Healthcare Risk Management™

May 2011: Vol. 33, No. 5
Pages 49-60

IN THIS ISSUE

Enclosed in this issue:
HIPAA Regulatory Alert
2011 Reader Survey
Legal Review and Commentary

Financial Disclosure: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

AHC Media

What makes clinicians fearful to speak up? The 'undiscussables'

New study: Many stay silent even when safety tools signal danger

For years, risk managers and other healthcare leaders have been pushing physicians and staff to speak up when they see a dangerous situation, but new data suggests the effort has been only moderately successful at best. The focus on providing tools to improve patient safety might have overshadowed what really matters most: behavioral changes.

Research and regulatory bodies have long confirmed that poor communication in health care is harmful at best and deadly at worst. A 2005 study called Silence Kills, conducted by VitalSmarts. a corporate training company in Provo, UT, and the American Association of Critical-Care Nurses (AACN), found that among 1,700 nurses, physicians, clinical-care staff, and administrators, more than half witnessed their coworkers break rules, make mistakes, fail to support others, demonstrate incompetence, show poor teamwork, act disrespectfully, or micromanage.

Specifically, 84% of doctors observed colleagues who took dangerous shortcuts when caring for patients and 88% worked with people who showed poor clinical judgment. Despite the risks to patients, less than 10% percent of physicians, nurses, and other clinical staff directly confronted

EXECUTIVE SUMMARY

A follow-up to the 2005 study Silence Kills indicates physicians and healthcare workers still are putting patients at risk by not speaking up when they detect a dangerous situation. Safety tools and procedures are no substitute for caregivers who are willing to speak up.

- Eighty-four percent of respondents say that 10% or more of their colleagues take dangerous shortcuts.
- Eighty-two percent say that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients.
- Providers should train clinicians to speak up by using certain techniques that have proven useful, such as defining vital behaviors.

their colleagues about their concerns.

With upward of 195,000 people dying each year in U.S. hospitals because of medical mistakes, the Silence Kills study suggested that creating a culture where healthcare workers speak up before problems occur was a vital part of the solution. Aware of the risks communication breakdowns have on patient safety and employee morale, the healthcare community has made substantial investments in the past five years to operating systems designed to reduce unintentional slips and errors such as handoff protocols, checklists, and computerized physician order entry systems.

While these safety tools are an essential part of the formula for solving avoidable medical errors caused by poor communication, a new study called The Silent Treatment, conducted by VitalSmarts, AACN, and the Association of periOperative Registered Nurses (AORN) in Denver, has found the tools aren't enough and that silence still kills.

Problems known but not discussed

Lead researcher **David Maxfield**, vice president of research with VitalSmarts, tells *Healthcare Risk Management* that the study of more than 6,500 nurses and nurse managers conducted in 2010 builds on the findings from the Silence Kills study.

The new research reveals that safety tools fail to address a second category of communication breakdowns, he says. These are the "undiscussables," which are risks that are widely known, but not discussed. The results suggest that without support from physicians, nurses, and administrators, these system improvements cannot guarantee patient safety, Maxfield says.

"Tools don't create safety; people do," he says. "If you take a perfectly good safety tool and drop it into a culture that is not supportive, you're going to have problems. Safety tools work and they are important, but they rely on the person receiving the warning or using the checklist being able to speak up to the others in the room and having them listen."

The Silent Treatment examines the calculated decisions healthcare professionals make daily to not speak up, even when safety tools alert them to potential harm. Specifically, the study shows that health care professionals' failure to raise the following three concerns when risks are known undermines the effectiveness of current safety tools: dangerous shortcuts, incompetence, and disrespect.

Tools aren't acted on

The Silent Treatment found that 85% of respondents have been in a situation where a safety tool warned them of a problem. Thirty-two percent said this happened at least a few times a month, which confirmed that safety tools work.

Healthcare Risk Management® (ISSN 1081-6534), including HRM Legal Review & Commentary™, is published monthly by AHC Media, a division of Thompson Media Group LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals Postage Paid at Atlanta, GA 30304.

POSTMASTER: Send address changes to Healthcare Risk Management®, P.O. Box 105109, Atlanta, GA 30348.

SUBSCRIBER INFORMATION

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcmedia.com). Hours of operation: 8:30 a.m.-6 p.m. Monday-Thursday; 8:30 a.m.-4:30 p.m. Friday.

Subscription rates: U.S.A., one year (12 issues), $499. Add $17.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. For approximately 15 CE nursing contact hours, $545. Discounts are available for group subscriptions, multiple copies, site-licenses or electronic distribution. For pricing information, call Tria Kreutzer at 404-262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. Back issues, when available, are $87 each. (GST registration number R128870672.)

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

Healthcare Risk Management® is intended for risk managers, health system administrators, and health care legal counsel.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Greg Freeman**, (770) 998-8455.
Executive Editor: **Joy Daughtery Dickinson** (229) 551-9195 (joy.dickinson@ahcmedia.com).
Production Editor: **Kristen Ramsey**.

Editorial Questions

For questions or comments, call Greg Freeman, (770) 998-8455.

Checklists, protocols, and warning systems are an essential guard against unintentional slips and errors.

However, the research also documented that the effectiveness of safety tools is undercut by undiscussables. Of the nurses who had been in situations where safety tools worked, 58% percent had also been in situations where they felt unsafe to speak up about the problems or where they were unable to get others to listen.

The Silent Treatment study collected data from more than 6,500 nurses and nurse managers from health systems around the United States during 2010. All research participants were members of AACN and/or AORN. *(For the full study results, go to http://silenttreatmentstudy.com and select "Download the study" at the bottom left.)*

The Silent Treatment concludes that there are three primary problem areas:

- **Dangerous shortcuts:** 84% of respondents say that 10% or more of their colleagues take dangerous shortcuts. Of those respondents, 26% say these shortcuts have harmed patients. Despite these risks, only 17% have shared their concerns with the colleague in question.
- **Incompetence:** 82% say that 10% or more of their colleagues are missing basic skills and, as a result, 19% say they have seen harm come to patients. Only 11% have spoken to the incompetent colleague.
- **Disrespect:** 85% of respondents say that 10% or more of the people they work with are disrespectful and therefore undermine their ability to share concerns or speak up about problems. And yet, only 16% have confronted their disrespectful colleague.

Some improvement seen

Not all survey respondents remained silent. The study identified a small minority of nurses who spoke up when they observed dangerous shortcuts, incompetence, or disrespect. By studying these successful outliers, the research uncovered the high-leverage behaviors all healthcare practitioners should master to change the trajectory of harmful patient care, Maxfield says.

"Despite the concerns here, this data doesn't mean all our efforts have not worked. Things have gotten better since our 2005 study," he says. "In 2005, nurses spokes up at about a 12% rate when they had concerns. Today they are speaking up at about a 25 to 30% rate. So we've seen dramatic improvement, but there's still a long way to go."

The authors suggest that when it comes to creating healthy work environments that ensure optimal quality of care, individual skills and personal motivation won't be enough to reduce harm and save lives unless speaking up is also supported by the social and structural elements within the organization. Changing entrenched behavior in health care organizations will require a multifaceted approach. To this end, the authors provide recommendations leaders can follow to improve people's ability to hold crucial conversations. *(See the story on p. 52 for the recommendations.)*

Put maximum focus on a few issues

To have the most impact on changing the social norms within your organization, Maxfield suggests that risk managers focus on only two or three key behaviors. One example of a key behavior would be the rule "every tool, every time," meaning patient safety tools are to be used without exception. Another is "everybody speaks, everybody listens."

"You throw everything you can think of at those behaviors," Maxfield explains. "Address the multiple sources of influence: personal, social, and structural. Some deal with motivation, making it a higher priority or a moral passion for people, while other influences have to do with ability, giving them a script or supportive people to call upon."

Research has shown that if you put four or more of these influences together, it is 10 times more effective than if you use just one of them, Maxfield says. "A lot of these influences are strategies or approaches that a risk manager uses all the time, but they use them in isolation," he says. "They might focus on a training program, which is important but only one part. Or they might focus on having people share stories about when speaking up made a difference. Again, that is important, but by itself, it is not enough." *(See the story on p. 53 for more on how you must define expected behaviors, rather than relying only on an insistence that employees do the right thing.)*

No tolerance for disrespect

The Silent Treatment also signals a need for zero tolerance regarding some workplace behavior that threatens patient safety, says **Linda Groah**, RN, MSN, CNOR, CNAA, FAAN, executive

director/chief executive officer of AORN and a co-researcher on the study.

"Shortcuts are not acceptable. Incompetence will be reported, and those without adequate judgment and skills will be held accountable," she says. "Disrespect will not be tolerated, and managers have the responsibility to respond and to react to the information they receive from their staff. It is their responsibility to support their staff and be respectful in their communications."

The study also underscores the need for teamwork in surgery, Groah says. "It is a call to action for members of the surgical team to sit down together and map out clear strategies that will result in a culture of safety," she says. "That means a culture of trust in which all members of the perioperative team are encouraged to provide safety-related data and are acutely aware of the distinction between acceptable and unacceptable behaviors."

With more focus on patient safety from accrediting bodies and government regulators, having a culture of safety might soon be more than just the right thing to do, says **Dorrie Fontaine**, RN, PhD, FAAN, dean and professor at the University of Virginia School of Nursing in Charlottesville and past president of AACN. "We would like to see hospitals and schools do the right thing without the threat of legal action, but this is now rising to the point that we could see this becoming a regulatory and compliance issue with serious legal consequences," she says. "We are seeing that policies must have teeth, that there must be consequences for bad behavior. People get demoralized when they see that there are no consequences for bad behavior. I would like to see us do it because it's right for families and patients, but the option of legal consequences should be out there."

The problem of "undiscussables" and people not speaking up can be found in even the best healthcare organizations, Fontaine says. Her school and the University of Virginia Medical System are highly regarded and considered among the country's best, but they recently had a situation in which patient safety was threatened when a caregiver's concerns were not heard and acted on, she says. "The former dean of nursing decided to bring everyone together — the OR nurses, physicians, the anesthesiologists — and we had several dinner meetings with all hands on deck to talk about listening," she says. "Now, they didn't call it listening. Nobody would come for that because they all think they know how to listen. She called it 'advanced listening,' and everyone showed up."

SOURCES

- **Dorrie Fontaine**, RN, PhD, FAAN, Dean and Professor, University of Virginia School of Nursing, Charlottesville, VA. Telephone: (434) 924-0141. E-mail: dorrie.fontaine@virginia.edu.
- **Linda Groah**, RN, MSN, CNOR, CNAA, FAAN, Executive Director/Chief Executive Officer, Association of periOperative Registered Nurses, Denver. Telephone: (303) 755-6304. E-mail: lgroah@aorn.org.
- **David Maxfield**, Vice President of Research, VitalSmarts. Provo, UT. Telephone: (801) 765-9600. ■

Want staff to speak up? Use step-by-step process

To improve patient safety by encouraging healthcare providers to speak up about their concerns, risk managers should focus on the influences that have the strongest effect on behavior, suggest the authors of The Silent Treatment, conducted by VitalSmarts, a corporate training company in Provo, UT, the American Association of Critical-Care Nurses, and the Association of periOperative Registered Nurses.

The authors suggest focusing on these six sources of behavioral influence:

- **Personal motivation.** If it were up to them, would the nurses want to speak up? Does it feel like a moral obligation or an unpleasant annoyance to them?
- **Personal ability.** Do the nurses have the knowledge and skills they need to handle the toughest challenges of speaking up?
- **Social motivation.** Are the people around them (physicians, managers, and co-workers) encouraging them to speak up when they have concerns? Are the people they respect modeling speaking up?
- **Social ability.** Do others step in to help them when they try to speak up? Do others support them afterward so the risk doesn't turn against them? Do those around them offer coaching and advice for handling the conversation in an effective way?
- **Structural motivation.** Does the organization reward people who speak up, or does it punish them? Is speaking up included in performance reviews? Are managers held accountable for influencing these behaviors?

• **Structural ability.** Does the organization establish times, places, and tools that make it easy to speak up, such as surgical pauses and handoff procedures? Are there times and places when caregivers are encouraged to speak up? Does the organization measure the frequency with which people are holding or not holding these conversations and use these measures to keep management focused on this aspect of patient safety?

The Silent Treatment also offers four recommendations for how health care organizations can use this multifaceted approach to create a safety culture where people speak up effectively when they have concerns:

1. **Establish a design team.** Enlist a small team that includes senior leaders; managers in the targeted areas; and opinion leaders among physicians, nurses, and other caregivers. This design team works with all caregivers to identify crucial moments, vital behaviors, and strategies within each of the six sources of influence described below. The design team then provides a few initial strategies within each of the six sources and helps teams in patient care areas select, modify, and create additional strategies.

2. **Identify crucial moments.** There are a handful of perfect-storm moments when circumstances, people, and activities combine to put safety protocols at risk. The design team needs to identify and spotlight these crucial moments so that people will recognize when they are in them. An example of one of these crucial moments is when the surgery schedule is pushed into the evening, and people are in a rush.

3. **Define vital behaviors.** People need to know what to say and do when they find themselves in these crucial moments. These are the vital behaviors that keep patients safe. Examples of vital behaviors include "200% accountability." Each staff member is 100% accountable for following safe practices and 100% accountable for making sure others follow safe practices.

Another example is saying "thank you" when you have been corrected. This helps make it make it safe for everyone to hold others accountable. When staff members are reminded of a safety practice, they thank the other person and redouble their efforts to keep the patient safe.

4. **Develop a playbook.** Safety requires that the vital behaviors be acted on in a highly reliable way, especially during crucial moments. The most powerful way to make sure these behaviors are consistently followed is to create a multifaceted influence plan that uses all six sources of influence. This plan is captured in a playbook that can be disseminated throughout the organization. ■

Define expectations to see improvements

Saying you put patient safety first is good, but you won't see any results until you specify what behaviors you expect to see, says **Ann Rhoades**, former chief people officer for Southwest Airlines and Doubletree Hotels, and one of the five founding executives of JetBlue Airways. She is also the president of People Ink, in Albuquerque, NM, a culture-change consulting firm that works with hospitals and other employers.

Health care providers must clearly define what behaviors they expect of physicians and staff, she says. "The behaviors are so critical. Every hospital puts values on the wall, but most of them don't define behaviors related to those values," she says. "Once they start defining those behaviors -- telling people that you expect them to speak up and tell the truth even when it's hard -- that's when you actually see those values take hold and make a change."

Rhoades recently worked with Loma Linda (CA) University Medical Center to encourage a culture of safety. Hospital leaders had been working for about a year and a half to encourage physicians and staff to speak up. A key part of that effort, in addition to the common efforts at education, has been the commitment by top leadership, Rhoades says. The hospital CEO committed the entire organization to not only hearing the concerns of physicians and staff regarding patient safety, but rewarding them and recognizing them for their effort, she says. Chief nursing officers emphasize to new employees that the hospital expects them to voice their concerns, and physician leaders make clear that doctors are expected to listen respectfully to staff concerns.

All Loma Linda caregivers are assessed on their annual reviews for their behavior regarding patient safety and speaking up, and the accountability is carried all the way up to the executive level, Rhoades says. Holding people accountable for their behavior is key, rather than just making them aware of the hospital's philosophy toward safety, she says.

At another hospital Rhoades worked with, a

cardiologist was berating people when they spoke up, acting directly in contrast to the effort to the culture of safety the organization was trying to instill. "He was a very well-known practitioner with great skills, but not someone who encouraged safety and quality. They did not renew his privileges, and it cost them a lot of money because their operating room time was down for a while," she says. "But then nurses wanted to work in that area again, and they knew it was the right decision. Great leaders have to make that kind of decision sometimes."

SOURCE

• **Ann Rhoades**, President, People Ink, Albuquerque, NM. Telephone: (505) 822-7934. E-mail: ann@peopleink.com. ■

Hospital revamps safety after wrong-site surgery

When a surgeon at Cayuga Medical Center in Ithaca, NY, performed a procedure on the wrong side of a patient's back in 2008, the sentinel event stunned the hospital's administration. But it wasn't long before hospital leaders were formulating a plan to make sure it never happened again.

The result has been a series of improvements that make the hospital a leader in patient safety. *(See the story on p. 55 for details on how the hospital addressed safety concerns.)*

The wrong-site error occurred in June 2008, says Cayuga CEO **Rob Mackenzie**, MD. The state health department investigated and issued an order in October 2008 that stipulated a fine of $8,000, along with requiring a plan of correction, continuing reviews of documentation of the surgical protocol checklist, three observations of pre-surgery procedures every day at the main campus and two a day at the hospital's outpatient surgery center, and quarterly progress reports to be submitted to the health department, according to information provided by the health department. Cayuga submitted its plan of correction by the end of 2008 and implemented it over the next two years.

The wrong-site surgery occurred because a staff member and the surgeon did not follow the hospital's existing safety protocol at the time, says **David Evelyn**, MD, vice president for medical affairs at Cayuga. Prior to a surgery intended to relieve the female patient's back pain, the surgeon and patient had agreed the operation would address only the left side, the source of the worst pain. But when the surgeon made a midline incision and found diseased tissue on both sides of the patient's back, he erroneously operated on the right side, Evelyn says

When that procedure was complete, the surgeon realized his error and operated on the left side, Evelyn says. The surgeon informed the patient and her family of the error immediately, and the hospital informed the state health department, Mackenzie says. The woman's back pain was relieved, and she did not sue the hospital.

The error happened because two steps of the hospital's safety protocols were not followed, Evelyn says. First, the scheduler did not specify on the schedule the exact location of the surgery, and the surgeon did not mark the surgical site beforehand.

Though the wrong-site surgery resulted in no grievous harm to the patient, Mackenzie says he and his colleagues considered it a serious warning sign that patient safety was not receiving proper attention at the hospital. He called together the medical executive committee and board of directors, and he asked them to form a task force on hospital safety.

"That task force worked quickly over the next six weeks to hear from all parts of our organization, not just surgery, but also environmental services, pharmacy, patient units, and we learned that we had not raised safety to the level we needed to," Mackenzie says. "We needed to say that safety at Cayuga Medical Center is the foundation for our clinical care and really needs to be job one." *(Mackenzie also started networking with other hospital CEOs on safety issues. See the story on p. 56 for more on these "CEO safety huddles.")*

EXECUTIVE SUMMARY

A hospital took an aggressive approach to improving patient safety after a wrong-site surgery incident. Several new policies and procedures now put the hospital at the forefront of safety innovation.

- The hospital implemented "safety cells" to encourage teamwork.
- New policies strengthen the use of timeouts and red rules, which are rules that clinicians are expected to follow all the time, no matter the circumstances.
- The hospital created a new position for a patient safety officer.

The task force studied high reliability organizations such as the National Aeronautics and Space Administration and the aviation industry, looking for characteristics that were common and determining how Cayuga could develop them within its organization, Evelyn says. One of the first conclusions was that organizations known for safety had a culture different from the typical hospital, and it was one in which safety was always at the forefront of everyone's mind.

Secondly, these organizations all had a specific safety leader to whom everyone looked for guidance and support. Also, they all had organizational structures uncommon in hospitals, in which safety was emphasized and monitored at the lowest levels rather than being mandated from the top. But at the same time, they had an executive-level emphasis on safety that supported the culture of safety.

The high reliability organizations also had boards that were actively involved in promoting a culture of safety, Evelyn says.

"Clearly there were common themes among these high reliability organizations, and we needed to adopt these at Cayuga," he says. "We wanted to be a high reliability hospital and we set out to achieve that."

Incident reporting simplified

The hospital implemented a just culture approach to encourage reporting of incidents and near misses, and part of that change was making the reporting procedure much simpler. Rather than using a multi-page written form, Cayuga staff now can report concerns on a one-page online form, Mackenzie says. As a result, the number of reported incidents went up sharply, Evelyn says.

Those reports are used to deploy resources and tailor training efforts to the hospital's particular needs, he says. Staff satisfaction surveys also are showing significant improvement on questions related to whether employees feel their superiors listen to their concerns and how they rate the hospital as a good place to work.

Since implementing the changes, there has been no new wrong-site error or other sentinel event, Evelyn says. The hospital has achieved 100% compliance with the Universal Protocol. During a recent survey by The Joint Commission, the surveyors complimented the hospital on how every physician knew the Universal Protocol procedure by heart.

"They said they've never seen that before. In other organizations, it's always led by the nurses, or there is a script on the wall," Evelyn says. "We've seen a dramatic change in the way people think about things. It's not just about how to get through your work day anymore; it's about how to get your patient through the day as safely as possible."

SOURCES

• **David Evelyn**, MD, Vice President for Medical Affairs, Cayuga Medical Center, Ithaca, NY. Telephone: (607) 274-4011. E-mail: develyn@cayugamed.org.
• **Rob Mackenzie**, MD, CEO, Cayuga Medical Center, Ithaca, NY. Telephone: (607) 274-4011. E-mail: rmackenzie@cayugamed.org. ■

Strong red rules and safety cells cut errors

In response to a task force's recommendations following a wrong-site surgical error, Cayuga Medical Center in Ithaca, NY, implemented these changes:

• **Safety cells.**

The hospital created safety cells made of groups of caregivers who are responsible for certain patients, such as everyone who works on a particular unit or all the staff who work in the cardiac cath lab. This safety cell meets regularly, often at the beginning of each day or the change of every shift. Members make sure each person knows about possible safety problems, such as a high-risk medicine being used in the ward or two patients with the same last name. They also discuss any safety breaches that occurred earlier.

"They will go over any issues such as falls that occurred recently, the cause of the fall, and what can be done immediately to prevent any other falls," says **David Evelyn**, MD, vice president for medical affairs at Cayuga Evelyn. "The safety cells also go over any issues discovered by other cells, so it becomes a way to quickly communicate any issues and solutions."

Each safety cell sends a representative to serve on the hospital's Safety Council, which meets regularly and includes the risk manager, Evelyn, the infection control manager, the patient safety officer, and other key individuals.

• **Stronger red rules.**

Cayuga already used red rules, which are rules

that clinicians are expected to follow in all the time, no matter the circumstances. One example is using two forms of identification with each patient for every interaction, such as administering medications or performing procedures. Another is labeling any samples taken from patients at the bedside, before there is a chance to lose or confuse them with another patient's samples. Staff underwent additional training.

"We emphasized the inviolate nature of our red rules," Evelyn says. "Every hospital has lots of policies and procedures, and sometimes you can't follow them because of the situation or it just seems unnecessary in those particular circumstances. We made it clear that these are rules you absolutely cannot violate. There can be no situation, no excuse that will make it OK to violate a red rule at Cayuga Medical Center."

• Tighter enforcement for the Universal Protocol.

Similar to its renewed dedication to red rules, Cayuga emphasizes to clinicians that the Universal Protocol must be followed without exception. The surgical team confirms the patient's name, date of birth, procedure, side the procedure should be on, equipment and supplies needed, position the patient should be in, and any extra safety precautions or allergies. Each team member must affirm each item, with full attention on the time out, before the operation can proceed, Evelyn says.

"If they don't do the Universal Protocol, the procedure is not going to happen," he says. "And we expect every person in that room to object if the protocol is not followed."

• A new patient safety director.

Cayuga leaders determined that the hospital needed a full-time patient safety director and hired **Karen Ames**, MA, director of performance improvement, to take on the role. Mackenzie says they chose to hire from within because they wanted someone who knew the hospital and its culture.

• A new executive level committee.

Cayuga developed an administrative committee made up of board members, executive level leaders, and administrators, called the Quality and Patient Safety Committee. This committee is charged with overseeing the hospital's patient safety efforts and encouraging a culture of safety. The involvement of the board of directors not only provides the in-house clout to make things happen, but it also signals to the entire organization that the hospital is taking patient safety seriously, Evelyn says.

CEO 'safety huddles' yield better care ideas

CEO **Rob Mackenzie**, MD, used his leadership position to help drive the culture change at Cayuga Medical Center in Ithaca, NY.

"I said I wanted to get more education on patient safety and be the flag bearer on this one," Mackenzie says. "I've shared our experience with other hospitals and sought information about their patient safety problems and improvements, and that turned into a CEO patient safety networking group that meets every other month to see what we can do as CEOs to raise this issue to a higher level in our organizations."

One idea that came out of that networking was for Cayuga to have a "safety huddle" for the top directors in the organization at the end of each week, acting in effect as an organization-wide safety cell.

"Just like the cells on the patient care units, we over any issues we know of throughout the organization and use that meeting as a communication tool," Mackenzie says. ■

Insurer focuses on OB, cuts rates for excellence

Hundreds of obstetrical nurses, midwives, residents, and doctors completing an intensive continuing education program focused on risk management are helping their hospitals lower professional liability costs through an obstetrics-intensive patient safety program. The program was launched by BETA Healthcare Group (BETA), the largest writer of hospital malpractice coverage in California.

The program has proven popular with hospitals, says **Annie Herlik**, RN, JD, CPHRM, vice president of risk management at BETA. With obstetrics (OB) posing some of the highest liability risks for hospitals, risk managers are eager for more training in best practices, she says.

BETA, on the other hand, is happy to provide the additional training and reduce the potential costs from malpractice cases, Herlik says. "BETA

understands that patient safety drives sound risk management, which in turn leads to reduced claims frequency and severity," she says. "The program is a win-win for our member hospitals, physicians, and medical teams and, most of all, for their patients."

BETA covers about 50,000 births per year at 35 facilities, says BETA CEO **Tom Wander**. There has been a significant increase in recent years in the cost to settle OB claims, he says. A birth-injury baby claim commonly cost the insurer about $2 million to $3 million five years ago, but now that same claim will result in a payout of closer to $10 million, he says. "We'd rather spend that money on care and training rather than giving it to plaintiffs," he says. "When we look at the proximate cause of those claims, there tends to be a small number of problems that continue to occur, many of which are preventable with good operating practice by the nursing staff and the [obstetricians]."

Wander notes that, while risk managers and nurses have embraced the program, obstetricians are not as enthusiastic. The reason? They are not covered by BETA and therefore not motivated by the premium credit, and also they can be resistant to thinking they have anything to learn, Wander says. BETA is making headway with obstetricians by encouraging them to see the program as a way to improve teamwork, he says.

Insurer subsidizes training

To assist hospitals in delivering the training to its OB teams through a program called "Quest for Zero: Excellence in OB."

BETA covers 50% of the costs of a perinatal safety training system, which includes up to 24 hours of eLearning and training focused on electronic fetal monitoring and analysis, team communications strategies, and emergency management in labor and delivery. The benefits of improved risk management, better patient care, and clearer, more consistent communications among staff emerge as OB nurses and doctors progress through the program and continue to grow as teams work together, Herlik says.

BETA's OB risk assessment and training program is available to all of its member hospitals, which includes over 10,000 licensed beds in more than 100 city, county, district and nonprofit hospitals and health care facilities in California. *(Much of the training material, including the OB best practices of six hospitals, is available to non-members at http://www.betahg.com/services/rm_ob_initiative.asp. Members also can participate in free online webinars at the same site.)*

The BETA program requires all members of the participating hospital's perinatal team to meet specific quality-of-care criteria, including proof of competency in reading and interpreting a fetal heart monitor, a common language in all communication, and multidisciplinary fetal monitor strip reviews. These reviews include OB physicians, labor and delivery unit nurses, residents, and midwives jointly reading and interpreting the monitor strip, which is a safety training measure that helps build teamwork and stimulates rich discussion while reinforcing a common language for describing fetal heart tracings. When a survey by BETA representatives shows that the hospital is 100% compliance with all elements of the program, a 5% rate credit is provided by BETA to reduce the hospital's health care professional liability coverage costs, Herlik says. *(See the story on p. 58 for details on how providers can select their areas of focus.)*

"That premium credit is the carrot, but this isn't just about the money either for BETA or for the clinicians involved. We're creating a strong focus on patient safety because this is an area in which quality can matter the most," Herlik says. "Our CEO is tremendously invested in never seeing another birth-injured baby at BETA. We have great support from him to make the system safer so that nobody has to go home with a birth-injured baby. That's our goal."

The effects on claims is not evident yet, mostly because there can be a delay in the filing of birth injury cases and the program has been in place only three years, Wander says.

"We are taking a little leap of faith that this is good not only for the clinicians but also for

EXECUTIVE SUMMARY

A large California insurer is offering providers training in obstetrical best practices and offering a premium discount for improving care. Much of the training material is available online to all risk managers.

- The cost of obstetric (OB) claims for the company have increased sharply.
- Participants undergo additional training in specific areas that are key to OB safety.
- All members of the hospital's OB team must participate and achieve compliance.

the moms and babies and that the end result will be lower claim costs," he says. "But we know that improving care and addressing these specific areas of improvement shown in our claims can only yield positive results in the end."

SOURCES

• **Annie Herlik**, RN, JD, CPHRM, Vice President, Risk Management, BETA Healthcare Group, San Diego, CA. Telephone: (858) 521-3690. E-mail: aherlik@betahg.com.
• **Tom Wander**, Chief Executive Officer, BETA Healthcare Group, Alamo, CA. Telephone: (925) 838-6070. E-mail: twander@betahg.com. ■

Hospitals can specify focus for OB safety

When the OB safety initiative sponsored by BETA Healthcare Group (BETA) started two years ago, it addressed the most important issues indicated by the company's OB claims, says **Heather Gocke**, RNC-OB, LNC, CPHRM, C-EFM, director of risk management and quality assessment at BETA's Glendale, CA, office. Those were interpreting fetal heart monitors, using common terminology, and using a team approach for reviewing fetal strips.

For 2011, BETA expanded the program by incorporating a tiered system for achieving the rate credit. Participants can select specific quality improvement goals to target over the next three years rather than all hospitals addressing everything at once, Gocke explains.

All participants must improve education for staff and use a standardized terminology in OB care before they can receive credit for any of the other 10 improvements that they can choose from, she says. "We feel strongly that those are so important to improving OB care that you must achieve those goals first," Gocke says.

The OB education and training is necessary because there is such variation in the way physicians and nurses are trained initially, Gocke says. **Anne Herlik**, RN, JD, CPHRM, vice president of risk magenemtn for BETA, says that the BETA program requires each individual involved in the hospital's OB program — nurses, physicians, and residents — to complete all the modules for the hospital to receive credit. The educational component is not merely a class that participants can attend and then the hospital receives credit for completion, she says. "The modules are very interactive and adaptive, building on any areas of weakness indicated by the way the participant answers the questions. The module will keep building on that area until the user shows competency," Herlik says. "After they complete the module, they continue learning by receiving a case study on that topic in their inbox each month."

SOURCE

• **Heather Gocke**, RNC-OB, LNC, CPHRM, C-EFM, Director, Risk Management/Quality Assessment, BETA Healthcare Group, Glendale, CA. Telephone: (818) 242-0123. E-mail: hgocke@betahg.com. ■

Expert: Drugs diverted for use in murders

A group of anesthesiologists is warning that, in addition to the perennial problem of drugs being diverted for personal use or resale, some powerful drugs are stolen from hospitals to be used as murder weapons.

In a recently published study, the anesthesiologists recount several cases in which drugs stolen from hospitals were used to kill and clinicians were convicted of murder.[1] They note that anesthetic drugs, opioids, and muscle relaxants can depress breathing and other vital processes enough to kill, and these drugs have thus been used for euthanasia, suicides, and state executions. Criminals also have recognized the lethal capabilities of anesthetic drugs, and during recent years have committed homicides using hypnotics, inhalational general anesthetics, opioids, and muscle relaxants, they say.

An analysis of 523 homicidal poisonings occurring between 1999 and 2005 found their rate increasing and that 65%, according to the study. An increasing recognition of the use of muscle relaxants and anesthetic drugs for homicides means anesthesiologists are likely to be involved in more homicide investigations and prosecutions, sometimes as an expert witness, but sometimes as the defendant, says **Robert E. Johnstone**, MD, in the Department of Anesthesiology at West Virginia University in Morgantown and one of the authors of the study.

"Anesthetic drugs can be used for harm as well

as healing. That's really new information for a lot of people," Johnstone says. "This was a revelation for me, and I think it will be for many anesthesiologists. We think of using these drugs carefully with our patients and protecting them from diversion for abuse, but the idea of preventing their use for criminal purposes is really a new thing."

Johnstone offers these two examples, which are explained fully in the study:

> *"This was a revelation for me, and I think it will be for many anesthesiologists. We think of using these drugs carefully with our patients and protecting them from diversion for abuse, but the idea of preventing their use for criminal purposes is really a new thing."*

• A 35-year-old nurse practitioner was convicted in 2007 for the murder of her husband. She became a murder suspect after investigators discovered she had lied about an extramarital affair and had surreptitiously left the hospital and driven to her house shortly before the house was discovered on fire with her husband inside.

Test results showed rocuronium concentrations of 4.9 mcg/ml in the blood and 14.4 in the liver. Review of the burned house materials revealed a charred needle cap, similar to those used in the hospital where the nurse practitioner worked.

• The wife of an anesthesiologist died suddenly and unexpectedly. Although the initial death certificate did not list homicide, the father of the wife suspected foul play. An investigation was launched. An anesthesiologist reviewing information about this case learned that the husband anesthesiologist had previously been tried for murder, and found not guilty. This previous trial followed the sudden and unexpected death of the husband of a woman with whom he had allegedly been having an affair. The district attorney and consultant anesthesiologist theorized that the anesthesiologist had injected the buttocks of the first victim with succinylcholine while he slept.

The body was exhumed and, on detailed examination, was discovered to have a fractured hyoid bone. It then was speculated that an injected dose of succinylcholine had produced apnea but begun to wear off before death, so the victim was strangled. A second autopsy of the deceased wife found a high concentration of choline in her buttocks. The husband anesthesiologist was tried for the murder of the second wife, found guilty, and sent to jail.

Johnstone advises risk managers to consider the potential criminal exploitation of anesthetic drugs when addressing drug security and diversion. "The drugs have been diverted primarily from hospitals, and of course we live in a very litigious society," he says. "We're seeing evidence that this is becoming more common, and I think it's probably only a matter of time before we see a hospital dragged into an ugly murder case with allegations that the hospital bears responsibility for not preventing their theft and use in a crime."

REFERENCE

1. Johnstone RE, Katz RL, Stanley TH. Homicides using muscle relaxants, opioids, and anesthetic drugs: anesthesiologist assistance in their investigation and prosecution. *Anesthesiology* 2011;114:713-716.

SOURCE

• **Robert E. Johnstone**, MD, Department of Anesthesiology, West Virginia University, Morgantown. Telephone: (304) 598-4122. E-mail: johnstoner@rcbhsc.wvu.edu. ■

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. ■

COMING IN FUTURE MONTHS

■ New patient safety professional organization launched

■ Workers' comp costs: Are you doing as much as you could?

■ What is the future of risk management? Look into the crystal ball

■ Make quality improvement your ally, not your competitor

CNE QUESTIONS

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 **June** issue, you must complete the evaluation form provided and return it in the reply envelope provided in that issue in order to receive a letter of credit. When your evaluation is received, a credit letter will be mailed to you.

16. According to the Silent Treatment study, 84% of doctors observed colleagues who took dangerous shortcuts when caring for patients, and 88% worked with people who showed poor clinical judgment. How many directly confronted their colleagues about their concerns?
A. Less than 10%
B. Less than 25%
C. Less than 50%
D. Less than 75%

17. At Cayuga Medical Center, what was the cause of the 2008 wrong-site error that prompted safety improvements?
A. The patient's identity was not confirmed with two forms of identification.
B. The scheduler did not specify on the schedule the exact location of the surgery, and the surgeon did not mark the surgical site beforehand.
C. The surgeon marked the wrong surgical site before the procedure.
D. The patient indicated the wrong surgical site to nurses before the surgery began.

18. What does BETA CEO Tom Wander say was one motivation for offering a program that would help hospitals improve patient safety in obstetrics?
A. There has been a significant increase in recent years in the cost to settle OB claims.
B. Insured hospitals demanded assistance because other training was unavailable.
C. A significant number of hospitals had been fined for poor OB practices.
D. The program was a condition of a settlement with the plaintiff in a high-dollar OB malpractice case.

19. According to Healthgrades, patients treated at those hospitals performing in the top 5% in the nation for patient safety were, on average, how much less likely to contract a hospital-acquired bloodstream infection?
A. 10%
B. 60%
C. 75%
D. 30%

ANSWERS 16. A 17. B 18. A 19. D

Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Hospital's allegedly failed to recognize syndrome —leads to permanent injuries, $800,000 settlement

By **Radha V. Bachman**, Esq.
Buchanan, Ingersoll & Rooney, PC
Tampa, FL

Leilani Kicklighter, RN, ARM, MBA, CHSP, CPHRM, LHRM
The Kicklighter Group
Tamarac, FL

News: A 58-year-old man presented to his local VA hospital with lower back pain and left leg pain. The decision was made to perform a laminectomy. Prior to surgery, the man had no problems with bowel function, urination, or sexual function. A short while later, the man underwent the recommended back surgery. Following the surgery, he began experiencing pain in his right leg as well as numbness in the scrotum. The man was ultimately diagnosed with saddle anesthesia and was taken back to surgery approximately two weeks later. Following the surgery, the man's condition did not improve. He was discharged. A month later, the man was seen by a neurosurgeon and was told that the saddle anesthesia and related symptoms were permanent. The man settled with the United States government pre-trial for $800,000.

Background: After experiencing lower back pain and left leg pain, which became worse with physical activity, a 58-year-old retiree presented to his local VA hospital. The ED physician recommended the man receive an L4-5 and L5-S1 laminectomy with transforaminal lumbar interbody fusion at L4-5. During the preoperative examination, the man did not complain of weakness or problems with bowel function, urination, or sexual function.

The surgery was performed as recommended. Shortly after the surgery was complete, the man began complaining of numbness in the scrotum, inability to feel sensation, and a dull sensation in his right leg. Over the course of the day, the symptoms became increasingly worse such that by the evening, the man was numb from the waist down. The man was diagnosed with saddle anesthesia, a loss of sensation restricted to the area of the buttocks and perineum and frequently associated with cauda equina syndrome. The neurosurgeon on call was notified of the man's symptoms and diagnoses, but no additional tests or exams were conducted. Two days after the surgery, the man's epidural drain was removed. Four days after the surgery, the man was unable to void after the catheter was removed. A neurological exam ultimately concluded that the man had no sensation in the perineum, buttocks, or either foot.

The man was taken back to surgery for thecal decompression and exploratory surgery. He was discharged after the surgery with little improvement in his condition. Approximately a month and a half after the second surgery, the man visited another neurosurgeon who indicated that the man's saddle paresthesia, penile/scrotum anesthesia, urinary and fetal incontinence, paresthesia lateral and posterior aspects of both legs and pedal and lower extremity edema had persisted for too long and were now permanent.

A follow-up evaluation was conducted by another VA hospital in the area. The man was diagnosed with cauda equina syndrome and chronic pain syndrome. Cauda equina syndrome has been defined as low back pain, unilateral or usually bilateral sciatica, saddle sensory disturbances, bladder and bowel dysfunction, and variable lower extremity motor and sensory loss usually due to mechanical compression of the cauda. The VA physician entered a note that the

man's symptoms shortly after surgery were manifestations of cauda equina syndrome and that immediate action should have been taken.

The man and his wife sued the United States alleging that postoperative changes were symptoms of cauda equina syndrome and that immediate action should have been taken to reduce pressure on the cauda equina nerves. The government's failure to timely respond to the symptoms fell below the standard of care. The man sued for damages and pain and suffering. The man's wife alleged loss of consortium. The government settled with the plaintiffs pretrial for $800,000.

What this means to you: As a result of this situation a 58-year-old man who apparently had a good quality of life with respect to his physical abilities is now wheelchair bound. Would this unfortunate devastating untoward outcome have been the same if intervention had been timely? That question remains unanswered.

This patient care scenario, as it is presented here, is a risk management challenge because it tends to raise more questions than answers. This scenario would appear to require several root cause analyses, such as one for the ED and the actual surgery, one for the overall care on the post-op unit, one for the medical aspects from initial admission to discharge, and then one overall to address the various issues in this unfortunate situation. In this particular scenario, in addition to the root cause analyses, this entire situation should be referred for a formal peer review evaluation, perhaps more than one, depending on the specialties of the physicians involved and how the peer review process is structured at the VA system.

If indeed the ED physician made the recommendation to the patient to have surgery, one would wonder the qualifications of the ED physician to make such a call, and upon what signs, symptoms, and test results the ED physician based his medical decision and recommendation. Those areas would be ones to further investigate from a risk-exposure and a standard-of-care view. Was the recommended surgery even appropriate? Furthermore, we do not know the specialty of this particular ED physician or whether he/she is a resident or an attending. At this particular VA facility, does the ED physician also perform the surgery? This area is the first challenge: To determine, within the VA Emergency Department structure, in addition to the culture, what is the process for evaluating patients, calling for consults, and making definitive surgical diagnoses. The thread needs to be followed to determine if, when the patient is handed off to the surgical specialist, the specialist acts independently to review and evaluate test results and to order additional tests as might be appropriate to arrive at an independent diagnosis and treatment conclusion. Or, does the specialist assuming the care of the patient take the ED physician's diagnosis and treatment conclusion and follows through on that without further review? In this set of facts, we do not know the specialty of the surgeon who performed the initial surgery either.

From the facts we are provided with, it appears the initial surgery was not done by a neurosurgeon since one was called in on consult after surgery. Our facts indicate the neurosurgeon was notified of the patient's postoperative signs and symptoms, but it does not indicate that the patient actually was seen and evaluated by the neurosurgeon. The diagnosis of cauda equine syndrome was made, and a call put out to the neurosurgeon, though we do not know who made that call. It would seem from the evaluation and comments made by the subsequent consultant evaluation at a different VA hospital that there is some urgency in reversing this syndrome to prevent permanent damage. The facts seem to indicate that the urgency required was not apparent to the parties involved. This raises another challenge for risk management and the peer review and root cause analyses: knowledge of the indications for the initial surgery, the appropriate intervention when the diagnosis is made, and why those interventions were not carried out.

Another issue to analyze and consider is the consult contact when the patient first began having the signs and symptoms. What is the practice for actual time of response? Do this system and the hospital use SBAR or other such communication process to be sure thorough and appropriate information is conveyed when contacting consultants and other physicians/surgeons? (SBAR is a formalized method of communicating with other healthcare practitioners used to report to a provider a situation that requires immediate action, to define the elements of a handoff of a patient from one caregiver to another, and in quality improvement reports.) Was that method used in this situation? Why didn't the neurosurgeon who was contacted evaluate the patient given the patient's history, surgery, and current signs and symptoms postoperatively?

The findings of the peer review process and root

cause analyses will give some direction on how to address the many questions this case raises. This particular situation is an example of risk exposures on many levels, all intertwined to create an interesting risk management challenge to address.

REFERENCE

United States District Court, C.D. California, Western Division, Case No. 2:2009cv06601. ■

$200,000 verdict granted in child's death

Failure to treat diarrhea alleged

News: A mother took her 4-year-old daughter to the emergency department with symptoms of gagging and watery diarrhea. The physician caring for the child determined that the child was not suffering from dehydration and provided a prescription for the child's nausea. The child's symptoms worsened. After the parent was told by the hospital to allow the medicine additional time to work, the child died. A verdict was entered against the hospital in the amount of $200,000.

Background: A 4-year-old child began experiencing water diarrhea and a gagging reflex. In response, the child's mother took the child to the emergency department. Upon arrival at the ED, the child came under the care of an emergency department physician. The ED physician determined that the child was not dehydrated and prescribed a drug typically used to relieve the symptoms of allergic reactions such as allergic rhinitis (runny nose and watery eyes caused by allergy to pollen, mold, or dust), allergic conjunctivitis (red, watery eyes caused by allergies), allergic skin reactions, and allergic reactions to blood or plasma products. The child was discharged with instructions for the mother to give her fluids.

The woman administered the drug to the child, but within a few hours the child's symptoms became worse. She became lethargic, had persistent diarrhea, and was unable to hold her head up to take a drink. Due to the increasing severity of the symptoms, the mother called the hospital and spoke to an ED nurse. While the contents of that conversation have been disputed, the mother alleges that the nurse told her to give the medicine additional time to work. Based on the information, the woman did not take her child to the hospital.

A few hours later, the child was found in her bed not breathing and frantic efforts were made to try and revive her. The child ultimately died.

For months, the child's death was considered a homicide by local police with the mother being the prime suspect. The police finally closed their case when an autopsy revealed that the child's death had been caused by dehydration secondary to body volume loss due to diarrheal enteritis or inflammation of the small intestine. The medical examiner also identified intoxication from promethazine as a significant contributing factor.

The child, her mother, father, and brother all had claims against the hospital. The plaintiffs also filed suit against the drug manufacturer, based on a higher concentration of the drug than was displayed on the label. The drug manufacturer ultimately was dismissed from the lawsuit as a court found that there was no solid evidence that the child's death was due to promethazine intoxication.

The claim against the hospital proceeded on the premise that the nurse should have instructed the child's mother to bring the child back when her symptoms were becoming worse. The hospital disputed this fact and put forth testimony that the nurse told the woman to bring the child back if the mother felt it was necessary. Both the physician and the hospital appeared to blame each other for the failure to provide adequate discharge instructions.

The jury returned a verdict in favor of the mother and the child's estate solely against the hospital in the amount of $200,000.

What this means to you: Hospitals should have a program to evaluate the competency of ED physicians to care for pediatric patients if the physician is not a pediatrician by specialty or there is no special pediatric emergency department. (Even then competency of all ED physicians periodically should be undertaken.) If the ED medical staff is provided to the hospital through contract, the contract should include the requirement that the contractor warrants that competencies of the most frequent types of conditions, or groups of signs and conditions, presenting to the ED are evaluated. Nursing staff should undergo a similar evaluation as well, especially if the ED does not have sufficient staff with pediatric education and experience.

It does not appear any blood work was drawn

on this child to provide information regarding electrolytes and other information that might have pointed at different treatment or evaluation to avoid this unfortunate untoward outcome.

Dosages, signs and symptoms and evaluations in a pediatric patient are different than in adults. When staff members who are not experienced in pediatrics are accustomed to crossing over to care for pediatrics, a potential risk for medical errors and resultant untoward events increase. In this case, we do not know if the prescribed medication dose was appropriate for this child's weight and age or if it really were a concentrated dose from the manufacturer by mistake. However, if it were an inappropriate dose, the nurse should have recognized that problem and brought it to the physician's attention.

Risk management should work with administration and ED nursing staff to establish scripts for responses when patients call into the ED. Children might become more dehydrated or dehydrate more rapidly than an adult. Electrolyte imbalance can be more significant in a child as well. If the person responding to this mother had no pediatric experience or appreciation for this child's volume of fluid loss, the appropriate response was not forthcoming.

To prevent confusion regarding what a parent conveys and the advice given to a parent, the quality improvement/patient safety/risk prevention initiative of this hospital perhaps should consider taping/recording all ED calls in accordance with applicable state law. With today's electronic capabilities, the recordings could be kept indefinitely and randomly pulled for evaluation on many levels. The answering message for all incoming calls could advise that all calls are recorded for quality improvement purposes. Return calls to patients could be done on certain phones that record all calls.

The hospital should undertake a root cause analysis to determine how to prevent such cases from recurring and to identify the root "why" this happened. There is no indication in this scenario that a disclosure meeting was held with the family. This issue is one that risk management should facilitate, even if not included in the actual disclosure meeting. In addition, this case should be referred to peer review for further evaluation

REFERENCE

Circuit Court of Indiana, Fifth Circuit, Jefferson County, Case No.: 39C01-0304-PL-182. ■

Hospital is first to settle under voluntary SRDP

$579,000 paid in settlement to CMS

Saints Medical Center in Lowell, MA, announced recently that it will pay $579,000 to settle alleged Medicare billing violations, the first settlement since the publication of the Centers for Medicare and Medicaid Services (CMS) voluntary self-referral disclosure protocol (SRDP).

The issue, which was disclosed in 2010 in connection with the release of Saints' audited financial statement, was related to "certain past relationships between Saints and some of its physicians," and did not involve the quality of patient care or fraud and abuse, according to the hospital statement.

The settlement amount is less than the reserve Saints set aside to address this issue, which was based on management's estimate of the low end of the range of the potential obligation, the hospital reported.

CMS won't reveal the initial overpayment calculation amount, but previous reports about the investigation suggested the repayment amount could be between $785,000 and $14.5 million, says **Julie E. Kass**, JD, a shareholder with the law firm of Ober, Kaler, Grimes & Shriver, in the Baltimore, MD, office.

Troy Barsky, CMS director of technical payment policy, announced recently that future settlements would be issued on a regular basis and would likely be announced quarterly. About 50 self-disclosures have been submitted through the SRDP, he said. A handful have been accepted, and CMS has requested additional information for others.

"Until more settlements are issued, and with minimal details disclosed by CMS, it will remain difficult to predict the outcome of disclosures for providers contemplating use of the Stark Self-disclosure Protocol for correcting Stark violations," Kass says. "Accordingly, providers should carefully consider their various options for correcting Stark issues, including filing a self-disclosure under the SRDP."

SOURCE

• **Julie E. Kass**, JD, Principal, Ober Kaler, Baltimore, MD. Telephone: (410) 347-7314. E-mail: jekass@ober.com. ■

Healthcare Risk Management

2011 Reader Survey

In an effort to learn more about the professionals who read *HRM*, we are conducting this reader survey. The results will be used to enhance the content and format of *HRM*.

Instructions: Fill in the appropriate answers. Please write in answers to the open-ended questions in the space provided. Return the questionnaire in the enclosed postage-paid envelope by **July 1, 2011.**

1. Please fill in all the areas for which you are responsible for risk management in your facility or system.

- O A. acute care
- O B. outpatient services
- O C. same-day surgery
- O D. home health services
- O E. rehabilitation services
- O F. extended care facility
- O G. hospice

In future issues of *HRM*, would you like to see more less coverage of the following topics?

	A. more coverage	B. less coverage	C. about the same amount
2. compliance	O A	O B	O C
3. malpractice	O A	O B	O C
4. patient safety	O A	O B	O C
5. patient restraints	O A	O B	O C
6. informed consent	O A	O B	O C
7. patient confidentiality/privacy	O A	O B	O C
8. patient falls	O A	O B	O C
9. medical errors	O A	O B	O C
10. root-cause analysis	O A	O B	O C
11. sentinel event reporting	O A	O B	O C
12. accreditation issues/audits	O A	O B	O C

13. Do you find the *Legal Review & Commentary* insert in *HRM* helpful?

O A. yes O B. no

14. Including *HRM*, which publication or information source do you find most useful, and why?

_____

_____

15. Do you plan to renew your subscription to *HRM*?

- O A. yes
- O B. no If no, why not?_____

_____

16. Are the articles in *HRM* written about issues of importance and concern to you?

- O A. always
- O B. most of the time
- O C. some of the time
- O D. rarely
- O E. never

17. How would you describe your satisfaction with your subscription to *Healthcare Risk Management* newsletter?

- O A. very satisfied
- O B. somewhat satisfied
- O C. somewhat dissatisfied
- O D. very dissatisfied

18. Which best describes your title?

- O A. risk manager or risk management director
- O B. VP or assistant administrator
- O C. director/manager of quality
- O D. medical director or director of nursing
- O E. other_____

19. Please indicate all of the activities for which you have primary management responsibility.

- O A. risk management
- O B. compliance
- O C. legal
- O D. quality or utilization review
- O E. other_____

20. Which area at your facility triggered the most incident reports in 2010?

- O A. emergency department
- O B. medical
- O C. obstetrics
- O D. operating room
- O E. other _____

21. *HRM* has been approved for 15 nursing contact hours using a 60-minute contact hour by the American Nurses Credentialing Center's Commission on Accreditation. If you participate in this CNE activity, how many hours do you spend in the activity each year?_____

Please rate your level of satisfaction with the following items.
A. excellent B. good C. fair D. poor

22. Quality of newsletter	○ A	○ B	○ C	○ D
23. Article selections	○ A	○ B	○ C	○ D
24. Timeliness	○ A	○ B	○ C	○ D
25. Length of newsletter	○ A	○ B	○ C	○ D
26. Overall value	○ A	○ B	○ C	○ D
27. Customer service	○ A	○ B	○ C	○ D

28. On average, how many people read your copy of *HRM*?

○ A. 1
○ B. 2
○ C. 3
○ D. 4
○ E. 5 or more

29. What is the bed size of your facility/system?

○ A. fewer than 200 beds
○ B. 200 to 400 beds
○ C. 401 to 600 beds
○ D. 601 to 800 beds
○ E. more than 800 beds

30. On average, how many articles in *HRM* do you find useful?

○ A. none
○ B. 1-2
○ C. 3-4
○ D. 5-6
○ E. 7 or more

31. What do you like most about *HRM* newsletter?

32. What do you like least about *HRM* newsletter?

33. Please list the top three challenges you face in your job today.

34. What issues would you like to see addressed in *HRM* newsletter?

Contact information _____