforcing standards that constrain ethical medical decision-making, is well described in: Nancy Dubler and Carol Liebman Bioethics Mediation, A Guide To Shaping Shared Solutions (United Hospital Fund 2004).

10) An example of how hard it is for intelligent, caring people to know how to define much less handle an inscrutable problem is illustrated in the story of a physician who became incapacitated over time due to mental health issues. It is described in the chapter, "When Good Doctors Go Bad" in Atwul Gawande's *Complications, A Surgeon's Notes on an Imperfect Science*, Picador (2002).

11) Malcolm Gladwell, *Outliers, the Story of Success*, Little, Brown & Company (2009).

12) E.g., Survey of Doctor-Nurse Behaviors discussed in series of short articles published online by American College of Physician Executives (available at: [http://net.acpe.org/Services/2009\\_Doctor\\_Nurse\\_Behavior\\_Survey/index.html](http://net.acpe.org/Services/2009_Doctor_Nurse_Behavior_Survey/index.html)).

13) The art or skill of mediating includes figuring out how to help people get past their opinions to open their minds to different problem analysis and approaches. I have a pithy guide called "The ABCs" of fatigued, "old", or unproductive

thinking which you can find on my website at [www.franklinsolutions.net](http://www.franklinsolutions.net).

14) Ellen B. Zweibel, Rose Goldstein, John A. Manwaring, and Meredith B. Marks, *What Sticks: Medical Residents and Academics Health Care Faculty Transfer Conflict Resolution Training from Workshop to the Workplace*, 25 *Conflict Resolution Quarterly* 3321 (Spring 2008).

15) A "step back," "time out," "slow down" concept, is finding its way into operating room protocols, I was recently told by a New York surgeon, who described how the OR team pauses before "opening," and runs through a protocol to check who the patient is, what the operation is, what the body part or location is, and other details, before a scalpel is raised.

16) Rule 3.03 in the American Health Lawyers Association ADR Service procedural rules applicable to mediation could suggest parameters of allowable neutral reporting. (available at: [www.healthlawyers.org/adr](http://www.healthlawyers.org/adr)).

17) Michael Jordan, "Representing the Disruptive Physician," in ABA Health esource, September 2009 (available at: [www.abanet.org/health/esource/Volume6/01/Jordan.html](http://www.abanet.org/health/esource/Volume6/01/Jordan.html)).

18) Theresa Brown, R.N., "When the Nurse is a Bully," *Well Blog NYTimes*, February 11, 2010 (available at: <http://well.blogs.nytimes.com/2010/02/11/when-the-nurse-is-a-bully/?emc=etal>).

# Social Networking for Health Lawyers: Do You Know Where Your Clients Are Today?



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Although the means and the methods change, the goals are the same: make yourself known, and clients will find you. The way health care clients find their lawyers today is different, but many lawyers still do not know the difference. Younger lawyers have grown up professionally without ever having used a typewriter or dictating machine, let alone engaging in dictation to someone using shorthand. Telephones tethered to wall sockets and having dials (no one "dials" a telephone number anymore and many have never used a dial telephone or even a pay by coin telephone) gave way to push button telephones that could easily be unplugged and to wireless telephones connected to one base device, which now seem to be anachronisms because cellular telephones and personal digital assistants including Blackberrys and iPhones have become the customary way of communicating using voice and texting.

Advertising by law firms, which used to be called business development, and before that wasn't even called anything because it would have been unseemly to talk about it, now appears on the web including on law firm home pages and elsewhere, albeit not always identified as what some might say it is, in fact. But changes have come slowly, including those relating to professional codes of lawyer conduct and how they affect social networking by health lawyers, and many laws have not changed at all with respect to new ways of advertising.

What should a health lawyer be doing in 2010 to provide a reasonable measure of protection, now that a minute of creation using a computer or personal digital assistant connection to the internet can result in transmission, in less than a minute, of a message to many thousands of recipients that never can be expunged by the sender? First, be humble: the new world of using technology to communicate and to become known to clients and to other lawyers is arriving quickly and, as with many features of

the internet, without an overall organizational framework, and wise lawyers are respectful of the awesome power of the internet and the complexities that must be mastered. Learning anything new can be difficult, whether in law or in using technology to enhance a law practice, and learning most everything of value takes time and study. Social networking is new and difficult for many lawyers to understand, and applying traditional rules relating to the sharing of information relating to lawyers and relating to clients can be confusing.

A basic rule regarding using social networking in connection with a health law practice is the need to remember that information disclosed to anyone via social networking conduits and information disclosed to anyone via what might be characterized as traditional conduits (by way of example, via speech and written paper-based correspondence) can be considered to be information that is disclosed inappropriately, particularly if health information is involved. So, insofar as disclosure is concerned, initially, the means of disclosure may not be relevant to the question whether there has been a disclosure, even though the consequences caused by those receiving any such disclosure can profoundly be different.

Disclosing information relating to a client or some other individual or entity, whether via social networking or via traditional means, has to be evaluated initially by determining whether the disclosure was authorized under applicable rules of professional conduct or other potential restrictions relating to the particular client or other subject of the disclosure. But the consequences of which means of disclosure is used can differ, particularly when the magnitude of potential recipients is considered. So, an inappropriate disclosure of client information by a lawyer to another person in a personal conversation, when compared with an inappropriate disclosure of such information via a

social networking feature on the internet that can involve many thousands of recipients of the inappropriate information, implicates substantially more adverse consequences for the lawyer involved.

But the threshold analysis that would be undertaken for the personal conversation disclosure and for the social networking disclosure is the same: should the disclosure have been made and was the disclosure authorized or permitted. Unfortunately, the ease of creating and disseminating information via social networking features on the internet can be conducive to a far greater risk of inadvertent disclosure and substantially more adverse consequences for the lawyer, particularly because "taking back" information so disseminated is likely to be impossible.

Special kinds of information require special attention. Information that can be considered to disparage or defame a client, whether disclosed in a personal conversation or via social networking features on the internet, likely will be considered to give rise to the consequences of disparagement or defamation, regardless of the means of disclosure. But the consequences of social networking disclosures can involve far more substantial magnitudes of damages, because the number of potential recipients, and the difficulty, and perhaps the impossibility, of mitigating damages, is so different from other forms of disclosure.

Another special type of information is health information, as health lawyers well know, and particularly health information that is considered, under the Administrative Simplification Subtitle of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as

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# SMFP

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intensive care beds.

Comprehensive changes to the SMFP were initially published in 2004, but implementation was delayed due to stakeholder concerns. Multiple comment periods and advisory committee meetings ensued, and the State Board of Health finally approved final revisions to the SMFP on July 18, 2008. The revised SMFP went into effect on February 15, 2009. 25 Va. Reg. Regs. 1707 (Jan. 5, 2009).

The "new" SMFP is an improvement in many respects, but some participants in the COPN process have contended that the new SMFP has some holes. For example, the MRI provision for adding or expanding mobile services is worded in such a manner that it appears to anticipate only the addition or expansion of mobile services by an existing provider, not by a new provider. In a recent review for radiation therapy services, a hospital applicant argued that the SMFP standard for new radiation therapy services should be set aside because, inter alia, it contains a threshold that had never been met in the planning district. The hearing officer discussed the set-aside request at length, noting that, "[t]he readoption of the [SMFP] reflects Virginia government's dedicated efforts to attain, in 2009, consensus with advocates of health care facilities planning, representatives of hospitals' interests and other interested persons over the various, prescriptive terms of a revised SMFP (major provisions of which dated to 1992). Provisions of the new SMFP should not be set aside offhandedly . . . the provision is reasonable; setting it aside pursuant to statute is unwarranted." Adjudication Officer's Recommendation in re: COPN Request Nos. VA-7622 and 7626 at 9 (August 21, 2009) (emphasis in original). Notably, despite the fact that the SMFP's volume thresholds were not met in that review and were not set aside, the underlying COPN application was approved, with the hearing officer recommending and the Commissioner deciding that the project was "generally consistent with the SMFP." Decision on COPN Request Nos. Va-7622 and 7626 at 2 (August 26, 2009); Adjudication Officer's Recommendation at 9-10, 16.

## SMFP Task Force

Lawmakers, regulators, and participants in the COPN process all recognized the challenge of a full-scale overhaul of the SMFP and the need to update the regulations more than once every 10 or 15 years. In 2008, the General Assembly enacted legislation establishing a SMFP task force and mandating review of the SMFP every four years. Specifically, Virginia Code Section 32.1-102.2:1 states: "The Board shall appoint and convene a task force of no fewer than 15 individuals to meet at least once every two years. The task force shall consist of representatives from the Department and the Division of Certificate of Public Need, representatives of regional health planning agencies, representatives of the health care provider community, representatives of the academic medical community, experts in advanced medical technology, and health insurers. The task force shall complete a review of the State Medical Facilities Plan updating or validating existing criteria in the State Medical Facilities Plan at least every four years."

The current task force consists of 25 people representing various stakeholders in the COPN process. Representatives of academic medical centers, children's hospitals, for-profit and non-profit hospital systems, nursing home operators,

payors, physicians, allied health providers, healthcare associations, the Virginia Department of Health ("VDH"), and the Division of Certificate of Public Need ("DCOPN") are on the task force. For a complete list of task force members, see: <http://www.vdh.virginia.gov/OLC/documents/2008/pdfs/SMFP%20TF%20roster.pdf>.

## Task Force Meetings

The task force first met in September 2008 and formed a number of subcommittees to address specific SMFP-related issues. These issues include the preferred source of population data to be used in need calculations, the formation of a medical advisory group to assist DCOPN in evaluating COPN applications for new uses of existing technologies, and the further revision of radiation therapy standards. Many participants in the COPN process had found these three issues to pose particular challenges in assessing public need and regulatory compliance. For example, the SMFP had mandated the use of Virginia Employment Commission ("VEC") population data, but many COPN applicants argued that VEC data were inadequate and instead advocated the use of other data sources. In addition, the clinical complexity of radiation therapy, coupled with the many different types of treatments that may be defined as "radiation therapy," had led to considerable dispute over the appropriateness of the SMFP's radiation therapy standards.

Additional meetings were held in late 2008 and throughout 2009 and addressed topics such as the frequency of task force meetings (thrice yearly), other revisions to the COPN law, and the role of the SMFP in offering guidance on how to weigh public support and competition in the determination of a public need. The most recent task force meeting was held on March 24, 2010. At the March 24, 2010, meeting the task force discussed the benefits of establishing additional service-specific subcommittees to report to the task force. The director of DCOPN, Erik Bodin, also noted that DCOPN had recently obtained new mapping software to aid in the review of COPN applications.

In the meantime, the radiation therapy subcommittee has been active. In January and February of 2010, that subcommittee surveyed providers with registered radiation therapy equipment on topics ranging from the number of single-modality machines to the average treatment time per patient. The survey response rate was 92.2% and revealed, among other things, that 66.2% of registered machines are multifunctional, less than 15% of facilities offer weekend hours, and treatment times vary widely among providers. The results of the survey were discussed at the March 24 task force meeting. Participants noted with enthusiasm the high survey response rate and the helpful survey results. Comments at the task force included observations that data showed that all "treatments" are not equal and that the data may support adjusting the SMFP's utilization thresholds on a more regular basis to reflect evolving technologies.

With approximately two years remaining in the SMFP review cycle, the task force will be considering a number of important issues. The next SMFP Task Force meeting has not yet been scheduled. The public may observe the meetings. A calendar of VDH meeting dates is available online at <http://www.vdh.virginia.gov/Administration/Meetings/>.

*The author wishes to thank Susan Gray Page for her research assistance.*

# Social Networking

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"protected health information" which a lawyer is given by a client that is a "covered entity" or a "business associate" under HIPAA. While an inappropriate disclosure of protected health information by a lawyer during a personal conversation could implicate potential violations of federal and state law and applicable professional rules of conduct, such an inappropriate disclosure via social networking features on the internet could involve thousands or even many millions of potential recipients and could cause governmental authorities to take a far more aggressive approach in seeking to enforce applicable law including the imposition of financial and professional and other sanctions.

Yet another concern is taking inconsistent positions regarding particular matters of health law. If a lawyer, during a personal conversation with someone, takes a position on a matter of law that differs from the position the lawyer is taking in a case being handled for a client, the likelihood of an adverse consequences likely will be minimal, unless the recipient of the information takes action that causes the lawyer's views to be publicized generally or transmitted to the lawyer's client.

But if the lawyer disseminates the lawyer's views regarding a matter of law via social networking features on the internet, the potential magnitude of recipients can be great, and the consequences are far more likely to be adverse for the lawyer, both under applicable rules of professional responsibility and otherwise.

Advertising by lawyers can be controversial, and some state bars likely will be using social networking and other internet-disseminated information as a basis for evaluating and if appropriate, sanctioning lawyers for transgressions of the applicable rules of professional conduct. The greater likelihood that social networking information will be available to the public and to potential clients, and possibly the more (inappropriately) convincing nature of such information, jointly could form the basis for more stringent enforcement and sanctions by state bars.

As the foregoing illustrates, social networking creates a new dimension of risk, far greater in magnitude and with likelihood of adverse consequences occurring than when information inappropriately is disclosed in personal conversation or in written paper-based correspondence.

Among the best ways for a health lawyer considering using social networking features on the internet to avoid transgressions is the creation of a policy setting forth evaluative and procedural rules for considering and, if appropriate, disseminating information via such social networking. These rules should include, *inter alia*, what types of information are appropriate for dissemination (including consideration of applicable health care laws involving the nature of the particular information and possible requirements for authorization or consent of others before dissemination occurs); how information to be

disseminated is created (by way of example, creation while off-line and without inserting an "addressee" in a draft electronic mail message always is best, because inadvertent activation of a "send" or "upload" feature of a social networking site or a related electronic mail front end application can be devastating and irreversible); and what type of validation process, before dissemination, will occur (so that there can be a second level of review that could prevent flawed initial reviews from being final reviews -- some electronic mail applications provide a "delayed send" feature so that an electronic mail message, even if "sent", can be stopped before being uploaded).

Lawyers also should consider what could occur if, in the event of either an inadvertent or wrongful intentional disclosure via social networking features on the internet, a claim is made against the lawyer either for damages or for

violation of law or for violation of applicable rules of professional conduct. Although policies of liability insurance may be available to address claims involving cybersecurity breaches and violations of laws relative to libel and slander and misappropriation of intellectual property, social networking-related claims might not fall within the provisions of existing insurance policies and protection might require special underwriting and endorsement, and possibly even

manuscripted endorsements.

Unfortunately, the privacy and security policies of electronic mail vendors, internet service providers, social networking web site vendors, and others involved in the internet-based electronic communications process likely are going to be inconsistent and not easily understood by a lawyer who is not skilled and experienced in reviewing and understanding the contracts involved and the applicable law. Accordingly, before engaging in social networking involving the internet, it would be appropriate to consider engaging the professional services of a lawyer who is competent to provide the necessary advice and who can assist in the preparation of policies and rules, and of an overall compliance program, in order to minimize risks and maximize the likelihood of compliance with applicable laws and the particular behaviors and the etiquette involved in effective social networking.

There is little doubt that in the next several years, the already dramatic increase in the use of social networking features on the internet by lawyers will increase even more, as devices such as multi-use cellular telephones and tablet computers, that can easily be used to create, transmit, and read, social networking information, are available in greater numbers and at lower prices.

The wise health lawyer already is preparing for the extraordinary changes in information disclosure and dissemination. Embracing change is a necessity and no longer a luxury, particularly when information technology and lawyers are concerned.





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### From the Editor's Pen

The article, *Addition of § 54.1-2910.2*, in the Fall 2008 issue of Health Law News, authored by Hon. Stephen D. Rosenthal, incorrectly indicated that, prior to the addition of § 54.1-2910.2, the Notice of the Board's allegations was posted on the Board's website when the Notice was sent to the provider. Prior to the statutory addition, the Board had adopted an internal policy of not posting a Notice on its website until after there was a final Order in the case. The Notice was still a public document and the website would indicate that "additional public information" about a provider was available. The Notice could be obtained by contacting the Board and requesting the "additional public information." Once the Order was final, the Notice and Order were then simultaneously posted. This included the posting of Notices and Order even if the provider was exonerated. Section 54.1-2910.2 codified the Board's internal policy and added a new provision that prevents the posting of Notices and Orders in cases that did not result in disciplinary action. The author regrets the error.

The editor expresses gratitude to Jeff Wurzburg of The Virginia Bar Association Health Law Section for editorial assistance with this issue.

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