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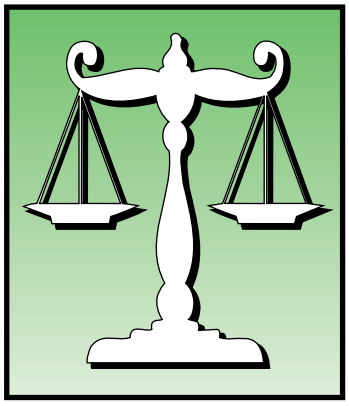

Healthcare Risk Management™

## INSIDE



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# Ex-cons in nursing homes present liability risk; feds raise alert status

*Government finds large number of cons in long-term care facilities*

Five percent of workers in long-term care facilities have a criminal record, according to one government study that suggests risk managers should take steps to protect patients by aggressively screening applicants and closely monitoring any employees with criminal backgrounds.

The report from the U.S. Department of Health and Human Services (HHS) in Washington, DC, shocked some health care professionals by revealing that more than just a few bad apples in the long-term care business have a criminal background. To up the ante for risk managers, testimony before Congress makes it clear that government officials see those staff as a threat and expect long-term care facilities to protect patients. That, in turn, means those workers pose a liability risk to the health care organizations employing them.

> **"If you have people in your facility convicted of crimes, why are we to believe they are going to behave appropriately now that they are at the workplace instead of in their neighborhood?"**

The problem is serious, says **Sandy Mahon**, vice president for risk management and quality assessment with Program Beta, the risk pool for hospital districts in California, based in Alamo. She coordinates risk management activities for 77 hospitals. Mahon first encountered the problem when she worked as an employment manager before becoming a risk manager.

"From a risk management point of view, personnel is one of the main risk exposures already," she says. "If you have people in your facility convicted of crimes, why are we to believe they are going to behave appropriately now that they are at the workplace instead of in their neighborhood? If they're selling dope in their neighborhood, why wouldn't they sell dope in your facility?"

The potential damage is tremendous. A patient can be molested, raped, or physically abused, and that can lead to civil lawsuits and

## Criminal history rate may be 10%, feds say

The 5% rate of employees with criminal backgrounds may be underestimated, according to the recent audit of Maryland long-term care facilities by the federal government. The figure may be as high as 10% because the databases used in the audit are incomplete, federal investigators say.

Even if just 5% of the work force has a criminal record, that's still too high, says **Thomas Roslewicz**, deputy inspector general of the Department of Health and Human Services, who presented the results of the audit to a congressional committee. The audit "demonstrated that there is no nationwide assurance that nursing home staff who could place elderly residents at risk are systematically identified and excluded from employment," he told the committee. He recommended strong federal oversight and increased collaboration with states.

Roslewicz said the state registries, found in 37 states, could be improved. Of the 37 registries, 94% did not initiate criminal background checks on those applying for certification or licensing, 29% did not require prior arrest or conviction information on renewal applications, and 13% did not provide a penalty for making false statements on the certification or license application.

Of the 51 staff with convictions in the Maryland audit, 43 stated falsely on their job applications that they had *not* been convicted, and another four didn't answer the question at all.

Federal officials endorse extensive use of criminal background checks. Roslewicz told the congressional committee, "We believe that criminal background checks offer long-term care facilities an important safeguard against hiring persons who abused or neglected vulnerable elderly residents or who have been convicted of other serious crimes." ■

regulatory penalties against your facility.

"The patients are so vulnerable in long-term care. They are most at risk because they often don't know what's going on," Mahon says. "It's very difficult for the risk manager because the district attorney looks at the employee's criminal record and says, 'Why didn't you know?'"

The alarm bells were sounded when **Thomas Roslewicz,** deputy inspector general of the HHS, presented the study results in a recent hearing of the Senate Special Committee on Aging. Government auditors conducted criminal background checks on 1,000 employees at eight randomly selected Maryland nursing homes and found that 5% had been convicted of crimes the report says "should raise concern over their employability."

The staff with criminal backgrounds held nearly every position in long-term care, including nurses, nurses' aides, food service, housekeeping, and maintenance. Their past crimes included assault, child abuse, robbery, and drug sales.

HHS studied only the randomly selected facilities in Maryland, but the report obtained by *Healthcare Risk Management* notes similar findings in Illinois. The state of Illinois recently checked the backgrounds of 21,000 long-term care employees and also found that 5% had criminal records. **(See above box for more on the results of the government audit.)**

Thirty-three states currently require long-term care facilities to do background checks on job applicants, but the HHS report notes that most states only require checks of their own state databases, not federal sources like the Federal Bureau of Investigation database. That means it is easy for criminals to just move to another state and get a nursing home job.

Another problem cited by Roslewicz was the incomplete nature of state registries. Providers are required to report to the state nurse aide registry or other appropriate licensing authorities any court actions against an employee that would

### *COMING IN FUTURE MONTHS*

- Responding to compliance hotline calls
- How to review contracts
- Home health under more scrutiny
- Coverage of ASHRM annual meeting
- How to best work with legal counsel

indicate unfitness for service as a nursing aide or other staff member. The HHS review of the Illinois registry, however, found that 13 known cases of abuse were not listed with the registry.

In addition, the Health Care Financing Administration prohibits facilities from employing anyone found guilty of abuse, neglect, or mistreatment of residents, or misappropriation of residents' property. No program payments can be made for items and services furnished, ordered, or prescribed by those workers. That raises the specter of federal investigators finding that your facility owes a huge refund for services involving an employee with a criminal history, plus possible fraud charges.

### *Checks reveal 5% of criminal applicants*

The 5% rate of criminals in long-term care is consistent with a figure reported earlier this year by *HRM*. The Shepherd Center in Atlanta, a hospital specializing in the treatment of spinal cord injuries and other major disabilities, has a strict policy of checking the criminal backgrounds of all new hires, and its experience has shown that 5% of them have criminal records they did not disclose in the application process. **(See *HRM*, May 1998, pp. 55-57. The May issue also includes information about screening applicants, pp. 58-60.)**

The Shepherd Center's policy was enacted soon after the Nov. 17, 1995, rape of one of the center's patients by a staff member who had felony convictions for forgery and robbery. The hospital had good reports from the man's references, he had passed a mandatory drug screen, and he had proper certification as a nursing assistant. Under the current policy, new employees, volunteers with access to patient care areas, employee and non-employee physicians, and any contract workers in patient care areas must undergo a criminal background check. Job applicants also are asked if they have a criminal background, and lying about that is considered justification for automatic revocation of a job offer.

Mahon says the 5% rate of employees with criminal backgrounds is surprisingly low. She would expect it to be much higher, especially in the long-term care industry. **(For more on the reliability of the 5% rate, see story, p. 134.)** People with criminal backgrounds are drawn more to long-term care and child care, the areas where they could do the most damage, because those fields tend to employ people with the lowest skill and experience levels, Mahon says.

"With the current low unemployment rate, it's tough to increase the job requirements because we just don't have a big pool of applicants," she says. "Health care providers are challenged to find good employees for these jobs, and increasing the requirements might mean you just don't have enough people to fill the spaces."

That is no excuse for hiring staff who can endanger your patients, of course, but Mahon says it's understandable why providers don't just establish much higher standards for applicants in long-term care. The solution must involve a way to check applicants' backgrounds, but that's more difficult than it sounds. No national database exists for background checks of long-term care applicants, whereas the National Practitioner Data Bank provides information when facilities credential or hire physicians.

You can ask applicants if they have ever been convicted of a crime, but that question is of limited value. The honest applicant probably has no criminal record, and an applicant with a criminal record probably isn't going to be honest enough to say so when it's clear the job may be lost. Actually checking the criminal records of applicants is an option, but as the Shepherd Center found out, the cost can be too high to do so for all applicants.

Be careful not to rely too much on state certification when hiring staff, Mahon cautions. State certification offers no assurance about a person's criminal history. Also, be sure you're not just relying on the person's employment history, because previous employers may been unaware of a criminal record.

"To a certain extent, I think we've been unknowingly passing around bad apples," Mahon says. "Nationwide, we have this warm body syndrome where we're just happy to have someone to do the work. It's not until something happens that we find out about the record, and then that leaves you liable to charges that you should have known." ■

## For More Information

❑ **Sandy Mahon**, Program Beta, 1443 Danville Blvd., Alamo, CA 94507-1973. Phone: (925) 838-6070.

# How to keep criminals out of your facilities

It won't be easy to keep people with criminal records from being hired at your facilities, but there are steps to take that can sharply decrease the chance of putting your patients in the hands of criminals. Here are some suggestions from **Sandy Mahon**, vice president for risk management and quality assessment with Program Beta in Alamo, CA, the risk pool for California hospital districts:

❑ **Conduct criminal background checks if you can afford them.**

The cost of the checks will vary depending on what service you use and the volume of inquiries, but $15 each is typical. That can be cost-prohibitive if you have a large network of facilities and a lot of applicants because of the high turnover rate common in some health care fields, such as long-term care. You may want to do background checks on just the new hires, not all applicants.

❑ **Do the background checks only in long-term care if your budget is tight.**

"Risk managers should be devoting more attention to long-term care because that's where the problem is," Mahon says. When it comes to staff with criminal backgrounds, not all of your departments are created equal. Your long-term care facilities are much more at risk for this problem than other departments, so it's a good idea to devote scarce resources to those problem areas.

❑ **Improve your interview techniques.**

The interview process should involve questions intended to ferret out those with criminal backgrounds. For starters, ask if the person has ever been convicted of a crime. If your organization has a policy prohibiting people with certain criminal backgrounds from working there, explain that policy and the fact that lying about one's background can cause dismissal. Such questions won't bring forth everyone's criminal record, but they may eliminate some that would have slipped by.

❑ **Closely monitor the employee's probationary period.**

Take advantage of the usual probationary period to scrutinize new hires closely. Step up your efforts in long-term care and don't tolerate any sign of criminal or unethical conduct.

"You're subject to any of their individual faults being played out in your arena," Mahon says. "If he's a thief, you're going to have lost patient valuables. If he's convicted of any kind of abuse or molestation, you run the risk of patients being physically abused or raped."

❑ **Watch night-shift employees more closely.**

Mahon says she expects those with criminal records to seek night-shift work because it usually allows them to work with less direct supervision and with fewer people alert in the facility. There is no evidence that those with criminal backgrounds seek the night shift, but Mahon says it's well-known that drug-abusing nurses and doctors seek night-shift work for the same reasons. ■

# Attorney contact policy helps handle large volume

Calls from attorneys looking for information about cases are an unavoidable part of working in health care. Usually, they amount to little more than a small nuisance. But when the calls come in by the hundreds every single day, they can create a huge workload for your staff and increase the chance of information being improperly disclosed or withheld.

That's when it's time to develop a facilitywide policy that will ensure the calls are handled properly, suggests **Helen Johnson**, RN, risk manager at Harborview Medical Center in Seattle. When her facility became overwhelmed with attorney inquiries a few years ago, she worked with colleagues at the University of Washington, which manages the hospital, and the state attorney general's office to develop a formal "attorney contact policy" that guides employees through the approved process for responding. The 411-bed hospital needed such a policy probably more than most hospitals would because of its size and heavy patient volume, but the need exists on a smaller scale at almost any acute care facility, she says.

Harborview serves as the trauma center for Washington, Alaska, Montana, and Idaho — about a third of the U.S. landmass. It also serves as the county hospital, so it has a huge volume of trauma patients every year in addition to the other patients. Because such a large percentage of those patients were involved in accidents of some type, staff get frequent calls from attorneys requesting records or answers to questions.

"There's a lot of third-party litigation involving these patients, so we get a number of calls to people all over the hospital," Johnson says. "They

call anywhere and everywhere. We have a hard time estimating how many calls we get, but we got 58 requests in just the orthopedic department in one day. That's typical."

With that volume of inquiries, it was impractical to have all of them referred to risk management, even though Johnson would prefer to handle that type of call herself to ensure it is done correctly. But just leaving staff to handle the calls as they saw fit also was not a good option, mostly because Johnson and her colleagues feared some calls would be handled improperly. Either the busy clinical staff would fail to comply with legitimate requests by attorneys, thereby failing in the hospital's obligation to turn over documents, or they would accidentally disclose confidential information simply because they didn't know what could be released.

"In addition to the volume problem, staff would get very nervous about complying," Johnson explains. "We also got a lot of expressions of frustration from attorneys that they didn't know how to best get information, and sometimes the staff didn't know how to help them."

### *A blueprint for response*

The solution was a formal policy that instructs staff on how to comply with attorney requests. The result: Staff have much more confidence in how to respond, and the risk managers can worry less about mistakes. The policy also helps streamline the way requests are handled, and that helps staff deal with the high volume of calls.

Johnson and her colleagues started developing the policy in 1995, but they could not find any similar policies on which to base it. So they created a new policy of their own. Johnson says she normally believes all policies should be kept to two pages or less, but this one had to be more extensive because it provides detailed guidance to staff who are not primarily responsible for releasing information and dealing with attorneys. The policy is 10 pages, plus a one-page algorithm that serves as a quick guide. **(See p. 138 for an excerpt from the policy and p. 139 for the algorithm.)**

"We first decided how to triage the calls and determine what was needed," Johnson says. "We wanted to provide an efficient response but not place an undue burden on the staff."

A large portion of the guidelines are simple and straightforward. They instruct staff to refer to the risk management department any calls that might involve litigation against the hospital, staff, or physicians. Other calls should be directed to the department that can help the attorney most directly. Many callers need medical records, so the policy states that those callers should be directed to the medical records department and provides the phone number.

Other callers want to know how to file a malpractice claim, identify a signature on a medical record, obtain a hospital policy, get information on psychiatric treatment, identify guardians, or learn about the University of Washington's business involvement. The policy outlines the correct

## Little risk in allowing staff to make some decisions

The attorney contact policy at Harborview Medical Center in Seattle might fly in the face of some risk management ideas by allowing front-line staff to handle attorney calls instead of referring all of them to risk management. Nevertheless, there is little risk if the policy is handled well, says **Lisa Vincler**, JD, assistant attorney general for the state of Washington in Seattle.

Vincler worked with Helen Johnson, RN, risk manager at Harborview, and University of Washington officials to develop the policy, making sure it didn't unduly expose the hospital or infringe on its legal obligations to release information. Vincler says the team considered the risk of putting more responsibility in the staff's hands but ultimately determined the risk already existed because, for better or worse, the staff already were taking the calls. Risk management was unable to field all the calls, so the best solution was to devise a policy that helped the staff handle them.

"There is a risk that mistakes may occur," she says. "However, the likelihood of mistakes can be greatly reduced through staff education. I am not aware of any disadvantages in having such a policy, provided staff receive some education about the policy and that staff don't hesitate to call either the risk manager or legal counsel if they need specific advice."

Two points were particularly important to get across to the staff, Vincler says. First, she wanted the policy to emphasize that "subpoenas are not 'invitations' and, when properly served, they require a response." She also made sure the policy reminded staff that original medical records should not be removed and taken to court or depositions by anyone other than medical records department staff. Doing so could threaten the integrity of the records. ■

departments that can help callers with those questions, and it provides other guidance on what kind of information staff may and may not release.

For instance, it is common for attorneys to call for help in identifying a signature on a medical record. They will call just about anywhere and ask whoever answers the phone for help, Johnson says. They usually don't get a good answer and keep calling all over the hospital. Under the new policy, the first employee to take the call directs the attorney to the medical records department for initial review and then to the treating unit's department manager for further help.

### *Help staff make good decisions*

Other portions of the policy go beyond just handling the initial phone call from an attorney, dealing with more involved attorney contact such as depositions and trial testimony. Because attorneys often take a scattershot approach to getting witnesses, the policy explains the difference between a fact witness and an expert witness. If an attorney calls and asks staff to testify as fact witnesses, they're obligated to do so. But if the attorney wants them to testify as expert witnesses, they are not obligated to comply. The high volume of such calls often left clinical staff feeling they were constantly being asked to participate in litigation, and the distinction sometimes was not clear to them.

"You have a duty to testify to the facts that you documented in the chart, but if they want expert testimony, that's an option you can decline," Johnson says. "We have requests sometimes where the attorney wants to speak with 25 members of our staff, and it's difficult to meet those requests and carry on business. We try to get them to pinpoint who they really need to talk to."

The policy required a series of discussions among risk managers, an assistant attorney general for the state of Washington, and others. Harborview's emergency department and burn units fielded a large number of calls from attorneys, so Johnson included managers from those departments in the discussions. **(See box, p. 137, for the assistant attorney general's advice.)**

Once the policy was finalized in 1995, it was adopted by Harborview and the University of Washington. Johnson calls the policy a tremendous improvement in the way attorney contacts are handled, and she suggests a similar one could be useful in most health care facilities in which patient volume is so high — or the risk manager so

*(Continued on page 140)*

## Policy offers staff guidance when attorneys call for info

This is the beginning of the 10-page attorney contact policy in use at Harborview Medical Center in Seattle:

**Policy:** Health care providers at Harborview Medical Center (HMC) and University of Washington Medical Center (UWMC) will cooperate in providing information within the scope of their job responsibilities and as provided by law to attorneys.

**Procedure:** When contacted by an attorney regarding a patient treated at HMC/UWMC, it is the responsibility of the faculty or employee to reply to the attorney unless otherwise advised by legal counsel or Medical Center/University Administration.

I. Prior to discussing any patient information, the person/entity requesting information must present a signed Consent for Release of Medical Information. A signed consent form is valid for 90 days.

II. Obtain the following:

A. The attorney's name, firm, and phone number.

B. The name of the attorney's client.

C. The name of the patient.

D. Confirmation/denial of any involvement in the case by the University, Medical Center(s), or affiliated site(s).

E. The type of the request and response:

1. For a malpractice claim: Refer the request to UW Risk Management. Decline to comment on the case without legal counsel.
2. For medical records: Refer the request to the Legal Desk, Patient Data Services (Medical Records). There is a required prepaid fee for this service. Direct inquiries to: [insert phone numbers and internal mail addresses for the medical records department].
3. Signature identification:

a. Refer the request to the Patient Data Services Department.

b. If signature identification is unsuccessful there, refer the request to the department manager of the treating unit.

4. For policy and procedure requests: When hospital staff are asked by an attorney to provide a copy of a hospital policy or procedure, notify the Department Manager. The Department Manager will evaluate the request and arrange for billing to cover the cost of the resources used in filling the request (see section VI). Risk Management and the Health Sciences Assistant Attorneys General are available for consult in deciding to deny or comply with the request. ■

# Attorney Contact

**ASK:**
1. Name of attorney and firm
2. Identity of client
3. Name of patient
4. **For a consent signed by patient to discuss/release medical information**
5. Type of request

1. **Medical Records/Subpoena Duces Tecum**
   Refer call to: Patient Data Services Legal Desk.
   (HMC 223-6052; UWMC 548-4342)
2. **Signature Identification**
   Refer call to: Medical Records.
   (HMC 223-3102; UWMC 548-4342)
   If unsuccessful, try: Department Manager.
3. **Policy & Procedure Request**
   Refer call to: Department Manager.
   Risk Management & Assistant Attorneys General will consult.
4. **Laboratory Information**
   Refer call to: Administrator, Laboratory Medicine.
   (548-6131 HMC & UWMC)
5. **Sexual Assault Information**
   Refer call to: Patient Care Coordinator, Sexual Assault Center. (548-1800)
6. **Psychiatric Involuntary Treatment**
   Refer call to: Lead Public Defender.
7. **Guardianship filed by HMC/UWMC**
   Estimate a time for the Guardian Ad Litem to see patient.
8. **Guardianship filed by parties other than HMC/UWMC**
   Hire a process server to serve papers and place administrative copy in medical record.
9. **UW Business/Involvement**
   Health Sciences AG Section. (543-9220)
   Or University A/G Division (543-4150)

10. **Expert Witness**

11. **Fact Witness**

Inform inquirer that:
You will review the request and call back.
Reimbursement is required for costs of providing the services.

To determine HMC/UWMC liability exposures, call:
HMC Risk Management. (223-6744)
UWMC Risk Management. (548-6303)

**No HMC/UWMC Involvement in Claim**

**Expert Witness**

Notify Manager or Chair

Not Part of Job (Optional)

Administrative Approval

Accept/Reject Offer

Establish Fee

**Fact Witness**

Notify Manager or Chair

Obligation
(Duty to testify to facts you documented in medical record. No duty to give opinion.)

Request:
1. Consent for Release of Information
2. Subpoena

Review Deposition Instructions (Addendum 4)

Respond to Request

**NOTE:** Subpoenas require a signed Consent for Release of Information before patient information may be discussed, except for a formal proceeding, i.e., deposition or trial.

*Source:* Harborview Medical Center, Seattle.

## For More Information

❑ **Helen Johnson**, Risk Manager, Harborview Medical Center, Box 359706, 325 Ninth Ave., Seattle, WA 98104. Phone: (206) 731-8744.

busy — that not all of them can be routed through risk management. "This policy has decreased phone calls to my office by about 20%," she says. "I still get the calls for matters that need my attention, but the policy has reduced the number of calls my office gets from staff who just want to know how to handle a request. I also don't hear complaints from attorneys they way I used to." ■

# JCAHO outlines causes of most wrong-site surgery

Operating on the wrong part of a patient's body is an obvious sign that there's a fault in your operating room (OR) system. New advice from the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) in Oakbrook Terrace, IL, can help you pinpoint the problem.

The mistake usually can be traced to multiple surgeons, multiple procedures, pressure to operate quickly, and unusual body characteristics, according to a recent JCAHO report. Its accreditation committee has reviewed 15 cases of wrong-site surgery in the two years since the sentinel event policy has been in place. A root cause analysis was conducted after each incident, and JCAHO used that information to determine the common characteristics of the incidents.

Wrong-site surgery occurred most commonly in orthopedic procedures, accounting for 10 of the incidents; there also were three urologic and two neurologic procedures. JCAHO reports that these factors apparently contributed to the wrong-site surgeries:

❑ **More than one surgeon was involved.** This could be because multiple surgeries were anticipated, or the patient's case was transferred from one surgeon to another.

❑ **There were multiple surgeries on one visit to the OR.** The risk is greater if multiple surgeries are on both sides of the patient.

❑ **The surgical team was pressed for time.** The pressure to move quickly could be related to an unusual starting time or pressure to hurry through pre-op procedures so the surgeon can start working.

❑ **The patient had unusual characteristics.** Any physical deformity could complicate the preoperative process and the procedure. Extreme obesity, for instance, can cause the surgical team to alter normal equipment setup and patient positioning.

As might be expected, poor communication is usually behind the wrong-site surgery incidents. The 15 hospitals cited the main causes as miscommunication and faults with pre-op assessment and the procedures used to verify the operative site. The communication problems fell into two broad categories: 1) failure to engage the patient or family in the process of identifying the correct surgical site and 2) incomplete or inaccurate communication among surgical team members. The poor communication among team members often took the form of excluding some members, such as the surgical technicians, from the site verification process. In other cases, the team relied solely on the surgeon to verify the correct operative site.

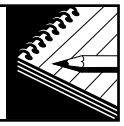
JCAHO cited these other contributing factors:

- failure to review medical records or imaging studies immediately before operating;
- no formal procedure for verifying correct site;
- no final OR check before starting procedure;
- no oral communication in verification process;
- failure to have all relevant information sources in OR;
- not using a checklist;
- atmosphere in which surgical team members felt they were not permitted to point out errors;
- attitude that surgeons should never be questioned.

With those findings in mind, JCAHO makes the following recommendations for preventing wrong-site surgeries:

- Clearly mark the operative site.
- Involve the patient in marking process to improve its reliability.
- Require each surgical team member to orally verify the correct surgical site.
- Use a checklist that includes any documents mentioning the correct site — including the medical record, X-rays, other imaging studies, informed consent documents, the OR record, and the anesthesia record — and direct observation of the marked operative site on the patient;
- ensure the surgeon personally takes part in obtaining informed consent;
- monitor OR procedures to ensure verification procedures are followed, especially for high-risk ones. ■

GUEST COLUMN



# Malpractice coverage for 'hard-to-place' physicians requires creativity

By **Rob Lee**
Senior Underwriter
Shand Morahan & Company Inc.

Today, a number of powerful forces are making it considerably more challenging for hospital risk managers to insulate physicians from medical malpractice exposures and guard their hospital's bottom line against costly malpractice lawsuits. Society's love of litigation, for example, has produced a steady rise in the number of medical malpractice lawsuits, in turn creating a new class of physicians who require support and guidance from risk managers because alleged errors in professional or personal judgment or physical or emotional disabilities have landed them in the "hard-to-place" insurance category.

Risk managers usually feel challenged by the task of finding insurance for those physicians, and rightly so. But the insurance is available if you know where to look and how to go about the process. Unfortunately, the challenge comes just as trends such as integrated delivery systems make it more difficult for risk managers to monitor quality of care in ancillary facilities — even as today's emphasis on strict treatment protocols and scrupulous collection of outcomes data provide increasingly little margin for error. To stay a step ahead of calamity in this increasingly perilous and fast-changing environment, risk managers must understand clearly the medical malpractice insurance options available to their hard-to-place physicians. At the same time, they must work to develop and implement policies and programs that control malpractice risks for physicians and hospitals alike.

Physicians practicing in the 1990s face greater liability risks today than they did during the previous decade, and that can spell trouble for hospital risk managers. According to data from the American Medical Association's Socioeconomic Monitoring System (SMS), the number of malpractice claims filed against physicians has increased from a low of 6.4 claims per 100 physicians in 1988 to almost 10 per 100 physicians today.

Jury Verdict Research reveals that medical malpractice awards rank at the top of all tort-related civil jury cases. Though slightly less than 60% of claims are either settled out of court or litigated to a verdict, both awards and settlement amounts are up sharply since 1990, with the median award increasing to more than $500,000 in early 1996.

Hospitals pay 26% of all medical malpractice damages awarded each year, according to a 1995 study by the accounting firm of Tillinghast-Towers Perrin.

These trends affect risk managers in several important ways. First, because insurance companies may not renew the policies of physicians named in medical malpractice lawsuits, risk managers often are asked to help these hard-to-place physicians find coverage from an alternative carrier so they can maintain their admitting privileges. Second, because hospitals are frequently named as codefendants in lawsuits brought against individual physicians, risk managers must do everything within their power to solidify the hospital's defense in the event of a lawsuit. Preemptive actions range from requiring every physician's medical malpractice coverage to meet specific standards for limits, policy terms, and the financial stability of the insurance carrier, to establishing specific guidelines for physicians that help mitigate a variety of malpractice risks.

## *Risk manager faces tough choices*

Today's environment makes the process of finding the appropriate coverage for physicians more complex than ever. To help hard-to-place physicians select the coverage that suits their unique needs, risk managers must know how individual carriers in both the admitted and the excess and surplus (E&S) markets define their respective comfort zones, and which policies deliver the best total value for the individual physician. In recent years, a bevy of insurance carriers have entered the medical malpractice arena, each with its own distinct underwriting criteria. Though some insurers in the standard market will consider hard-to-place physicians, most physicians with claims histories or disciplinary problems will have better luck in the E&S market, which specializes in underwriting hard-to-place risks.

When it comes to purchasing malpractice coverage, many physicians make their decisions based on price alone, without examining the important details that differentiate one policy and carrier from another. A low premium is of little consolation, however, if a lawsuit ensues and the physician believes his insurer is not providing adequate representation, or perhaps worse yet if the insurer lacks the financial resources to pay a claim. Problems like these quickly can become issues for the hospital, too, as plaintiffs and their lawyers target entities with deep pockets. To protect their physicians and hospitals, risk managers should consider the following policy features before recommending a specific policy or insurance carrier:

❑ **Consent to settle.**

Some E&S carriers are silent on the consent-to-settle clause, and the insurance carriers might construe these policies as not requiring the physician's consent to settle a lawsuit. This is an important consideration, however, because settlements made in the interests of expediency may carry with them an implied admission of guilt that can be costly to a physician's professional reputation. For those physicians whose reputation already is damaged, such a cloud could spell the end of their career. Because consent-to-settle clauses give physicians direct input into the outcome of their cases, they should not surrender this privilege voluntarily.

❑ **Demand forms vs. incident forms.**

Demand forms limit coverage to actual demands for reimbursement made during a policy period. Incident forms extend coverage to protect physicians from adverse results that later may develop into a claim. They allow physicians to report incidents during a policy period even though no charge has been filed. The policy will cover the incident if it later develops into a claim, regardless of the status of the physician's current coverage.

❑ **Policy "tails."**

Insurers vary widely on their approach to "tails" that provide coverage for prior acts after a policy expires. Some standard markets offer these tails with no additional premium for death, disability, or retirement by building the cost into the original pricing of the policies. E&S companies usually price tails separately, and costs vary widely. Risk managers should encourage physicians to look into this aspect of the coverage and inquire about these costs upfront. Physicians also may want to do a cost-benefit analysis to see how best to cover future expenses in the event they either practicing medicine or replace coverage with a carrier unwilling or unable to provide prior acts coverage.

❑ **Financial strength.**

Physicians also should look at the individual insurance carriers and evaluate their financial strength, their commitment to and understanding of the medical malpractice business, and their claims-handling expertise. A carrier's rating by A.M. Best and other agencies provides a clear indication of the company's financial stability — and its ability to meet financial obligations.

## Doctors should look out for themselves, too

Because medical malpractice coverage is such a vital asset to physicians, risk managers should counsel them to perform additional due diligence before purchasing a policy to ensure that the carrier they've selected meets acceptable standards for financial stability and responsive claims handling. Specifically, physicians should:

- Review the policy carefully to obtain a clear understanding of its terms, conditions, and any exclusions.
- Ask the carriers to explain their approach to controlling defense costs.
- Make sure the policy contains a clearly worded consent-to-settle clause.
- Call colleagues within their profession who have faced lawsuits and ask how satisfied they were with the representation the insurance carrier provided.
- Contact the state insurance board and ask whether there have been complaints filed against the carriers under consideration.
- Check the reputations of the law firms these carriers use to handle malpractice suits.

## Make preemptive strikes to protect yourself

Beyond helping physicians find suitable malpractice coverage, risk managers face the much greater responsibility of insulating the larger hospital entity from malpractice risks. Specifically, they must address the liability issues that surround the hospital as a corporate entity, the medical staff committees that grant admitting privileges, and the hospital's governing board of directors.

Risk managers can go a long way toward controlling these risks by ensuring that the hospital has a clear credentialing process in place and that

it adheres to it without exception. In the absence of any national, centralized credentialing system, it's tempting to take a physician's word on matters of credentials, training, employment history, and claims history, but oversights can prove extremely costly.

In addition, many risk managers have the authority to set and enforce hospital policies that address specific risks. These risk management policies not only protect the best interests of physicians, they also strengthen the hospital's defense in the event of a malpractice lawsuit.

Many hospitals, for example, require their physicians to follow established protocols that have been developed for procedures such as childbirth, and they insist that physicians deliver all outcomes data to a central location for inclusion in a database. Accurate outcomes data often alert risk managers to problems that can be addressed before it's too late.

### *More risk avoidance tactics*

Other hospitals develop practical guidelines for health care practitioners that include the following tactics:

- Refer patients for all necessary tests and admit rather than nonadmit when in doubt.
- Document all visits carefully, including all follow-up appointments. Many patients are noncompliant, and missed appointments can contribute to unfavorable results.
- Have another medical professional or a family member present when treating patients of the opposite sex — especially minors — to prevent unfounded allegations.
- Create a "safe haven" for nurses so they feel comfortable reporting signs of questionable medical practices, emotional instability, or substance abuse.
- Have a thorough consent form for all procedures and take direct responsibility for discussing it with patients and securing their signatures.

*[Editor's note: Rob Lee is a senior professional at Shand Morahan & Company, Inc. of Evanston, IL. Shand Morahan is the underwriting manager of the Evanston Insurance Company, which markets medical malpractice, professional liability, E&O, D&O, and casualty insurance products nationwide through wholesale brokers. Contact: Rob Lee, Shand Morahan & Company, 1007 Church St., Evanston, IL 60201. Phone: (847) 866-2800.]* ■

# Yale fraud investigation settled for $5.6 million

Yale University School of Medicine in New Haven, CT, has agreed to pay $5.6 million to settle a major billing fraud investigation. The payout will end one of the most closely watched dramas in the government's recent spate of fraud investigations.

The school announced the settlement recently but noted that it does not include an admission of liability. Liability or no, Yale is losing a big chunk of change.

The settlement agreement with the U.S. attorney for Connecticut and the U.S. Department of Health and Human Services requires Yale to refund $500,289 (including interest) to the federal government for billing irregularities concerning Medicare and other federal health care programs.

*(Continued on back)*

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General Manager: **Thomas J. Kelly**, (404) 262-5430, (tom_kelly@medec.com).
Publisher: **Brenda Mooney**, (404) 262-5403, (brenda_mooney@medec.com).
Executive Editor: **Susan Hasty**, (404) 262-5456, (susan_hasty@medec.com).
Production Editor: **Terri McIntosh**.

**Editorial Questions**

For questions or comments, call **Greg Freeman** (404) 320-6361.

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*(Continued from page 143)*

In addition to paying the refund, Yale will pay $1.8 million to a number of insurance companies and $2.5 million to individuals and other companies. The school also is paying $700,000 to the federal government for "complete resolution" of the claims.

The payments will end an investigation of credit balances at Yale related to medical billing. The credit payments resulted from duplicate payments from multiple payers, as well as payments that could not be matched to outstanding charges for patient care. Yale attributes the credit balances to faulty administrative systems that are now being upgraded.

Yale anticipates $120 million in payments for patient care this year, so the $5.6 million represents about 5% of the year's total patient care income. ■