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Metrics should play major role in risk management, experts say

Sophisticated data collection and usage becoming mandatory

If you haven't yet incorporated metrics into your risk management program, you should begin immediately, because the use of metrics will drive much of what happens in the field in coming years, say risk managers and other experts. Risk managers who are using metrics may be ahead of the curve, but still need to ensure they are getting the most out of them.

Metrics are measurements that allow quantitative measurements of your success, problem areas, and efforts to improve. More than just data compiled on individual issues, metrics are analyzed and combined in ways that provide risk managers and health care leaders with the insight to understand the implications of the data more than if they focused only on the individual "silos" of information about different topics, explains **Ed Hall**, MS, CSP, senior director of risk management controls and education at Stanford University in Palo Alto, CA, including the Stanford Hospitals and Clinic.

The metrics are often compiled in "dashboard" reports to senior leaders to help them visualize and track trends on every level of the organization and to align activities with key goals, Hall says.

"We use metrics and dashboards for a lot of our value-driven cost justification in our program," Hall says. "We have a full range of 20 or 30 projects going at any time, and for our internal risk management, we use

EXECUTIVE SUMMARY

The use of metrics and dashboards is becoming more common in health care risk management and will be seen as mandatory in the coming years. Metrics can yield substantial benefits to a risk management program when the data are of high quality and the information is used strategically.

- Metrics help eliminate isolated "silos" of data.
- Risk managers can improve their visibility and stature by using metrics.
- The 2012 push for value-based purchasing will increase the need for metrics.

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[a] dashboard that shows us where all the projects are and what the status is. We review that in our weekly meetings with our senior cabinet. When we start to get a little more quantitative with some initiatives, especially the larger ones, we'll use a value-driven approach."

With the value-driven approach, Hall and his colleagues pull in all the value drivers associated with a particular program, anything that could add value to it, and determine the value associated with each element. For instance, he says, for a safe patient handling program, the drivers might be reduction in patient falls, reduction in workers' comp costs, reduction in lost time, reduction in employee turnover, and an increase in patient referrals.

"We try to put a value on each of those to come up with a total value of the program to the organization," he says. "Then, we do a tornado diagram to see which one has the most value associated with it. We found that the biggest value was associated with the reduction in turnover, not the reduction in workers' comp, the way you might expect."

ROI always a hot topic

Stanford also uses a waterfall diagram to show the costs and the total value associated with the segments of each program, showing the total return on investment (ROI), always a major concern in the C-suite. The hospitals and clinic also work with their insurer to benchmark medical malpractice data and compare the performance to other facilities.

"We just started a dashboard this past year where we take our medical malpractice and workers' compensation data and present that dashboard to our senior leadership," Hall says. "That allows them to see in real time, within three or four days of our reserves changing, what our total incurreds are, what our largest claims are, and what incidents were involved with those events. We use the dashboard to communicate with our executives about what is going on with the risk program and where we are as that relates to our financial losses."

Stanford has been using metrics and dashboards increasingly in the past few years, and Hall urges other risk managers to adopt the tools more. Metrics can have a direct impact on the risk management program by allowing you to focus your efforts and resources more effectively, he says. Stanford's safe patient handling program was aiming for a 30% reduction in patient handling injuries, but actually achieved a 40% reduction over the first year — a success that Hall attributes in part to the effective use of metrics to determine which elements of the program could have the most effect.

"We exceeded expectations by about 33%, which is pretty good for the first year of a program," he says.

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Many sources for metrics help

Although the term "metrics" can imply that it is an entirely new concept, Hall points out that risk managers have long gathered data to study issues and justify their efforts. Metrics simply takes that information gathering and usage to a new level that yields better results, he says, mostly by making connections and taking information out of silos. Stanford offers metrics classes to risk managers, in conjunction with the American Society for Healthcare Risk Management (ASHRM), which also provides educational materials. (For more information on the ASHRM offerings, go to www.ashrm.org. For the Stanford classes, go to www.http://scpd.stanford.edu/landing/sdrm_health.jsp.)

The National Quality Forum (NQF) and the Institute for Healthcare Improvement (IHI) also offer information on the use of metrics, notes **Carol Burkhart**, RN, MS, ARNP, CPHRM, senior vice president for clinical health care consulting with Marsh Risk Consulting in Chicago. (For the NQF, go to http://www.qualityforum.org/, and for the IHI, go to http://www.ihi.org/ihi.)

Metrics will become even more important when the federal government launches its value-based purchasing initiative in 2012, Burkhart says. Part of health care reform's emphasis on value and eliminating fraud, the value-based purchasing initiative will require providers to demonstrate that they are providing quality care at the best possible price, she explains. That will require extensive data collection and analysis, she says.

"The Office of Inspector General has emphasized the importance of metrics and dashboards in reporting to the board, which ultimately has the responsibility for ensuring quality," Burkhart says. "Risk managers cannot afford not to have a grasp of metrics."

Burkhart cautions that how you present the data to the board is important. Dashboards are a good method for synthesizing and illustrating complex data to the board, but she warns that color-coding in the dashboard can be misleading. A dashboard with lots of green to represent good outcomes, for instance, might be misleading if the board does not understand how the threshold for good and bad outcomes was set.

Can be a career enhancer

The adoption of metrics can help experienced risk managers keep up with younger people entering the field, notes **Douglas Coleman**, account manager with the Health & Human Services Industry Team at The Graham Company, a consulting firm in Philadelphia. Those who have been in the field for many years may be stuck in the old way of doing things, whereas those coming out of college and rising into risk management leadership positions are more likely to use metrics and dashboards, because they are generally more familiar and comfortable with technology, he says.

Strategic use of metrics and dashboards can help the organization better understand its patient population, apply a holistic approach to patient care, and identify and eliminate wasteful spending, he says.

"It's going to result in a better understanding of risk management concerns," Coleman says. "Most organizations are driven to accumulate a lot of data, but usually that data is isolated in silos. By using a metrics and dashboard approach, this data can be integrated and tell a much more complete story."

Adopting metrics can begin with simple initiatives, Coleman says, such as tracking malpractice claims and which ones were not covered by insurance and the details of how those claims came about, how they were handled, and the different costs incurred by the provider.

"Without studying the data in the big picture, you're going to focus on insurance premium upfront costs and consider that a success," he says. "But when you can see the big picture, you realize that maybe it's worth it to enhance the coverage on your insurance so that you avoid these uncovered claims, which are hitting you a lot harder than the insurance premium was."

Culture change may be needed

Using metrics can require a culture change, Coleman says. This type of data analysis may put the spotlight on people within the organization who are not used to being the subject of such attention, and so the use of metrics and dashboards should be supported at the highest levels of the organization, he says.

"A lot of organizations have metrics they use for financial analysis, and some use metrics for some administrative functions, but when it comes to focusing on patient care, a lot of providers use data analysis sparingly," Coleman says. "That's surprising, because patient care yields some of the most costly expenses for an organization, like malpractice claims."

Coleman offers the example of one health care provider he worked with to determine why a high percentage of malpractice claims were coming from a particular segment of patient care. By using metrics to cross-match data about the claims, the patients, and the way the care was provided at that clinic, the organization determined that a large percentage of patients claiming improper care also had missed many appointments. The clinic, however, was not keeping good records on missed appointments or efforts to remind patients about scheduled visits.

"They instituted a plan to call every patient 24 hours before their appointments, and if they find out the patient is going to be a no-show, they work with the patient to reschedule," Coleman says. "If they miss the appointment after that, the clinic documents the file a lot better than before, providing support in claims defense because they can demonstrate in court that the person's injuries were due in large part because they just weren't coming to treatment."

Not just a QA activity

Risk managers should not cede metrics and dashboards to the quality assurance department, says **Roberta Carroll**, ARM, CPCU, MBA, CPCU, CPHQ, CPHRM, senior vice president with Aon Risk Solutions, a consulting firm in Odessa, FL. In the past, risk managers have shied away from in-depth data analysis, leaving that to quality and relying only on a more silo-like aggregation of data about malpractice claims and other risk issues, she says.

With more data available now on the cost of injuries or illnesses to the provider, risk managers can develop more sophisticated analyses that show their ROI, she says. For instance, national data show that a fall with injuries can cost you somewhere around $36,000, Carroll says.

"If you prevent just one of them, you can show a good ROI," she says. "Risk managers are starting to see that data can be your friend, and how it can help you show added value to the organization. Up to now, it has been a challenge to calculate the cost of risk if you didn't really know the cost of the sequellae of the outcome."

Metrics represent an opportunity for risk managers to quantify their department's value to the organization, which will improve the visibility and stature of the risk manager within the organization, Carroll says. Metrics also will help you get the funding you need, especially in times of tight budgets.

"In order to get approval for the project that needs some investment of resources, you need to be able to say what you anticipate your return on investment will be," she says. "You have to say that you're going to reduce these incidents by 25% or whatever, and the cost of those incidents minus your investment shows this is a worthwhile expenditure. Data is king. Data can be your best friend."

Carroll suggests that risk managers partner with other departments that may already be using metrics more extensively, such as quality and performance improvement, both to learn more about the use of metrics and also to share data that may reveal a bigger picture.

Crucial to career success

Incorporating metrics and dashboards is crucial to the career success of a risk manager, she says. Risk managers who lag behind in the use metrics may find themselves struggling to find a role in the organization.

"My fear is that the organization has a quality person who is adept at this, and now they've probably hired a patient safety person in the past few years; and that person is probably using metrics," Carroll says. "You've got people doing parts of your job, so what is the risk manager going to do if they use this data to elevate their roles? Is the risk manager going to be relegated to counting falls and chasing lost dentures? You need to find a spot for yourself, and being better able to evaluate and use data is going to get you there."

SOURCES

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Top metrics to follow in risk management

The metrics tracked in your risk management program will vary according to your own needs and concerns, but this list of commonly applicable and useful metrics comes from Alan Rosenstein, MD, medical director of Physician Wellness Services, a consulting company based in Minneapolis:

- **Core Financial/Legal**

—For physicians, the denominator should be RVUs.

—For hospitals, the denominator should be beds.

—Claims

—Losses

—Premiums (Gross, but also per dollar of revenue and per FTE providers)

- **Clinical**

—For physicians, the denominator should be FTE providers.

—For hospitals, the denominator should be beds/units.

—Health care-acquired conditions

—Medication errors

—Objects left in surgery

—Hospital-acquired infections

—Occurrence of selected other adverse events such as falls or wrong-site surgery per month

—In-patient surgery issues

—Total number of incident reports (patient/staff) per month

—Number of malpractice cases per month. ■

Be wary of legal issues related to metrics

As good as metrics and dashboards can be for a risk management program, they can bring legal risks if not handled properly, cautions **Ari Markenson**, JD, MPH, an attorney with the law firm of Benesch Friedlander Coplan & Aronoff in White Plains, NY.

Markenson recently was the in-house counsel for a large long-term care organization, and he advised leaders there to consider the legal ramifications as they adopted metrics and dashboards more widely for risk management issues. While he is a strong proponent of using metrics to study risk management issues, he points out that the collection of extensive data can come back to bite you if you don't respond properly to what the data show you.

"From the legal angle, I was very, very concerned that the operations team would be putting these metrics together, finding all this software and all these tools, and then they would have all that information; but they don't use it," he says. "You create liability for yourselves. You set up this dashboard or bought this software package, created this great system with all these metrics, but no one is actually spending a considerable amount of time looking at the data you're getting."

Markenson compares the risk to another that is familiar to risk managers: having a policy or procedure but not following it. A plaintiff's attorney loves to tell a jury that the hospital had a solid policy in place, but did not follow its own policy.

For instance, Markenson says, perhaps the metrics indicate that over the last year, your facility is admitting more patients for outpatient dialysis than it ever has before. The risk manager may notice the upsurge and notify the medical director.

"That's great, but from a legal perspective is that really enough to follow up on that potential risk management issue?" he says. "I would say probably not. You have to really dig into that information and see what it means. You have to act on it, because if you don't, you have the potential for further liability; because it's one thing for someone to engage in behavior that results in liability, but it's something else for the institution as a whole to have information indicating there is an institutional problem and not do something about it."

The response to such data must be carefully thought-out and thorough. Simply writing a report to someone else and suggesting that person look into the data is not enough, Markenson says.

"As we move to more and more technology, there is tons of data available to us that allow us to connect the dots and see things we never could have seen before," Markenson says. "Twenty years ago, if you wanted to figure out why dialysis patients were starting to be admitted more, it would have taken someone going through stacks of paper charts. It wasn't something you could find out in real time. Now that you can find out, legally you have an obligation to do so."

A health care provider using metrics and dashboards needs to make a full commitment to using them fully and appropriately, he says.

"The last thing you want is for a plaintiff's attorney to ask you what data you've collected on patient falls, and all of a sudden you realize you have a huge database on patient falls over the last seven years; and you've done zero about it," Markenson says. "That attorney is going to explain to the jury that it's bad enough when you don't even have the data to know how to prevent falls, but it's a lot worse when you have it and just don't do anything with it. It would be much better if you could point to all the changes and improvements you put in place in response to that data."

SOURCE

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Study behavioral issues with metrics

Some topics are obvious when it comes to using metrics, but using metrics to study the behavior of employees and physicians doesn't get as much attention, notes **David G. Danielson**, JD, CPA, senior vice president for clinical risk management with Sanford Health, a health care network based in Sioux Falls, SD.

Businesses can use metrics to measure various financial issues, and health care providers also study various clinical issues; but less known is how metrics can be used to study behavioral issues, Danielson says.

"Typically, it's people that cause problems," he says. "People do things that cause us to end up in a lawsuit later or which can cause patient harm. So, we started looking at items like patient complaints and staff complaints, and I think that's where the future of risk management is going to go. Really, the core of what we're trying to do in risk management is to avoid lawsuits and avoid paying claims, so you have to focus on the key cause, and that is the people who generate those claims for you probably 80% of the time."

Focusing on behavioral issues does not negate the efforts to improve systems and procedures, and it is not a matter of trying to pin the blame for errors or quality issues on individuals, says **Alan H. Rosenstein**, MD, MBA, medical director with Physician Wellness Services, Minneapolis, a consulting firm that has worked with Sanford Health to develop risk management metrics for the health system. But it would be equally wrong to overlook the importance of behavioral issues in patient safety and quality, he says.

"You can look at outcomes all day long, but safety researchers are showing us that you can build the best system in the world; and in the end it still comes down to human behavior," he says. "So, in order to prevent some of these missteps from happening, you need to have to study human factors and behaviors. The new generation of risk management metrics really need to look at some of these human behavioral issues that lead people to do their jobs well or poorly, may lead to incident reports, create communication issues, and ultimately have a negative impact on the hospital's risk."

Danielson says risk managers must tailor their use of metrics to the particular concerns of their own organization. Some measures will be common to most health care providers, but each organization will have its own concerns; and the metrics should be developed accordingly rather than trying to use only a set of standard metrics, he says.

"This hasn't typically been the purview of risk management," Danielson says. "It's something we need to get more involved in and focus on, in order to do our job more effectively."

SOURCES

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Prepare for rising liability costs

Hospitals and physicians should prepare for increasing liability costs, according to the 2010 Hospital Professional Liability and Physician Liability Benchmark Analysis created by Aon Risk Solutions, the global risk management business of Aon Corporation, in conjunction with the American Society for Healthcare Risk Management (ASHRM) in Chicago.

In its eleventh year, the study confirms an emerging change in the liability environment: The frequency of claims against hospitals has entered a growth phase, says **Erik Johnson**, FCAS,

MAAA, Health Care Practice leader for Aon Risk Solutions' Actuarial and Analytics Practice and author of the analysis. Combined with continued claim severity growth, this uptick is expected to drive liability costs up at a rate higher than general inflation, he says

"Last year was the first year in which we thought we saw an increase in claims, and this year we certainly have confirmed that the number of claims has entered a growth phase. It's not huge, at 1%, but it is growing," Johnson says. "The severity of claims has been very consistent in rising over a 10-year period and continues to grow at about 4%. That means we think the cost of claims is increasing at a 5% annual rate, which is quite a bit higher than inflation."

The Hospital Professional Liability and Physician Liability Benchmark Analysis has examined trends in frequency, severity, and overall loss rates related to hospital and physician professional liability for the past 11 years, Johnson says. The 2010 analysis includes 119 hospital systems and more than 1,800 facilities, representing 23% of the total U.S. hospital industry segment.

Erosion of tort reform one cause

A number of things could be driving the increased number of claims, Johnson says. There was a significant drop in claims in 2003 through 2006, which can be attributed to tort reform, a stronger focus on patient safety, and more investment in safety technology, he says. In the current environment, the number of claims is being affected by an erosion in those earlier tort reform efforts and a lack of new tort reform, he says.

"The continued economic stress on households is another factor," Johnson says. "The increase in claims is modest, but it is significant for an industry that is used to seeing a decrease or a flat level of claims. We're going to have to get used [to] a growth pattern in claims."

U.S.-based hospitals are expected to face more than 44,000 claims arising from incidents occurring in 2009, according to the report, with anticipated costs exceeding $8.6 billion. Claims resulting from incidents in two key hospital risk areas, the obstetrics unit and the emergency department, make up more than a quarter of that expected expense, Johnson says.

Loss rates, which measure the total cost of medical malpractice claims per hospital bed, are expected to grow 5% annually. In 2011, hospitals are expected to experience a rate of $3,280, reflecting a $150 increase from 2010's expected rate of $3,130 and a $300 rise from 2009's rate of $2,980.

From 2000 to 2006, tort reforms, patient safety initiatives, and sympathetic public attitudes were influential in the reduction of medical malpractice costs. Today, there is less momentum associated with establishing new tort reforms, and existing tort reforms face serious legal challenges in several states, Johnson says.

"The uncertainties of health care reform and difficult economic times represent significant sources of risk for many hospital systems," Johnson says. "While many hospitals have grown accustomed to declining professional liability costs, the underlying claim frequency and severity cost drivers have entered a period of growth. Whether commercially insured or self-insured, hospitals and physicians should prepare for increases to their professional liability costs in the coming years."

Compare to your own stats

Risk managers should use this information to guide their financial strategy, says **Dominic Colaizzo**, managing director of Aon Risk Solutions' Health Care Practice.

"This challenging environment increases the pressure on health care providers to seek the most appropriate and cost-effective risk financing programs — and to monitor and manage the overall cost of risk per exposure," Colaizzo says.

Colaizzo and Johnson point out these additional findings of the analysis:

- Claim severity (indemnity and claim-related expenses) continues to increase at a consistent rate of 4% annually.
- Hospital professional liability claim frequency is growing at a rate of 1% annually.

EXECUTIVE SUMMARY

A recent survey from Aon and ASHRM indicates that claims frequency and higher claim severity are leading to rising liability costs. Costs are expected to rise faster than the rate of inflation.

- Hospital professional liability claim frequency is growing at a rate of 1% annually.
- Hospitals should expect to incur $204 per birth for liability costs associated with obstetrics claims and $6.30 per visit for emergency department claims.
- Hospitals are employing more physicians, and as a result, the health care industry may experience a shift in claims costs from physician professional liability to hospital professional liability.

• For accidents occurring in 2010, hospitals should expect to incur $204 per birth for liability costs associated with obstetrics claims and $6.30 per visit for emergency department claims.

• Hospitals are employing more physicians and as a result, the health care industry may experience a shift in claims costs from physician professional liability to hospital professional liability. From 2005 to 2009, the average number of employed physicians per hospital bed increased 12% annually.

Johnson advises risk managers to study their own claims in light of the patterns revealed by the Aon study.

"Risk managers should be aware of their own statistics and the underlying cost drivers. The premiums reflect losses, but they also reflect drivers in the marketplace like capacity, surplus, and competition; and that's one reason premiums have been flat or decreasing," he says. "But risk managers should be paying attention to frequency and severity of their losses as well, because ultimately that will drive their total cost of risk."

SOURCES

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Court ruling limits demands for records

The Appellate Division of New Jersey has delivered a resounding victory to the provider community, protecting them from endless and harassing requests for confidential business information while "investigating" whether providers should receive payment for services.

In a case handed down recently in which attorney **Charles Gormally**, JD, of the Roseland, NJ, law firm Brach Eichler represented a group of medical providers, the court instructed insurance carriers that they are not entitled to bully medical providers into producing information beyond that expressly allowed by statute.

In *Selective Insurance Company v Hudson East Pain Management* Docket No. A-0433-09T1, the Appellate Division barred the carrier from requesting "corporate charters, partnership agreements, annual reports, shareholder agreements and lease agreements." The court accepted all of the arguments Gormally made on behalf of providers and ruled that insurance policies' cooperation provisions do not require that medical providers produce this information, Gormally says.

The ruling specifically applied to New Jersey's statute regarding personal injury protection (PIP), a type of no-fault automobile coverage that is available in many states. PIP can include coverage for medical bills, loss of income, funeral expenses, and other expenses. Gormally says the ruling will affect more than just PIP and will influence other states besides New Jersey.

"It's a dispute that's been going on for a while, out of the courts, between health care providers and automobile insurance carriers for some time," Gormally says. "It's good to get one decided and published by the appellate course with such clarity and direction."

Insurers made huge requests

The statutory provisions governing PIP disputes do not require that medical providers produce this information, the court ruled, and New Jersey's public policy of curbing insurance fraud does not, without specific allegations of wrongdoing, require production of this information. (*See the story on page 141 for more details about the ruling.*)

"This ruling dismissed the carrier's complaint and delivered a significant blow to the insurance industry's delay payment strategy of holding up payment to medical providers for failure to produce information," Gormally says. "The ruling was ordered to be published, which will provide support for providers in their dealings with carriers in the future."

The statute in New Jersey that sets the framework for payment of PIP benefits states that when a provider submits a bill to the insurer, the car-

EXECUTIVE SUMMARY

An appellate court ruling in New Jersey limits the document demands of insurers responding to medical claims. The ruling is seen as a significant victory for health care providers.
• The ruling is expected to have influence in other jurisdictions.
• Insurers had used extensive document demands to delay payment.
• Providers still must respond to reasonable document requests.

rier has a right to request certain information to confirm that the services were provided, were medically necessary, and related to a motor vehicle accident. Those requests are reasonable and legitimate most of the time, Gormally says.

"But two or three years ago, we started to see in the industry, arising from the effort to ferret out insurance fraud, insurance carriers started to request information far beyond what was related to a specific patient or a specific treatment," he says. "Instead, they started to submit these really onerous requests, and when I say onerous I mean they were way beyond what was pertinent to the case. I do litigation for a living, so I'm no stranger to document requests, but [the] amounts of these requests were way out of line."

The requests typically came from an insurance adjuster to the health care provider, acknowledging receipt of the bill and noting that more information was required before it could be processed. Attached would be a 10- or 15-page document requesting information about everyone who worked at the facility, all the information related to corporate governance, such as the officers' and directors' backgrounds and formation documents, licenses for all professionals, equipment inventories, serial numbers for all the equipment, a listing of all liens on the equipment, and other mundane information.

"They did it under the guise of determining whether or not the medical provider was qualified to submit a bill for reimbursement," Gormally says. "They supposedly were trying to make sure that your facility was properly licensed and in good standing to submit a bill. It was a very, very deep and invasive query, and for the providers it was expensive and time-consuming to reply."

Ruling will influence other states

Many providers responded as well as they could, but often the insurer would point to minor omissions as reason to delay or deny the claim, Gormally says. The insurers knew that providers did not have the staff or money to devote to such invasive queries, so the insurers benefitted when a large number of claims were delayed or moved to an arbitration proceeding, he says.

In the case heard by the appellate court, Gormally represented a physician practice that refused to hand over the information unrelated to the patient's treatment. The trial court ruled that, largely due to the intense focus throughout the industry to prevent health care fraud, the insurer was allowed to make extensive requests and the provider had to comply if it wanted to be paid. The appellate court disagreed. (*See article below for an excerpt from the appellate court's opinion.*)

Though the ruling technically only applies in New Jersey, Gormally says he expects it to have influence in other jurisdictions.

"Often, when our courts struggle with interpretation of our PIP statute, they look to other states that have compulsory medical coverage for automobile accidents to help interpret our statute," Gormally says. "They track what other states are doing. I would expect that any state in which these kind of onerous document requests are occurring, or if they start occurring later, would look to the New Jersey ruling for guidance."

SOURCE

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Court: Provider doesn't have to hand over records

The ruling in *Selective Insurance Company v Hudson East Pain Management*, Docket No. A-0433-09T1, makes clear that health care providers can sometimes say no when insurers demand records.

In the case at hand, the court said, the insurer did not even allege a violation of New Jersey's physician self-referral law, known as "the Codey Law" for its sponsor, state Senator Richard J. Codey, but still demanded extensive documents intended to show violations of the law.

"In fact, Selective's complaint does not even allege a violation of the Codey Law, but merely a suspicion of unlawful self-referrals and kickbacks among defendants," the ruling states. "Moreover, Selective has pled no specific facts in support of this possibility, which its sprawling discovery demand is designed to substantiate. Consequently, its complaint makes no claim for substantive remedial relief, such as termination of PIP payments to defendants, enjoining arbitration, or recovery of compensatory damages, but rather only seeks to compel discovery beyond which it would be entitled through the arbitral process."

The ruling goes on to say that "We find this

approach not only subverts the established legislative mechanism for obtaining information from health care providers providing medical treatment to insureds, ibid., but also improperly circumvents clearly defined statutory remedies for claimed medical provider misconduct.

"In conclusion, we find that the cooperation clause in Selective's insurance policy does not bind defendant assignees and therefore cannot be the basis for the broad discovery demand at issue here. Rather, plaintiff's entitlement to discovery from defendants is limited by N.J.S.A. 39:6A-13(g), which provides the exclusive mechanism for obtaining information from medical providers in the arbitral process. Outside that process, in an action filed pursuant to the IFPA for substantive remedial relief from claimed violations thereof, plaintiff would be bound by, and subject to, the ordinary rules of discovery governing civil actions in the Law Division, with their usual limitations as to relevance and protections against oppression and harassment. Selective's declaratory judgment action in this instance simply does not qualify as such. Having otherwise offered no sound basis in law in support of its discovery demand, we conclude plaintiff is not entitled to the materials sought." ■

RI fines hospital for alleged errors

The Rhode Island Department of Health is fining Rhode Island Hospital in Providence $300,000 for what the state says is a pattern of significant surgical errors.

The health department received notification from Rhode Island Hospital that during a neurosurgery procedure at RIH on August 4, 2010, a piece of a broken drill bit was left in the patient's skull after the surgery was completed, according to a state report.

The department conducted a joint investigation with the Center for Medicare & Medicaid Services (CMS) and discovered that the hospital "is not actively ensuring that the operating room staff is following existing hospital policy," the report says. "RIH's surgical count policy states that if a surgical tool or device is unaccounted for at the end of surgery, an X-ray of the patient should be done before the patient leaves the operating room to assure that the tool or device is not inside the patient. In this incident, no X-ray was taken, and the surgical count was documented as correct." (To view the health department's statement of deficiencies of the incident, visit http://www.health.ri.gov/discipline/hospitals/RhodeIslandFindings201010.pdf.)

The investigators also found that numerous staff reports of incorrect surgical counts have gone unanswered by the hospital. Similarly, reports from nursing staff that an anesthesiologist did not wear a surgical mask in the operating room were not addressed by medical leadership, according to the report.

The fine is the third and largest imposed against Rhode Island Hospital for surgical errors.

In addition to the $300,000 fine from the state, CMS has asked the health department to conduct a full survey of all areas of the hospital and to ensure that the hospital is in compliance with all of the Conditions for Participation for Medicare. (To view the letter to the hospital from CMS and the CMS statement of deficiencies, visit http://www.health.ri.gov/discipline/hospitals/RhodeIslandFederalFindings201010.pdf.) Two physicians and one nurse also are being referred to their licensing boards for review, according to Rhode Island Director of Health **David R. Gifford**, MD, MPH, who announced the action.

"There is a troubling pattern of disregard for established policies that are designed to protect patient safety and prevent medical errors in Rhode Island Hospital's operating rooms," Gifford said. "When reports from staff about problems in the operating rooms are not adequately addressed, employees are less likely to speak up and report potential problems or concerns."

In addition to the instance with the surgical drill bit, a surgical instrument was discovered on Oct. 15 in the abdomen of a patient who had undergone surgery at Rhode Island Hospital three months earlier, the hospital announced in a news briefing recently. The item was discovered when the patient underwent an imaging test as follow-up for the surgical procedure and the clinicians were surprised to see a tool that appeared to be forceps, the hospital reported.

The portion of the drill bit was discovered when the patient underwent an MRI. The testing revealed the presence of metal, which the health department says could have been dangerous for the patient if the MRI's magnet had moved it within the patient's head.

Health inspectors also reported that hospital

officials failed to respond to "numerous reports" of inaccurate counts of surgical instruments, and did not act on reports of an anesthesiologist who repeatedly walked into the operating room with his mask down.

Mary Reich Cooper, senior vice president and chief quality officer of the hospital's parent company Lifespan, issued a statement indicating that every problem reported is addressed, but that some are not always documented.

The Health Department report described an interview with a risk manager, who confirmed that no investigation was done on a report about sloppy accounting of surgical tools. It also quoted the chief of anesthesia saying that "this was the first time he had heard of the situation" involving the anesthesiologist who wouldn't wear his mask.

The incidents are the latest in a string of surgery-related problems for the hospital. In October 2009, a surgeon at Rhode Island Hospital operated on the wrong finger joint, the fifth wrong-site surgery at the hospital in about three years. The Health Department fined the hospital $150,000 and ordered it to hire a consultant to observe surgery for three years, shut down surgery for one day and conduct mandatory training on surgical procedures, and install audio- and video-monitoring equipment in the operating rooms for periodic observation. ■

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CNE OBJECTIVES

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

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

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a certificate of completion. When your evaluation is received, a certificate will be mailed to you. ■

CNE/CME ANSWERS

ANSWERS: 21. C; 22. A; 23. B; 24. A

COMING IN FUTURE MONTHS

■ Enterprise risk management — How to do more

■ Case studies of success with metrics

■ What kind of dashboard is best for your board

■ Strategies for getting better on-call specialist coverage

CNE QUESTIONS

21. According to Ed Hall, MS, CSP, senior director of risk management controls and education, at Stanford University in Palo Alto, CA, including the Stanford Hospitals and Clinic, Stanford's safe patient handling program was seeking a 30% reduction in patient handling injuries but metrics helped achieve what reduction over the first year?
A. 20%
B. 35%
C. 40%
D. 50%

22. Why does Carol Burkhart, RN, MS, ARNP, CPHRM, senior vice president for clinical health care consulting with Marsh Risk Consulting in Chicago, say metrics will soon be even more important than they are now?
A. When the federal government launches its value-based purchasing initiative in 2012, providers will have to demonstrate that they are providing quality care at the best possible price.
B. The federal government will mandate the use of metrics in 2011.
C. Joint Commission accreditation will require proof of extensive use of metrics in 2013.
D. Most state governments are requiring the use of metrics by acute care hospitals.

23. According to Erik Johnson, FCAS, MAAA, Health Care Practice leader for Aon Risk Solutions' Actuarial and Analytics Practice and author of Aon's recent analysis of malpractice claims, what is the trend with claims severity?
A. The severity of claims has been inconsistent, dropping often over a 10-year period and continuing to drop at about 5% per year.
B. The severity of claims has been very consistent in rising over a 10-year period and continues to grow at about 4% per year.
C. The severity of claims has held steady for more than 10 years.
D. The severity of claims rose for the first time in 2009.

24. In Selective Insurance Company v Hudson East Pain Management Docket No. A-0433-09T1, what was the issue before the appellate court?
A. Whether a health care provider must comply with extensive document requests that do not directly involve care of the patient.
B. Whether a health care provider must comply with any document request from an insurer, even if the court deems the request reasonable.
C. Whether a provider could demand supplementary information from a patient before submitting a bill to the insurer.
D. Whether the insurer could provide additional health information to the provider without the patient's consent.

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PLEASE NOTE: If your correct name and address do not appear below, please complete the section at right.

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CNE Evaluation

Please take a moment to answer the following questions to let us know your thoughts on the CNE program. Fill in the appropriate space and return this page in the envelope provided. **You must return this evaluation to receive your credit letter.** Thank you.

CORRECT ● **INCORRECT** ◌ ✓ ✗ ⊘

1. If you are claiming nursing contact hours, please indicate your highest credential: ◌ RN ◌ NP ◌ Other _____

	Strongly Disagree	Disagree	Slightly Disagree	Slightly Agree	Agree	Strongly Agree
After participating in this program, I am able to:						
2. Describe legal, clinical, financial, and managerial issues pertinent to risk management.	◌	◌	◌	◌	◌	◌
3. Explain the impact of risk management on patients, physicians, nurses, legal counsel and management.	◌	◌	◌	◌	◌	◌
4. Identify solutions to risk management problems in health care for hospital personnel to use in overcoming the challenges they encounter in daily practice.	◌	◌	◌	◌	◌	◌
5. The test questions were clear and appropriate.	◌	◌	◌	◌	◌	◌
6. I am satisfied with customer service for the CNE program.	◌	◌	◌	◌	◌	◌
9. I detected no commercial bias in this activity.	◌	◌	◌	◌	◌	◌
10. This activity reaffirmed my clinical practice.	◌	◌	◌	◌	◌	◌
11. This activity has changed my clinical practice.	◌	◌	◌	◌	◌	◌

If so, how? _____

12. How many minutes do you estimate it took you to complete this entire semester (6 issues) activity? Please include time for reading, reviewing, answering the questions, and comparing your answers to the correct ones listed. _____ minutes.

13. Do you have any general comments about the effectiveness of this CNE program?

_____

I have completed the requirements for this activity.

Name (printed) _____ **Signature** _____

Nursing license number ***(required for nurses licensed by the state of California)*** _____

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