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INSIDE

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Preventing Hospital Violence Requires Proactive Strategy

Hospitals are focusing more on violence and how to prevent it in the healthcare setting, but they still need to adopt a more proactive approach that includes all forms of violence, not just the big notable incidents, experts say.

More hospitals have addressed violence in recent years, partly to comply with requirements or guidelines from The Joint Commission, OSHA, and other regulatory bodies. Most are not going far enough, says **Monica Cooke**, BSN, MA, RNC, CPHQ, CPHRM, FASHRM, a behavioral risk management and quality improvement consultant with Quality Plus Solutions in Annapolis, MD.

"Healthcare organizations are beginning to get more of an idea that they need to take a stand on workplace violence, but we're still pretty far behind," Cooke says. "They're developing workplace violence programs and policies, but they still tend to be reactive. They are all about how to respond when the event happens, as opposed to a more proactive approach to violence prevention and mitigation."

> "HEALTHCARE ORGANIZATIONS ARE BEGINNING TO GET MORE OF AN IDEA THAT THEY NEED TO TAKE A STAND ON WORKPLACE VIOLENCE, BUT WE'RE STILL PRETTY FAR BEHIND."

Organizations often make the mistake of focusing their efforts on Sentinel Event violence, the unusual incidents such as an active shooter or hostage-taker, Cooke says. Just as important, and perhaps even more so, are the far more common smaller incidents of violence, she says. "These are the daily incidents of

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AUTHOR: Greg Freeman
EDITOR: Jill Drachenberg
EDITOR: Jonathan Springston
AHC MEDIA EDITORIAL GROUP MANAGER: Terrey L. Hatcher
SENIOR ACCREDITATIONS OFFICER: Lee Landenberger

EDITORIAL QUESTIONS
Questions or comments?
Call Editor **Greg Freeman**, (770) 998-8455.

aggression and abuse that staff have to tolerate from patients, visitors, and even staff to staff. This occurs all the time and sometimes doesn't get the attention it deserves," Cooke says. "You need the plans in place for the big Sentinel Events, but you also need plans for mitigating the day-to-day aggression. I have not seen a whole lot of that."

Time to Act

Failing to address those more common incidents can lead to the bigger incidents when aggression is left unchecked and people see there are no consequences for bad behavior, she says. In addition, people are unlikely to be effective in addressing serious incidents of violence if they have not been provided the training and resources to respond to more common everyday incidents, she says.

Hospitals have taken a big step forward in awareness of the problem, Cooke says, and they have changed the healthcare culture so that violence is not seen as an unsolvable problem or a byproduct of clinical work that must be tolerated. The next step, she says, is to produce a meaningful effect on violence.

"It's time to implement practices, and programs, and systems that can work to minimize the level of aggression in your facility, to prevent it or minimize it," Cooke says.

"We don't want to wait until the patient is screaming and banging the walls or throwing things before people get alarmed and take action. We need to develop training and promote competency in this among all staff, including receptionists, housekeeping, maintenance, and anyone else that comes into contact with the patients and the public."

That training should include issues such as what the hospital expects of them when they encounter an aggressive or violent person, methods for de-escalation, and the steps to take before calling for help from security or others, she says.

Response Teams for Violence

Knowing at what point to step back and call for help is a key component of staff training, Cooke says. Also, the organization must determine who is going to respond to that call for help and it's not always going to be security officers. It might be co-workers or a supervisor, and many hospitals employ rapid response teams (RRTs) similar to the clinical RRTs and code teams that nurses rely on when a patient's medical condition needs immediate attention.

The violence RRTs include various staff members who have advanced training in de-escalation and physical defense, as well as behavioral health

EXECUTIVE SUMMARY

Hospitals have made strides in addressing violence, but still are not proactive enough. Even small incidents of violence should be addressed thoroughly.

- Policies and procedures should focus on prevention and de-escalation.
- Staff must be trained and given the necessary resources.
- Documenting a patient's history of violence can prevent future incidents.

professionals who can talk to the violent person and, if necessary, provide medications.

Without such a resource, the same nurses and other clinicians who depend on clinical RRTs are left with few options in a different kind of emergency, Cooke notes.

"Too many hospitals have a policy that essentially says, 'Call security.' In reality, security should be the last resort because their presence often escalates a situation and it can turn into something bigger than it had to be," Cooke says. "There should be an effort to de-escalate and prevent the violence that will need a security response, and that can only happen if staff are given the right training and resources."

Code Violet Brings Help

Nationwide Children's Hospital (NCH) in Columbus, OH, takes a proactive approach to violence, which is especially necessary because the facility treats a high number of young people for behavioral health issues. The hospital's response plan for violence uses the name "Code Violet," notes **Dan Yaross**, MSM, CPP, CHPA, director of security at NCH. A violent patient will prompt staff to call a Code Violet, and that brings representatives from several different departments to help.

The Code Violet response alerts a security offer, nurses, a member of the hospital's behavioral health crisis management team, the attending physician, and a pharmacist who can provide sedation if necessary.

"Everyone has a role, and we also have enough people to implement safe holds if necessary," Yaross explains. "De-escalation is the goal, but if we have to go hands-on, we need a number of people with the right training to do that. There's a specific procedure for controlling each limb and securing the head so they don't slam it on the floor, and the people on the response team have that training."

NCH uses a broad definition for violence or aggression that may require intervention, Yaross says. In addition to physical violence, aggression includes verbal threats or passive aggressive comments suggesting a threat, yelling, throwing objects, and body language. All NCH employees have been trained to recognize the signs of potential violence and are authorized to call for help.

"Every employee is authorized to activate Code Violet whenever they see the need," Yaross says. "We don't restrict that to just certain people like supervisors or someone else with authority."

Violent History Documented

For violent persons other than patients, the staff calls a "Code Violet — Security," which alerts a security officer and, in the evening, the nursing supervisor who is in charge of the hospital at night when administrators are away. These incidents may involve siblings and parents, other visitors, and people who have no business at the hospital but come in off the street and cause a disturbance, Yaross says. *(See the story on page 52 for information on how NCH screens visitors for security.)*

The hospital also notifies the social work department after an incident with a non-patient so they can follow up with family members if they were victims, or with unrelated patients or visitors who may have witnessed the violence.

NCH made the program more proactive over the past couple of years after witnessing harm to

Debrief All Violent Acts, Not Just the Big Ones

Debriefing should be a core part of any violence prevention and response plan, says **Monica Cooke**, BSN, MA, RNC, CPHQ, CPHRM, FASHRM, a behavioral risk management and quality improvement consultant with Quality Plus Solutions in Annapolis, MD.

It is typical for hospitals to fully investigate a major incident of violence, but not necessarily the more common instances of aggression and violence in the workplace, she notes.

Hospitals should, at a minimum, debrief anyone involved with or witnessing any act of violence, no matter how small, Cooke says. A deeper investigation and other action may be warranted in some cases.

"A crisis is a learning opportunity. Every incident must be debriefed or you're letting that opportunity pass by," Cooke says. "You step back and ask what just happened, what led to it, what could we have done to prevent it, what did we do right, why did other actions fail, and what should we do next time? You can't be a high reliability organization if you don't look at your defects and figure out why they're happening, and aggression is a defect in healthcare." ■

employees that could have been mitigated if staff had known certain information beforehand, Yaross says. The hospital now documents any Code Violet in its electronic medical record (EMR) system, and that puts a purple warning banner on the patient's record. In the notes section, the hospital details the nature of the incident, what triggers to avoid, and anything else that might prevent or de-escalate violence.

"If that record indicates that the only way to control the individual and prevent him or her from verbally abusing staff is to have security present, we will have a security officer right there when the parent arrives with the child," Yaross explains. "The child sees the officer and behaves. We don't do that with every child with a history of violence, but we know that's what works for this family."

To be even more proactive, the EMR system produces a list every Monday of patients scheduled for appointments at the hospital in the coming week who have a history of violence, Yaross explains. That list is seen by several administrators, including security, which reaches out to the clinic where the patient will be seen. Security alerts the staff that the patient could be violent and offers to have a security officer present with the patient or available nearby, whichever the clinic staff prefer.

"That has been useful in reducing the number of employee injuries because we can anticipate the problem and prevent it, rather than responding after the fact," Yaross says. ■

SOURCES

- **Monica Cooke**, BSN, MA, RNC, CPHQ, CPHRM, FASHRM, Quality Plus Solution, Annapolis, MD. Telephone: (301) 442-9216. Email: mcooke@qualityplussolutions.com.
- **Dan Yaross**, MSM, CPP, CHPA, Director of Security, Nationwide Children's Hospital, Columbus, OH. Email: daniel.yaross@nationwidechildrens.org.

Badges Identify Visitors After Screening

With responsibility for the safety of young patients, visitor management is a top priority for Nationwide Children's Hospital (NCH) in Columbus, OH. The hospital uses a system that checks the background of visitors and issues a temporary identification badge noting what type of visitor they are.

The visitor management system software links to the federal sexual offender database, notes **Dan Yaross**, MSM, CPP, CHPA, director of security. There was some reluctance among administrators to conduct sex offender checks on all inpatient visitors, but Yaross demonstrated that an increasing number of children's hospitals do so and provided data on how many potentially dangerous people could be screened out. Administrators also were swayed by concern over the negative publicity that could result, not just from an actual sexual assault, but even from parents finding out that a convicted sex offender was allowed on the same floor as their child.

The screening system was initiated about two years ago.

> THE HOSPITAL USES A SYSTEM THAT CHECKS THE BACKGROUND OF VISITORS AND ISSUES A TEMPORARY IDENTIFICATION BADGE.

"We got hits on it right away, convicted offenders coming here and wanting to go upstairs and see a patient. Some wanted to stay overnight," Yaross says. "We've had a number of people who were not allowed to go upstairs."

For family members who are convicted sex offenders, NCH customizes a security plan. If the person is a parent or guardian and has direct contact with the patient at home, the hospital will determine what is necessary for that person to be allowed to see the patient. Depending on the particular history and situation, the hospital may require that the person be escorted by a security officer at all times or that an officer be posted near the patient room. The time allowed for visiting will be limited, and overnight visits are unlikely to be allowed.

The visitor management system also produces temporary identification badges that indicate the person is a parent, grandparent, or other visitor. The designation helps NCH staff better understand what access is appropriate for the visitor, Yaross explains. ■

Coders Play Important Role in Compliance Efforts

Coders are in a unique position to spot a wide range of noncompliance issues, so they must be trained on their obligation to report what they find, a coding expert says. The hospital or health system should ensure that coders know how, what, and when to report noncompliance.

Because they review many types of documentation to determine the proper coding, coders are among the healthcare professionals most likely to spot a problem, says **Rose T. Dunn**, MBA, RHIA, CPA, FACHE, FHFMA, CHPS, chief operating officer with First Class Solutions in Maryland Heights, MO.

Coders can contribute to monitoring compliance, risk management, and revenue cycle, Dunn says. They often will be able to raise a red flag for further investigation by compliance and risk management leaders, she says.

"They're going to see untimely preparation of reports such as operative notes or discharge summaries," Dunn says. "Operative notes, for instance, can become a risk management issue when there is a complication and the op note doesn't get dictated until 30 or 40 days after the patient is discharged. If that case goes to litigation, it's going to be hard for the surgeon to explain how he could accurately describe what happened in the procedure when the operative report is so old and he had done dozens of other operations before writing it."

Dunn recalls one example in which the coder saw all the progress notes had been entered at the time of discharge, dictated on the same date by the nurse practitioner who worked with the physician, and signed by the physician.

"That coder reported a compliance issue, wondering how other members of the caregiving team could provide care without the progress notes for the patient, and also a compliance issue with everything being done at the end, and then a risk management issue because it is an employed physician," she says. "You're billing for their services, and the documentation to support the billing was not done in a timely fashion."

Falls Not Reported

The coder can discover other risk management issues. For instance, they may be aware of falls and small injuries to patients that were not reported to risk management. Coders can be taught to log all instances of a fall or injury, forwarding that information to risk management at regular intervals in case any of them were not reported, Dunn says.

"That provides a check and balance to risk management," she says. "They should have a report for that incident from nursing, but if that didn't happen for whatever reason, then risk management has documentation to go back to and follow up."

Since coding is performed usually at the time of discharge, a timely notice from the coder gives the risk manager a good chance at contacting the patient and employees reasonably soon after the incident, she says.

Coders also may see what coders call "biting," comments in the medical record that do not concern the patient, such as a nurse detailing abusive language comments from a physician. Or a physician may state that another physician was not prepared or performed poorly. The name derives from the idea that they are biting each other with the comments.

"When the coders see something inappropriate, they should say something," Dunn says. "You have to give them a way to do that quickly so that they're not taking a lot of time away from their primary work. They can have a form to send a quick note to risk management saying, 'Please see this progress note,' with blanks for the record number and a short list of potential concerns to check off."

Coding reports often are used to track healthcare-acquired conditions, but Dunn notes that those final reports may not be available in

EXECUTIVE SUMMARY

Coders are in a position to recognize many forms of noncompliance. The coders in a hospital or health system should create a structure for reporting noncompliance.

- Coding reviews can reveal falls and injuries not reported to risk management.
- Coders will need a quick and easy way to report concerns.
- Concerns about coding productivity must be addressed.

the computer system immediately. Directing coders to report these conditions to quality improvement or risk management allows the hospital to address the problem sooner, she says.

When educating coders and providing resources, remember that coders may be spread throughout a facility or health system, coding for both the hospital and physicians, and they often have no centralized reporting structure, Dunn says.

In the revenue cycle, coders may identify incorrect charges or the omission of legitimate charges, Dunn says. They also may come across incorrect use of abbreviations and terminology in the medical record, which could lead to noncompliance or liability.

"There are a lot of millennials at the bedside now and these physicians are used to a world of texting and abbreviations," Dunn explains. "A coding professional may notice that, unless it's a millennial coder, as well as things like the abbreviations on the do-not-use list."

Another issue is clinical plagiarism, in which text is copied from one provider's notes to another's. Coders can be the eyes and ears of risk management and report many issues that might have gone unnoticed, Dunn says, but only if they are given a process and a culture that allows them to report quickly and safely.

"If you have a coding team that is focused solely on productivity because you have a CFO who only wants productivity, they are not going to be able to collaborate with risk management. Even if it takes one minute to report the issue, that's one minute taken from coding productivity, and it matters," Dunn says. "If you can show the value in what coders report to risk management, you can overcome that concern about productivity. Then risk management is going to hear about more problems than they ever imagined." ■

SOURCE

- **Rose T. Dunn**, MBA, RHIA, CPA, FACHE, FHFMA, CHPS, Chief Operating Officer, First Class Solutions, Maryland Heights, MO. Telephone: (314) 209-7800. Email: rose.dunn@firstclasssolutions.com.

Captive Insurance Can Be Tool for Enterprise Risk Management

*By **M. Michael Zuckerman**, JD, MBA*
Temple University
Fox School of Business and Management
Department of Risk, Insurance and Healthcare Management

A captive insurance company can be a valuable enterprise risk management (ERM) tool if structured properly and focused on risk management.

Captives are wholly owned insurance subsidiaries structured to insure the risks of their parents. If the captive covers only one healthcare entity, it is known as a single-parent captive, and a captive covering more than one entity is known as a group captive. Either way, it is structured to fund its parent's risk. It operates outside the commercial marketplace, which enables it to fund any predictable risk — not just traditionally insurable risk. This enables the risk-centric captive to be a valuable ERM tool.

Not Just a Checkbook

Captive regulation is designed to ensure solvency and liquidity, but also provides the flexibility needed to address its parent's unique risks and risk financing goals. However, a captive requires capital and may be expensive to operate. Therefore, a captive that is not risk-centric can be a very inefficient risk management tool. A properly managed risk management-centric captive, on the other hand, can help drive the parent's ERM program.

A captive used as a "checkbook," with the primary purpose to support a fronted insurance program, is not ERM or even traditionally risk management-centric. Furthermore, it may be an inefficient use of capital and credit needed to collateralize the commercial front's credit risk. There may be other risk financing solutions that would not consume capital, and available lines of credit, that should be considered.

An ERM or risk management-centric captive is one that is used to promote risk management within the parent organization. To this end, the captive's board should be a diverse group providing

a multidisciplinary approach to captive and risk management. Each board member should bring expertise needed to manage the captive properly, such as finance, parental operational knowledge, law, and risk management. The captive board meeting agenda must include detailed presentations about program structure, analytics, underwriting, reinsurance, and detailed reports about the parent's claims, loss prevention, and loss reduction programs.

The board also will spend time on the captive's strategic planning to determine how the captive can be used to increase support of the parent's risk management program, enabling it to meet its business goals. This requires an understanding about risk identification, assessment, and the parent's strategic goals and risk profile.

Captive Can Be Transformative

Therefore, the mission of an ERM-centric captive requires it to have a transformative effect on the parent's corporate risk management program and strategic business goals. A captive that proactively and proficiently improves its parent's risk financing and risk control program is transformative because it is contributing to the growth of the parent's and its stakeholders' value. Regardless if the parent is for-profit or nonprofit, increasing stakeholder value is essential for any organization's long-term resilience, competitiveness, and strategic growth.

The captive should be linked inextricably to its parent's ERM program. The question is: How do we appropriately measure a captive's effect on ERM?

One quantitative measure of a captive's contribution to stakeholder value is the return on capital invested by the parent or insured/member (also known as the shareholder) in the captive. If the return on capital invested in the captive is greater than the member organization's weighted average cost of capital, then the captive is creating economic value. But is this a fair analysis?

Value Added Analysis Can Work

The risk management value-added analysis is more complicated than that. According to a quote from *Captive Insurance Company Reports* in August 2012, ERM can turn currently unidentified and potentially consequential business or insurable risk into a quantifiable portfolio of expected loss that can be predictably funded. Again, because a captive operates outside the commercial insurance marketplace it can be used to fund all risks, not just insurable risks, if these retained risks are predictable and properly funded to manage cash flow variability.

> A CAPTIVE, THEREFORE, IS A PERFECT RISK MANAGEMENT TOOL TO SUPPORT ITS PARENT'S STRATEGIC AND ERM PROGRAM.

Of course, the captive must be appropriately capitalized. Furthermore, the captive is an insurance company and can transfer risk to the reinsurance market, traditional or funded by the capital markets. A captive, therefore, is a perfect risk management tool to support its parent's strategic and ERM program.

Aim for Proactive, Transformational

How does this happen? To be proactive and transformational, a captive must have a positive effect on both risk financing and strategic business goals. Risk financing goals should focus on strategic risk financing, not simply seeking the cheapest deal or playing market cycles. For example, a firm must ensure that it can pay for its losses over the long-term regardless if it is transferring, retaining, or using a hybrid of transfer and retention to fund its portfolio of expected losses. If a firm retains a portion of its risk, then it must ensure that it has the funds to meet its self-insured liabilities and can manage cash flow variability (fluctuation in interest income and expected losses).

Moreover, the risk financing program must comply with all local insurance regulations and customs, contractual obligations, and bond covenants. The overall risk financing goal is to reduce the cost of risk or diminish its growth at a rate less than a selected financial benchmark such as the growth of revenue, earnings before interest and taxes (EBIT), net income, or surplus for nonprofits. Because the captive is an insurance company with access to the reinsurance market, it can manage expected loss variability and assist the parent's ability to manage a portfolio of risks addressing risk interdependency, minimizing

budgetary and earnings volatility.

Healthcare providers have used captives to fund traditional pure risks, such as medical professional liability and workers' compensation, for more than four decades. But the dynamic nature of the healthcare industry requires a strong ERM program to manage risk and grow stakeholder value. A strong captive board that follows best captive management practices will contribute to the ERM program by improving risk culture and enhancing risk communication, addressing inherent and residual risk with a focus on the source of risk, cost drivers, and claims and risk management practices.

Addresses a Variety of Risks

Specifically, a transformative captive can be used to address a variety of enterprise-wide risks such as third-party liability, business interruption, human capital, regulatory, medical stop loss, catastrophic property loss, and cyber/privacy risks, by funding the predictable layer of risk, and transferring the less predictable portion of these risks to the reinsurance or capital markets. Therefore, the captive becomes a valued risk management partner for its parent because its board meetings (operational and strategic) will improve the risk management dialogue focusing the parent's senior management on cost of risk drivers, and all enterprise-wide risks. Additionally, emerging/evolving risks continually present new challenges to the captive for drafting captive coverage statements, forecasting expected losses, and underwriting the insurance program. This also assists with making the case for investment in improved risk and claims management practices.

Captive Board Helps Communication

It also helps when the captive has a board that understands its role, and proactively improves risk communication between the parent and the captive as a product of robust and state-of-the-art captive board meetings. Furthermore, the entrepreneurial captive can contribute to improving the parent's strategic relationships within its alliances that address population healthcare needs, such as community-based physicians or other healthcare partners, by offering these stakeholders fair market value insurance coverage and relevant risk management services. This entrepreneurial employment of the captive will enhance the healthcare provider's ability to increase market share and improve its strategic relationships.

WHETHER A SINGLE PARENT OR GROUP CAPTIVE, IT SHOULD BE ABLE TO REDUCE COST OF RISK BY POOLING PREVIOUSLY DECENTRALIZED EXPOSURES FOR THE HEALTHCARE SYSTEM, ITS AFFILIATES, AND PARTNERS.

The test for an ERM-centric or transformational captive is one that enables the parent to meet its risk-financing goals, positively affect its ERM program, and achieve strategic business goals by providing a platform to centralize and focus the parent's risk management program when driven by a highly skilled multidisciplinary risk-oriented captive board.

Again, this captive board will create a strong risk management communication channel to the parent. And this will enable the parent to address the interdependency of its risk by better managing risks as a portfolio. The captive's mission is to fund this portfolio of risk and stimulate strong risk management practices increasing the efficient use of risk capital. Strengthening risk management practices should be a natural outcome if the captive holds its parent/insured accountable for its losses as well as loss control and claims management processes through its board reporting and underwriting/cost allocation methodology.

Whether a single parent or group captive, it should be able to reduce cost of risk by pooling previously decentralized exposures for the healthcare system, its affiliates, and partners. Finally, reduction in the parent's cost of risk should grow the captive's retained earnings, which then can be used to leverage the funding of new or growing exposures, including emerging and evolving risks.

Does the captive facilitate the parent's risk financing strategy to enable achievement of its risk financing goals and consequently contribute to the accomplishment of its strategic business goals? If so, then the whole program is

truly transformational because the parent has met the risk needs of its stakeholders while growing the firm value regardless of the return on capital invested in the captive.

Case Managers Can Maximize Workers' Comp Resources

Case management for workers' compensation patients should include an early look at the resources available and how to best use them — not just the clinical concerns, says **Zack Craft**, vice president of rehab solutions, life assessment, complex care education, and national product leader at One Call Care Management.

A nursing case manager plays a critical role in determining how much is spent on a workers' comp case and which options will be best for the patient, Craft notes. For instance, the case manager will be instrumental in determining if home modifications — a major expense in some cases — are necessary, and to what extent. That kind of assessment should begin early, Craft says.

"The case manager is going to be the liaison to the family and help set expectations for what home modifications might be possible," he says. "Early engagement is best, rather than leaving home modifications for the very end, which is usually how it's done. You need to understand what you can expect from this claim and how to best manage it moving forward."

In many cases, care and recovery decisions are made solely by clinicians, Craft notes. Empowering the case manager to contribute early in the decision process improves the use of resources and can improve outcomes, he says.

"It's a much more proactive approach to a claim, empowering that case manager to assess what might be necessary and draw on available resources to do the best thing for the patient," Craft says. "The case manager will see comorbidities that will affect purchase decisions and opportunities to improve recovery, and that works to the benefit of the patient and employer." ■

SOURCE

- Zack Craft, Vice President, Rehab Solutions, Life Assessment, Complex Care Education, National Product Leader, One Call Care Management, Jacksonville, FL. Telephone: (800) 848-1989.

NPSF/IHI Merger Could Help Risk Manager Credentialing

The merger of the Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF) should increase opportunities for risk managers to obtain credentialing in patient safety, says NPSF President and CEO **Tejal K. Gandhi**, MD, MPH, CPPS.

Expanded Offerings

Effective May 1, the merger combined two groups that each have a history of raising awareness around patient safety issues and educating the healthcare workforce about best practices, Gandhi says. The new group will use the IHI name, but patient safety-focused products will be branded as "NPSF at the IHI."

One driver for the merger was the desire to minimize confusion about the roles of the two groups and the resources available from each. The group will continue to offer the NPSF patient safety credential as before, and Gandhi says there should be more opportunities for the required educations.

Recertification Options

"We expect to grow and get more certificate applicants, both nationally and internationally," Gandhi says. "Recertification requires getting credit for certain activities, so we're going to try to have IHI offerings count for recertification, which will mean more opportunities for meeting those recertification requirements. People should see more resources and tools they can use to accelerate their progress in patient safety."

Gandhi will lead the merged patient safety teams, which will combine existing NPSF and IHI patient safety programs. All NPSF programs, including the NPSF Lucian Leape Institute and the Certified Professional in Patient Safety credentialing program, will continue, Gandhi says. ■

SOURCE

- Tejal K. Gandhi, MD, MPH, CPPS, NPSF President and CEO, Boston. Telephone: (617) 391-9900.

Email Credentials Risky for Healthcare Hacking

Despite a growing awareness among healthcare risk managers of the vulnerability of their computer systems, hackers still get in. Often, they break in through the organization's weakest link: end-user email credentials.

Research released recently by Evolve IP, The Cloud Services Company, located in Wayne, PA, included an analysis of 1,000 healthcare organizations and illustrates the need for proactive threat monitoring coupled with near real-time disaster recovery solutions, the company says. Employee email represents one of the greatest risks, the analysis suggests.

The research determined that 68% of the healthcare organizations analyzed have compromised email credentials and nearly 80% of compromised data include actionable password information, simplifying hackers' efforts to infiltrate the network.

An estimated 7,500 individual incidents occurred across the study where healthcare companies had email credentials compromised due to phishing or key logging attacks. Any one of these vulnerabilities could rapidly escalate to ransomware, denial of service attacks, or data breaches across an entire enterprise, the company says.

Nearly one-quarter of the stolen passwords were available for sale or trade on the dark web as unencrypted, clearly visible text, the company says. The rest of the passwords were encrypted, but the company says the level of encryption used presents no real hurdle to professional hackers that want to crack them.

The full report is available online at: http://bit.ly/2nxoflT. ■

Paid Medical Malpractice Claims Decrease, Compensation Up

Paid medical malpractice claims decreased but compensation amounts increased in a new analysis of national claims by specialty from 1992-2014.

The research is the first analysis to evaluate paid claims by physician specialty at the national level. Using data from the National Practitioner Data Bank (NPDB), physicians at Brigham and Women's Hospital analyzed the trends in paid medical malpractice claims for physicians in the United States from 1992 to 2014. The findings were published in the March 27, 2017, issue of *JAMA Internal Medicine. (An abstract is available online at: http://bit.ly/2o9Q3l5.)*

The researchers found that the overall rate of claims paid on behalf of all physicians dropped by 55.7%. Pediatricians had the largest decline at 75.8%, and cardiologists had the smallest at 13.5%. After adjusting for inflation, researchers found that the amount of the payment increased by 23.3% and also was dependent on specialty. Neurosurgery had the highest mean payment, and dermatology had the lowest. The percentage of payments exceeding $1 million also increased during the same period.

> MOST COMMON AMONG THE MALPRACTICE ALLEGATIONS WAS AN ERROR IN DIAGNOSIS, FOLLOWED BY ERRORS RELATED TO SURGERY, AND ERRORS RELATED TO MEDICATION OR TREATMENT.

The report noted that previous research has shown that physicians' perceptions of their risk of liability can influence their clinical decision-making, and the authors suggested that a better understanding of the causes of variation among specialties in paid malpractice claims may both improve patient safety and reduce liability risk.

Most common among the malpractice allegations was an error in diagnosis (31.8% of all paid claims), followed by errors related to surgery (26.9%), and errors related to medication or treatment (24.5%). Thirty-two percent of paid claims were related to a patient death, with pulmonologists most likely to be involved in a claim that involved a patient death. Plastic surgery and dermatology had the highest percentage of claims that were considered low-severity, with minor physical or emotional injury. ■

More Data Access Means More Risk of Breach

Greater access to healthcare data increases the risk of a security breach, according to a recent report.

Larger hospitals and teaching-focused facilities typically provide greater access to healthcare data and are therefore more at risk, according to a recent study published by *JAMA Internal Medicine*. *(An abstract is available online at: http://bit.ly/2oJEaFv.)*

The researchers note that there is a "fundamental trade-off" when providing access to health data for hospital quality improvement efforts, research needs, and education requirements. More access means more opportunities for a data breach, they say.

That conclusion comes from an analysis of information from the Department of Health and Human Services (HHS) on reported data breaches from late 2009 to 2016. There were 257 reported data breaches in that time frame, occurring at 216 hospitals. Thirty-three of those hospitals also were breached at least twice, with more than one-third of the facilities classified as a major teaching hospital.

The median number of beds at the breached facilities was 262, according to the study. For non-breached facilities, the median number of beds was 134.

Similarly, 37% of the breached organizations were major teaching facilities, while 9% of the non-breached hospitals were classified as the same. ■

Study Identifies Surprising Priorities Of Chronically Critically Ill Patients

To explore the expectations and goals of chronically critically ill patients, researchers interviewed 30 patients and 20 surrogates at a long-term acute care hospital.[1]

Daniela Lamas, MD, the study's lead author, expected the patients would value life prolongation above all other goals. "However, I found that living as a long as possible no matter what was, in fact, the least important priority ranked for the majority of people surveyed," says Lamas, a pulmonary and critical care fellow at Brigham and Women's Hospital in Boston.

Life prolongation fell below cognitive effect and physical function for the majority of people surveyed. This held true for both patients and families.

Chronically critically ill patients are frequently cared for in long-term acute care hospitals, yet little is known about their experience in this setting, notes Lamas. "The results of our work suggest to me that it is our ethical duty to try to understand our patients' goals," she says.

The findings indicate overly optimistic expectations about returning home, and unmet palliative care needs. This suggests the need for integration of palliative care within the long-term acute care hospital setting.

Lamas says clinicians have an ethical obligation to try to give patients the care that they want, and not to give care that patients do not want or care that does not move patients toward their goals.

"Long-term acute care hospitals, even if it is aggressive care for ill patients, can be appropriate if it aligns with a patient's goals," she says. ■

REFERENCE

1. Lamas DJ, Owens RL, Nace RN, et al. Opening the door: The experience of chronic critical illness in a long-term acute care hospital. *Crit Care Med*. 2017; 45(4):e357-e362.

CME/CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

COMING IN FUTURE MONTHS

- Waivers for required meal periods
- More patient abandonment with ACA reform
- Missing business associate agreements
- Reviewing OR fire safety

HEALTHCARE RISK MANAGEMENT™

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To earn credit for this activity, please follow these instructions:
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CME/CE QUESTIONS

1. **What violent incidents should be followed by a debriefing of those involved, according to Monica Cooke, BSN, MA, RNC, CPHQ, CPHRM, FASHRM, a behavioral risk management and quality improvement consultant with Quality Plus Solutions?**

   a. All of them
   b. Those resulting in serious injury or death
   c. Those likely to lead to litigation
   d. Those involving non-employees

2. **Who is empowered to call a "Code Violet" for violence at Nationwide Children's Hospital in Columbus, OH?**

   a. Department heads
   b. Nursing supervisors
   c. Clinicians
   d. All employees

3. **According to Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, CHPS, chief operating officer with First Class Solutions, what is necessary for coding to collaborate with risk management?**

   a. Overcoming concerns about coding productivity
   b. An endorsement from the hospital board
   c. Creation of a task group
   d. Anonymous reporting

4. **What is an enterprise risk management or risk management-centric captive?**

   a. One that is used to analyze coverage options
   b. One that is used to promote risk management within the parent organization
   c. One run by managers unaffiliated with the hospital or health system
   d. One that reduces medical malpractice claims significantly

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

$4.7 Million Verdict for Fatal Failure to Monitor Medication

*By **Damian D. Capozzola**, Esq.*
The Law Offices of Damian D. Capozzola
Los Angeles

***Jamie Terrence**, RN*
President and Founder, are Risk Services
Former Director of Risk Management Services (2004-2013)
California Hospital Medical Center
Los Angeles

***Morgan Lynch**, 2018 JD Candidate*
Pepperdine University School of Law
Malibu, CA

News: In August 2013, a woman presented to a hospital for treatment of her fingernails and toenails. She was prescribed medication for nail fungus and was instructed to take it every day for 30 days, with three refills. The patient refilled the prescription and took it over four months.

The next month, the patient returned to the hospital for unrelated treatment, and testing showed ordinary liver function. Over the next three months, the patient visited the hospital three times complaining of various ailments, culminating in admission to the hospital for acute liver failure. The patient died from complications of liver failure.

The estate — the patient's surviving family — sued the hospital and medical professionals. The three-day trial concluded with a $4.7 million verdict for pain and suffering after a 1.5-hour jury deliberation.

Background: On Aug. 19, 2013, a woman presented at a hospital and was treated by a doctor of osteopathic medicine (DO) for problems involving her fingernails and toenails. The DO diagnosed the patient with onychomycosis (nail fungus). She was then prescribed 200 mg of ketoconazole to be taken daily for 30 days, with three refills. The physician neglected to obtain a baseline liver function/liver test before the patient began the prescription.

OVER THE NEXT THREE MONTHS, THE PATIENT VISITED THE HOSPITAL THREE TIMES COMPLAINING OF VARIOUS AILMENTS, CULMINATING IN ADMISSION TO THE HOSPITAL FOR ACUTE LIVER FAILURE.

The patient used the medication for more than four months, and returned to the medical facility for swelling in her wrist and thumb on Sept. 13, 2013. She was seen by a nurse practitioner, who performed lab tests. It was determined that the patient's liver function/enzyme tests were in the normal range at that time.

Two months later, the patient returned to the primary care clinic reporting vaginal issues and constipation. She returned on Dec. 24, 2013, complaining of a cough, runny nose, and ear pain for two to three days; coughing up yellow mucus that day; dark urine for three days; and significant loss of appetite. A urinalysis was performed, but liver function/enzyme tests were not ordered or obtained from the patient at this visit. The patient was prescribed the antibiotic ciprofloxacin.

On Jan. 2, 2014, the patient returned because her family informed her that she looked yellow, she felt very tired for over a week, and eating and drinking caused her stomach pain. Clinic staff noted the patient was "very jaundiced" with right upper quadrant pain and tenderness. The assessment read: (1) right upper quadrant

pain and (2) gross jaundice. The patient's lab test results showed profoundly abnormal liver function. An abdominal ultrasound performed that day also was abnormal. She was admitted to the hospital on Jan. 3, 2014, because of her acute liver failure, but unfortunately died on Jan. 24 from liver failure and related complications.

The estate, represented by the patient's surviving adult children and husband, sued the physician, nurse practitioner, the DO's practice, and the hospital for wrongful death and medical malpractice. Interestingly, the hospital stipulated to liability prior to the outset of trial after initially denying liability. Because the defense already conceded liability as well as the cost of the funeral expenses, it only contested the damages to which the plaintiff was entitled. At trial, the plaintiffs elicited testimony by the surviving husband regarding his loving, deceased wife in her capacity as a mother of seven, grandmother to 17, and great-grandmother to one. The plaintiff's counsel contended that the DO failed to monitor the patient's use of ketoconazole after she returned to the clinic several times. The attorney further alleged that "the doctors only obtained a single liver function test over the more than 19-week period [the patient] took the medication."

After the three-day trial, the jury deliberated for 90 minutes. The jury unanimously delivered a verdict in favor of the estate for $4.7 million. The hospital was 100% liable through respondeat superior and other theories of agency-principal law applicable in the jurisdiction where the case was tried.

What this means to you: This case illustrates the consequences of failing to monitor a patient's use of hepatotoxic drugs. Medical professionals should ensure they understand the side effects of the medications they prescribe, and communicate those side effects to patients. This is, of course, the basic logic behind informed consent. While it is not necessary for patients to consent in writing before taking the prescribed medication, the patient here should have been informed that the medication can cause liver damage, what symptoms to be aware of, and to report symptoms to the physician immediately should they occur. Additionally, if the patient was taking any other medication known to affect liver function, the oral antifungal medication should not have been offered as a treatment option.

The patient's symptoms in this case changed significantly toward the end of her life. It does not appear that the nurse practitioner or DO considered the relationship between the medication and the new symptoms, evidenced by the failure to obtain liver testing. In any case, medical professionals must keep up with patients to ensure the patients are tolerating the medication.

It is well-known in the medical community that antifungal medications can cause skin rashes and liver damage. The standard procedure for antifungal medications always should include a baseline test for basic liver function. Once that baseline is established, physicians must order follow-up blood testing throughout the course of the medication. This patient lost her life because the physician failed to manage his patient and failed to conduct proper testing each time she returned to the clinic. Medical facilities should conduct internal audits to ensure physicians are properly managing their patients' medications and following other hospital procedures.

In consultations, physicians and nurse practitioners need to be very thorough with patient interviews to ensure that all of their symptoms are reported and considered. This will provide the physician with a full profile of the patient and his or her symptoms, allowing the best diagnoses possible. Some patients may be reluctant to acknowledge or have difficulty explaining their symptoms, so medical professionals must be diligent in their interviewing process.

Regarding nail fungus, treatment can be more effective when different treatment methods are combined. Some potential treatment options include oral antifungal drugs such as those prescribed in this case, medicated nail polish, medicated nail creams, and possibly even laser- or light-based therapies. If the physician here had instructed the patient to use some of these other remedies, she may not have stayed on the medication as long, and may not have sustained such a high degree of liver damage.

This case also illustrates that hospitals should work with knowledgeable counsel in their jurisdictions and consider whether and how to insulate themselves from liability arising out of negligence by medical professionals. Laws vary from state to state, and it may be worth exploring whether liability exposure can be reduced through categorizing workers as independent contractors rather than employees. Shifting liability to the physicians and nurses can prevent accidents from happening since their insurance premiums are on the line, rather than the hospital's. If recategorizing employees is not an option, another way to reduce respondeat superior liability is to argue that the actions of medical professionals are not within the scope

of their employment when they injure patients or stray from the standard of care. This argument makes sense where procedures are in place and physicians fail to follow them. The scope of the employment may end if the medical professional strays too far from established procedures. ■

REFERENCE

Decided on June 9, 2016, in U.S. District Court, N.D. Georgia, Case No. 1:14CV03319.

Hand and Toe Amputation Results in $10.4 Million Jury Verdict

News: In late 2007, a man presented to a hospital with diarrhea. He was taken to surgery a week later, where he was administered Levophed, a vasopressor medication. After the surgery, the treating physicians switched the patient's medication to Neo-Synephrine.

Because of the poor blood circulation due to the vasopressors, the patient's hand and toes became gangrenous and required amputation. The patient subsequently filed suit for breaching the standard of care. The crux of the patient's legal argument was that the high doses of vasopressors caused his gangrenous extremities. At trial, a battle of experts ensued, and the jury delivered a verdict in favor of the plaintiff for $10.4 million.

Background: On Sept. 4, 2007, a man presented to a hospital after experiencing diarrhea for several days. The man was admitted and taken to surgery 11 days later to remove his toxic megacolon. During surgery, the medical staff administered the vasopressor medication, Levophed, to correct a drop in the patient's blood pressure.

Postoperatively, a consulting cardiologist ordered the medical staff to wean the patient off of Levophed and administer Neo-Synephrine if his systolic blood pressure dropped below 100. The vasopressors caused poor perfusion, and as a result, the plaintiff's left hand and all his toes became gangrenous and required amputation.

The patient-plaintiff and his (now) ex-wife filed suit against the hospital and several of its nurses. The defendants were accused of breaching the standard of care. The plaintiff sought recovery of compensatory damages for medical expenses, lost income, and damages for disfigurement and other non-economic recovery.

At trial, the plaintiff argued that from Sept. 15 to Sept. 17, the hospital's ICU nurses neglected to perform dynamic response testing on the arterial line that was used to evaluate plaintiff's blood pressure. As a result, he argued, the evaluation was falsely reading systolic blood pressures below 100 when his true blood pressures were higher. Therefore, the nursing staff gave the patient the maximum doses of vasopressors when his blood pressure was close to, if not, normal. This excess administration of vasopressors resulted in vasoconstriction in the patient's blood vessels and poor perfusion to his extremities, causing them to become ischemic, necrotic, and eventually gangrenous. The plaintiff's counsel maintained that the patient went to the hospital to cure his abdominal problem, but was left without a hand or toes, without any explanation from his doctors.

The defense argued that the plaintiff was in septic shock with five system multi-organ failure and the poor perfusion was the result of a coagulopathy cascade caused by the sepsis and the body's native shunting of blood to vital organs for survival. The defense further asserted that the plaintiff would have died without the high doses of vasopressors.

Just before the verdict was read, parties reached a high-low agreement ensuring recovery of at least $3.5 million but capping liability at $12 million. In the end, the parties' agreed range proved correct, as the jury deliberated for 2.5 hours before returning a verdict for $10.4 million. The breakdown of the award was as follows: $2 million for disfigurement, $1 million for loss of normal life past, $1 million for normal life future, $2 million for past pain and suffering, and $4 million for future pain and suffering. The patient's ex-wife also received $25,000 for value of services and $25,000 for society, companionship, and relations. The available information suggests the hospital ultimately absorbed the liability.

What this means to you: The plaintiff attorney's theme about the plaintiff leaving the hospital missing a hand and toes without an explanation from the doctors was apparently very powerful. Hospitals must be transparent. Patients have a right to know everything that is happening to them and why. Their questions deserve our best answers. If a patient

believes the physicians, nurses, and hospital are doing everything in their power to provide the best care, informing them of concurrent risks and benefits of treatments, and are forthcoming with information both positive and negative, they are less likely to litigate. Gone are the days of pretending bad things don't happen in hospitals. One Google search on a patient's cellphone will reveal that not to be so.

To avoid angry, litigious patients in circumstances such as those presented in this case, if appropriate, hospitals should provide a genuine apology for the catastrophic result. Many jurisdictions have "I'm Sorry" laws, which are designed to encourage open communications following an adverse result and which were implemented in response to the rising number of medical malpractice suits. It is important to note that the information communicated to the patient should not include an admission of legal fault, but should contain statements that express condolences, sympathy, and empathy. The various protections offered by the "I'm Sorry" laws should be researched carefully to ensure hospitals do not apologize themselves into legal fault, but injured patients may be less inclined to pursue a legal claim if they feel the hospital and medical professionals treated them with respect and candor in light of a traumatizing experience.

However, to avoid adverse results and prevent the need for apologies as much as possible, hospitals should ensure that nurses get proper instructions and consult experts early in treatment for all procedures. To this end, it is important to provide medical professionals with repeatable guidelines. The benefit of implementing these guidelines is twofold. First, it prevents deviation from the standard of care by medical professionals. To serve this purpose, the guidelines must conform to the industry standard of care. Second, repeatable rules for medical professionals show juries that hospitals are truly concerned about the safety of their patients. It is easy to criticize juries as irrational or unpredictable, but most juries do reach verdicts grounded in the evidence. A system from which defense counsel can argue only can strengthen the case.

The fact that the nurses in this case failed to notice the patient's gangrenous symptoms for two days brings to light a need for routine physical symptom monitoring in the aforementioned guidelines. For example, the Academy of Medical-Surgical Nurses has indicated the following practices given by hospitals in response to the question, "What is the EBP standard for assessment of the postoperative patient after discharge from PACU, [and] how often should these assessments occur?"

1. Every 1 hr. x 4, then every 4 hr. x 24 hr., then per MD order — this is the standard.

2. Upon arrival to the unit, in 1 hr., then every 4 hr. for 24 hr., then every 6 hr. throughout stay.

3. Within 15 minutes of arrival to unit, in 30 minutes, then every 1 hr. x 2 or until stable, and every 4 hr. for 24 hr., then every 6 hr. for remainder of stay.

Each of these practices, if implemented by the nurses in this case, could have caught the patient's gangrenous hand and toes within the two-day period in which he exhibited the symptoms.

Nurses have a responsibility to understand the side effects of all medications they administer, especially high-risk vasoactive medications. The physician also must observe his or her patient for symptoms of well-known adverse reactions to medications such as the loss of peripheral circulation caused by vasopressors. Both nurses and doctors must look beyond the technology, the monitor, and the computer, and focus their eyes and place their hands on the patient. A simple check of peripheral pulses or noting temperature and color changes in the patient's extremities might have led to a change in the dosing of the vasoactive drugs. Finally, monitoring a patient's cardiac functioning via an arterial line is a highly specialized skill that requires additional training even for ICU nurses. The hospital must ensure that staff required to monitor patients using A-line data are competent to do so.

Finally, it is important to note the dangers of overmedicating and failure to test. Some people avoid hospitals and physicians out of fear of overmedication and tragic experiences like the plaintiff's in this case. Of course, that is detrimental to the health of those individuals. To remedy this situation, medical facilities may consider implementing a campaign to the public to demonstrate they understand that concern and that they have taken measures to prevent overmedication or incorrect medication. Certainly, hospitals and medical professionals should re-evaluate a patient's symptoms frequently after a change in medication. Many experts contend that Americans are overmedicated, and hospitals and medical professionals should help combat this problem. ■

REFERENCE

Decided on October 15, 2015 at the Circuit Court of Illinois, Cook County Judicial Circuit; Case No. 09L1448.