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## *The Legal Environment*



Risk Management  
Compliance Planning  
Ethical Issues

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This module presents three topics related to legal influences on the business of seniors’ housing and care:

**Risk management:** Controlling the uncertainties related to the operation of seniors’ facilities; taking action that can reduce the possibility of adverse consequences, anticipated and otherwise.

**Compliance planning:** Developing a comprehensive strategy to reduce risk and protect the organization by establishing high levels of quality care and ensuring compliance with laws and regulations.

**Ethical issues:** Some of the tradeoffs that facility managers must make to find the right balance between sometimes conflicting principles.

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### NOTES:

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*Why Manage Risk?*



- Loss of Property
- Liability/Tort Litigation
- Workers Compensation
- Criminal Conduct
- Officer Liability
- Loss of Reputation
- Loss of Public Funding
- NATCEP Prohibition
- Loss of Licensure
- Termination of Provider Agreement

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“Let me count the ways!”

Several factors can jeopardize a seniors’ housing facility’s profitability or even close it down. The facility must adhere to legal requirements if it receives public funding; these requirements often come from all levels of government. Under any circumstances, the facility must meet licensing requirements to stay open and meet standards of care to avoid declining occupancy or even lawsuits.

Increasingly, seniors, their families, and others are filing major lawsuits against facilities, particularly when they hold the facility responsible for abuse or wrongful death of a patient.

Some have led to awards in the millions; further, some facilities’ officers and staff members are now being held personally liable.

However complex, demanding, and at times seemingly pointless regulations might be, they are a fact of life in seniors’ housing and care. Of even greater importance, however, managing risk is a critical part of facility and corporate operations—regulations notwithstanding.

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*Areas of Risk*



- Nursing
- Medical Director
- Administrative
- Human Resources
- Third Party Contracts

3

**Risks associated with nursing.** As detailed in “Long-term Care and the Law/Risk Management,” the most common citation and negative survey areas related to nursing are:

- Improper care planning and assessment
- Poor-quality patient care
- Improper restraint care
- Improper falls assessment
- Elopement/wandering
- Pressure sores and pain management

**Risks associated with Medical Director:**

- Failure to act as back-up in need
- Failure to monitor physician performance
- Failure to respond to patient change in condition
- Failure to provide appropriate support
- Failure to resolve contract issues

**Administrative risks:**

- Failure to monitor contract issues with third-party providers/attending physicians and medical directors
- Failure to implement and follow ethical guidelines in such areas as use of feeding tubes and euthanasia
- Failure to comprehend seriousness of survey cycle
- Failure to monitor state licenses/licensure status and qualifications of physicians and/or staff

**Human resources/personnel risks:**

- Understaffing/failure to screen staff adequately
- Failure to train staff regarding survey process

**Third-party contract risks**

- Failure to address proper concerns in contracts
- Failure to address responsibility for third party actions
- Failure to require and coordinate proper documentation

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*New Tools*



- False Advertising Statutes
- Criminalization of Survey Citations
- Increased Tort Litigation
- Qui Tam (False Claims)
- FBI/OIG Involvement

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The government is no longer limiting its attention to the use of surveys and their attendant remedies. A variety of other tools have surfaced over recent years:

**False advertising statutes:** Advertising (in any form) can adversely affect litigation if it makes unrealistic promises to the resident or family. Such statements as “aging in place” or claims of above-average quality of care can put the facility at risk, including from a class-action suit.

**Criminalization of survey citations:** Omnibus Budget Reconciliation Act (OBRA) regulations, initially designed to

create a standard of care, have become a liability standard. This development is being attacked on several fronts because it is a violation of the regulations’ original intent and because they require substantial, not perfect, compliance. But it is being pursued regardless.

**Increased tort litigation:** There has been a significant increase in suits for alleged negligence resulting in resident injuries—from those caused by staff removal of side rails or patients becoming entangled in bed rails to suicide.

**Qui tam (false claims):** In these actions, a plaintiff sues on behalf of the government to secure damages for illegal acts. The government then decides to take over the claim, in which case the plaintiff receives a percentage of the recovery. The plaintiff can still sue independently if the government does not take over the claim.

**FBI/OIG:** Increasing involvement of the Federal Bureau of Investigation (FBI) and the Office of the Inspector General (OIG)—primarily attorneys—reflects enhanced and continuing Federal Government scrutiny of seniors’ housing.

## *The Litigation Avalanche*



- Malpractice
  - Duty
  - Breach
  - Causation
  - Damages
- Vicarious Liability

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During the 1970s and 1980s, juries started awarding very large amounts of money in response to professional malpractice suits, much more than those typically awarded for automobile accidents and other incidents. Often, the amount awarded seemed to have little relationship to the actual professional transgression or harm caused.

Four elements must be established to indicate negligence:

**Duty:** Reasonableness based on community expectations, although the definition of “community” is becoming broader, sometimes national, in scope

**Breach:** Violation of the duty

**Causation:** Proof that the alleged negligence was a substantial factor in the damages in question

**Damages:** That the plaintiff was, in fact, damaged or injured

Vicarious liability increases the facility’s exposure by making it liable for the acts of employees if those acts are related to their employment. The extension of this liability to private physicians can be problematic, since residents are free to choose their own physicians. The facility, therefore, is liable for the actions of professionals they did not select and who have no formal connection to it.

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## NOTES:

## *New Consequences*

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- Market Reputation
  - Insurer Hesitancy
  - Impact on P/L
  - Hitting All Sectors

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**Market reputation** and the effects of heavy media coverage of lawsuits can be as damaging as the suit itself. A facility that comes to be known as “the place where that patient died because they gave her the wrong medication” will have considerable trouble attracting new residents. As recent articles in “Consumer Reports,” the “New York Times,” and other publications suggest, this is not a problem limited to nursing facilities.

**Insurer hesitancy:** There used to be 40 long-term care insurers in Florida; now there are only 20; only 4 of these are actively

writing policies. Such major insurers as The St. Paul Companies no longer provide long-term care coverage at all.

When juries started awarding such large judgments in malpractice suits, insurance companies dramatically raised their premiums. Some physicians responded by increasing their own rates, while others gave up malpractice insurance altogether.

The problem has been even greater for facilities. Many nursing homes, for example, can’t even get liability insurance, which not only puts them at risk but adversely affects their ability to get loans. The result may be an increase in the number of facilities going bankrupt.

**Impact on profit and loss:** One nursing home operator, Beverly Enterprises, Inc., recently agreed to pay the government \$175 million in a fraud settlement. Such expenditures have had obvious impact on the already financially troubled chains, which have had to increase reserves to stay in business.

**Hitting all sectors:** Suits no longer affect only nursing homes. For example, Alterra was forced into a recent settlement by the state’s Attorney General regarding staffing and other issues in a Minnesota facility.

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*Control of Risk*



- Do Right!
- Document!
- Quality Assurance
  - Reporting
  - Resident Satisfaction Surveys
  - Informed Consent
  - Evaluation of Care Plans

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Obviously, the best way to control risk is to prevent negligence or malpractice in the first place. And the best way to prevent negligence or malpractice is to institute effective *quality assurance*. The facility should have a formal quality control plan that addresses the following issues:

- Assessment and care planning issues, including reviewing physicians’ work and auditing care plans
- Quality of care and related staffing issues

- Adequate staffing plans, including employee recruiting/screening and retention and training; dealing with turn-overs and absenteeism
  - Regular and effective training programs with full documentation of topics, attendees, etc.
  - Exit interviews with employees to gain information regarding facility procedures
  - Procedures to deal with suspected neglect or abuse
- Thorough *documentation* is another effective way to protect the facility. The OIG provides these guidelines:

- Keep all records and documentation required by government agencies at all levels, including the resident assessment instrument, treatment plan, and corrective actions in response to surveys
- Keep documentation required by private payers
- Maintain data that support financial records
- Provide records that confirm compliance and the program’s effectiveness.

In addition, OIG recommends securing the information, keeping both hard and electronic copies, and limiting access.

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*Corporate Compliance:  
What It Is*



Formalizes the Standards and Guidelines

- That Govern the Operations of Corporation in Accordance With:
- All Known Legal Duties, and
- The Highest Standards of Ethical and Professional Conduct

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The OIG believes that a facility’s compliance policies should start with a statement that affirms its commitment to provide the care and services necessary to maintain the resident’s highest practicable physical, mental, and social well-being. To achieve the goal of providing quality care, facilities should continually measure their performance against comprehensive standards that, at a minimum must include Medicare, Medicaid, and licensure requirements.

A sample introduction to a compliance plan:

Our residents live in a variety of settings, including independent living apartments and cottages, assisted living suites, special care units, and skilled nursing units. Much of what we do is regulated by law, but our responsibility does not end there. We are obligated to our residents to treat them fairly and ethically with dignity, respect, and the utmost attention to their needs and desires. This compliance plan applies to all aspects of our operation and is intended to ensure not only legal compliance but that the service and care provided to our residents meets our own high standards.

An effective compliance program can be good for business and manage the risks associated with business operations by:

- Helping ensure compliance with applicable laws, regulations, and program guidance
- Improve operational functions
- Improve the quality of services
- Reduce costs.

*Corporate Compliance:  
What It Is Not*



- Book
- Manual
- Limited
- Someone Else’s Responsibility

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Virtually every facility has some kind of compliance manual, set of standard operating procedures, etc. But if the material is ignored, out-of-date, insufficiently detailed, inaccurate, etc., it will be worthless.

An effective compliance manual has three characteristics:

- Participation by the entire staff (or representatives from all departments and disciplines) in preparing the manual
- Ready access to the manual and encouragement of the staff to use it regularly

- Ongoing updating so it reflects—or drives—changes in policies or procedures.

The manual must become an active part of the facility’s culture and mindset. While it can support the organization in legal matters, its ultimate purpose is to establish and maintain internal quality standards and a “culture of compliance.”

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**NOTES:**

### *WHY---Internal Forces*



- Corporate Mission
- Growth and the Resulting Complexity of Operating and Controlling the Organization.
- Increasing Number of Personal Injury Claims
- Survey & Enforcement Trends

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Seniors' housing is becoming more complex, between expanding medical treatments on the one hand and increasing scrutiny on the other. The scrutiny is coming from numerous sources, including public (government funders, local licensing boards) and private (residents' families, advocacy groups, consumers' publications). As this scrutiny becomes more intense, more individuals become liable—from corporate officers to nonprofessional staff.

But, even were that not the case, it should be a part of any corporate mission to adhere to generally accepted policies and procedures in managing corporate operations.

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*WHY--- External Forces*



- Increased Anti-Fraud Enforcement Activity
- Increase in Qui Tam Claims
- Regulatory Compliance
  - GAO Report Nursing Facilities, March 1999
  - GAO Report Assisted Living, April 1999
  - Health Care Fraud Control Act 1999
- Legislative/Regulatory Action AL
- Consumer of Service

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A reflection of increasing government scrutiny is that health care fraud is the #2 priority of the Department of Justice. Last year, the Federal Government spent over \$200 million to fight health care fraud and abuse. It took in \$524 million in judgments and settlements.

In addition, in 1994, 36% of qui tam lawsuits were related to health care; this year, 61%.

Federal acts that have affected long-term care:

- **Medicare and Medicaid Acts:** Establishes standards facilities must meet to receive payment
- **State common law:** Becomes an issue in most malpractice actions
- **False Claims Act:** Provides criminal penalties for any false claims or statements related to Medicare or Medicaid
- **Nursing Home Reform Act:** Requires facilities to meet federal standards regarding care
- **Civil Monetary Penalties Act:** Provides penalties and damages for fraudulent claims
- **Balanced Budget Act of 1997:** Restricts nursing home involvement of individuals convicted of a felony; increases penalties for individuals or facilities that violate anti-kickback provisions.
- **Health Insurance Portability and Accountability Act of 1996:** Further limits individuals who may participate in the long-term care field.

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*Goals*



- Improve Operational Functions and Quality of Service Delivery.
- Establish Internal Controls to Achieve and Sustain Compliance With All Applicable Standards.
- Ensure Legal Duty Not to Submit False or Inaccurate Claims and Engage the Health Care Community in Combating Fraud /Abuse.

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Fortunately, three necessary and worthwhile goals are sufficiently related that achieving one results in achieving the other. These goals:

- Provide quality care, which ultimately increases occupancy and profitability
- Establish policies and procedures to monitor success in achieving the first goal
- Meet government standards, protecting the facility from legal action, loss of funding, or revoked license

The best protection is a proactive approach: operating a quality facility that meets standards of care is the best way to adhere to government regulations.

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*Benefits (Mission/Customer)*



- Demonstrates Commitment to Responsible Corporate Conduct in Accord with Customer Expectations,
- Increases the Likelihood of Identifying and Preventing Behavior Inconsistent With the Corporate Mission, Thereby
- Improving the Quality, Efficiency, and Consistency of Corporate Services.

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The OIG goes on to identify twelve specific benefits of a compliance program:

1. Provides a mechanism to bring public and private sectors together to reach mutual goals of reducing fraud and abuse, improve operational functions, improve quality, and reduce costs
2. Helps implement effective internal controls to assure compliance with rules
3. Fosters a public image of commitment to compliance

4. Provides a structured method to evaluate employee and contractor behavior
5. Helps to identify unlawful or unethical behavior
6. Enables the employer to react quickly to employee concerns and to target resources
7. Improves the quality, efficiency, and consistency of service
8. Provides employees with a mode of communication for reporting potential problems
9. Creates a centralized clearinghouse for information on rules
10. Provides a mechanism for improving internal communications
11. Provides an effective investigation mechanism
12. May reduce penalties through early detection and screening

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**NOTES:**

### *Benefits(Internal Operations)*



- Improved Internal Communications,
- More Timely and Accurate Assessment of Employee and Contractor Behavior,
- Mechanism to Report Potential Problems, Investigate and Take Corrective Action, Thus
- Affording Quicker and More Effective Reaction to Employees’ Concerns.

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As previously noted, every compliance program should be based on detailed written compliance standards, procedures, and practices. Ordinarily, the compliance officer will oversee development of the compliance document (and its updating), supported by the compliance committee, operations managers, and perhaps outside authorities in long-term care operations.

The compliance document informs all employees of day-to-day procedures and how their positions fit into these procedures.

The material should be provided to the following:

- All employees
- Physicians
- Suppliers
- Facility agents
- Contractors

The procedures should also address non-clinical areas, such as administrative and financial services.

Finally, the document can support quality control activities by identifying standards, on-the-spot resolution of minor problems, reporting of other issues, and, when necessary, escalation of the issue to a higher level of authority.

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*Benefits (Legal/Regulatory)*



- Centralized Source of Information on Law, Regulations and Other Program Directives,
- Internal Controls to Ensure Compliance With Rules, Laws and Regulations,
- Reduced Exposure to Civil Damages, Penalties, Criminal Sanctions, and Administrative Remedies.

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The OIG draws the following conclusion regarding compliance programs:

“The OIG recognizes that the health care industry in this country, which reaches millions of beneficiaries and expends about a trillion dollars annually, is constantly evolving. The time is right for...facilities to implement a strong voluntary health care compliance program. Compliance is a dynamic process that helps to ensure that [long-term care] facilities and other health care providers are better able to fulfill their commitment to ethical behavior, as well as meet the changes and challenges being placed upon them by


Congress and private insurers. Ultimately, it is the OIG’s hope that a voluntarily created compliance program will enable ...facilities to meet their goals, improve the quality of resident care, and substantially reduce fraud, waste, and abuse, as well as the cost of health care to Federal, State, and private health insurers.”

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“Managing Long-Term Care Services for Aging Populations”

*What’s Included*



Seven Basic Compliance Elements

- Standard of Conduct/ethical Behavior
- Training and Education
- Effective Lines of Communication
- Internal Review and Audit Program
- Protocols for Problem Investigation
- Program of Remedial Actions
- Designation of Compliance Officer

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**Standard of conduct/ethical behavior:** This discussion reflects and reinforces the facility’s commitment to ethical operations.

**Training and education:** The program should be regular and “on-target” and include all employees.

**Effective lines of communication:** Communication should include a hotline or other reporting system that employees can use to register complaints. There should also be a mechanism to protect individuals who identify ethical issues and other problems within the organization.

**Internal reviews:** The reviews can evaluate such areas as compliance, problem areas, and ways to reduce identified problems.

**Protocols for problem investigation:** These protocols identify ways to investigate identified issues.

**Remedial actions:** The program must reflect how to initiate the prompt and proper response to detected offenses, such as corrective action, repayments, and preventive measures.

**Compliance Officer:** The compliance officer should be responsible for developing, operating and monitoring compliance. This individual should report directly to the owner, governing body, and or/CEO.

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**NOTES:**

## *The Ethical Dilemma*



- Marketing vs. Ethics
- Cost Containment vs. Ethics
- Capacity vs. Ethics
- Risk Management vs. Ethics

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A few of the many ethical dilemmas a seniors' housing manager can face:

- Unrealistic promises: Seniors' housing faces the old dilemma of marketers making promises that operations can't meet. How does the facility maintain an aggressive marketing campaign while being honest about the services it can offer?
- Cost containment: For many reasons, such as residents' aging, costs can significantly increase. How does the

facility keep costs in line while maintaining the quality of care?

- Resident admission and discharge: How do you decide which applicants you should not admit because you can't provide the level or type of care they need? More difficult, how do you determine when to discharge residents?
- How can you balance residents' right to make their own decisions, even if they are medically counter-indicated? For example, a resident with diabetes may want to eat ice cream regularly, medical risks notwithstanding. Should the facility prevent him or her from doing so? What if the patient is not really capable of making his or her own decisions?

These and similar dilemmas clearly involve risks, but their resolution is far from clear.

Negotiated risk agreements are one popular method of dealing with some of these issues. Unfortunately, they have yet to be tested in court and may or may not survive legal challenges.