# Healthcare Risk Management™

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# Whistleblowers and privacy rights: How to manage the overlap

*Work to avoid revelation of patient data, but be prepared for conflicts*

A physician complained to the chief of staff and hospital management that surgical equipment is not being sterilized properly and a patient died as a result. In another case, two doctors reported overcrowding in the emergency department that compromised patient care. In another, the physician reported an unlicensed therapy program.

The common thread? In all these cases, the hospital responded by firing the physicians, says **Dave Scher**, JD, a principal with The Employment Law Group in Washington, DC, who handled these cases and specializes in representing whistleblowers.

Retaliation against whistleblowers in healthcare is risky, probably illegal, and simply not good strategy, say legal experts. Risk managers should work to formulate internal structures that minimize the chances of an employee going outside the organization to report problems, they say, and risk managers should be prepared with a more effective response in the event that someone does blow the whistle.

Even if so inclined, the ability to constrain a whistleblower is limited, says Scher. Firing the whistleblower rarely goes uncontested and can lead to other penalties. In the case of the physician who was fired for complaining about poor sterilization, the complaint led to a federal investigation that shut down the surgical suite for four days. Subsequently, the hospital had to settle with the physician for firing him, which is a common outcome, Scher says.

In healthcare, risk managers often wonder how confidentiality requirements


## EXECUTIVE SUMMARY:

Whistleblowers in healthcare might reveal confidential patient data when reporting fraud or other wrongdoing. Some protection is provided for this breach, but providers should understand the limitations.

- Retaliating against a whistleblower is not a good strategy.
- Federal and state laws provide some protection for healthcare employees who reveal patient information for a good reason.
- Employees should be encouraged to report concerns internally and not to do their own investigations.

restrict a whistleblower's ability to reveal potentially damaging information. The overlap can be tricky, Scher says, but in most cases patient privacy concerns do not prevent the disclosure. Confidentiality agreements, often used in settlements in an attempt to keep damaging information under wraps, can provide a false sense of security, Scher says. *(See the story on p. 4 for an example of one hospital's lawsuit against a whistleblower.)*

"Claiming that you had a confidentiality agreement and you disclosed a private agreement, therefore you can't be trusted, is almost always just a smokescreen," Scher says. "It's a weak argument, and the organization does not tend to be looked on favorably when they try to use that defense."

Whistleblowers in healthcare are protected by multiple laws, more than employees in most industries, says **Kevin Troutman**, JD, an attorney with the law firm of Fisher and Phillips in Houston, TX. Healthcare providers must take into account the many protections when considering how they will respond to whistleblowers, particularly the whistleblower exceptions for the Health Insurance Portability and Accountability Act (HIPAA), he says.

"I've found that this really surprises managers sometimes. They are shocked that they can't discipline an employee for violating confidentiality or revealing patient information," Troutman says. "Sometimes you can inadvertently set up a whistleblower claim if you take action without really analyzing the circumstances and the protections that might apply."

Healthcare providers often use HIPAA as an excuse when trying to dissuade an employee from revealing damaging information, Scher says. HIPAA privacy concerns have been drilled into employees so effectively that many people can be convinced that it is impossible to report fraud without violating the law themselves, he says. "We see it all the time. It's very, very common," Scher says. "It's an easy hook to say, 'Sure you can expose the fraud, but you violated HIPAA so you're out.' That is completely the wrong strategy for the employer and usually will just make matters worse for you."

That does not mean, however, that healthcare employees can recklessly reveal protected health information (PHI) as part of their effort to report problems, Scher says. To encourage responsible reporting and avoid potential post-reporting conflicts, risk managers should establish internal procedures that allow employees to voice concerns while still maintaining patient confidentiality, he says.

"We have them disclose information by case number, rather than by naming the individual," he says. "If you don't provide a mechanism for reporting concerns, and then you jump on the employee for violating confidentiality, you are going to be seen as trying to avoid the real issue."

It is possible to fire a whistleblowing employee and cite a reason other than reporting fraud or other misdeeds, such as blaming it on improper disclosure of patient information, but Scher says that move is a desperate one that often backfires in the form of litigation and a costly payout. A better plan, he says, is to foster a culture that results in people wanting to

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discuss their concerns internally and to have a procedure for responding to those concerns. *(See the story on p. 4 for steps to take in responding to whistleblowers, and below for the dangers of staff investigating on their own. See the story on p. 4 for federal and state protections for whistleblowers.)*

Troutman advises risk managers to work closely with human resources to determine when whistleblower protections might apply. If you wait until human resources already has disciplined or fired the employee for a confidentiality breach, it might be too late to avoid the damage, he says.

Aside from retaliation being a bad strategy, there is another reason for healthcare providers to provide an appropriate mechanism for reporting concerns. Without guidance and a safe way for employees to speak up, the employer can be held responsible for the whistleblower's privacy breach, explains **Tammy Marzigliano**, JD, partner with the law firm of Outten & Golden in New York City. Marzigliano represents employees in litigation regarding employment law. "That's one reason it makes sense to give employees a constructive way to bring these concerns to you without violating HIPAA," she says. "If you don't, their next step may be to go public and blurt out a lot of information or hand over documents to the media that they shouldn't, and you as the employer are going to be held at least partly accountable for that."

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# Beware of staff probing on their own

Violations of the Health Insurance Portability and Accountability Act (HIPAA) are a growing focus for whistleblowers, says **Tammy Marzigliano**, JD, partner with the law firm of Outten & Golden in New York City.

Marzigliano recently spoke with a potential client who was concerned that her healthcare employer was not adequately protecting a database with PHI. The employee reported her concerns internally, but the healthcare provider did nothing, Marzigliano says.

"So she started working with IT, gathering documents and investigating herself, which is the wrong way to go about it," the attorney says. "HIPAA does provide protection for those trying to report problems, but it requires that you include the minimum amount of patient information possible. She was going way beyond that leeway."

In a situation such as that one, the employer might have a legitimate reason to terminate the employee, Marzigliano says. The employee overstepped her bounds and violated HIPAA in a way that is not protected no matter how good her intentions, so dismissal could be justified, she says. "But the employee is going to argue that you dismissed her because she complained and you retaliated," she says. "In this case, you might be able to prove otherwise. But you still have a messy situation, some expensive litigation, and you still haven't addressed the root problem. You would have been better off listening when she first came to you with her concerns."

HIPAA does allow individual healthcare employees to copy records and provide them to their attorneys if they think some violation has occurred, says **Kevin Troutman**, JD, partner with Fisher & Phillips, Houston, TX. "It's not entirely clear how far that they can go with that, but there is an exception," Troutman says.

Education is key in this area, Marzigliano says. Having an employee hotline is not enough, she says. In addition to encouraging people to come forward, risk managers also must educate employees about where their obligations stop. Many employees will be under the impression that they cannot report potential fraud, for instance, without having the evidence to back up their claims. In trying to gather and provide that evidence, they might violate HIPAA and other regulations, which creates additional trouble for the employer and could rob the whistleblower of protections that otherwise might be available.

"They need to know that it's their job to speak up but not their job to investigate," she says. "It can be really unfortunate when you have someone who has the best intentions, and whistleblowers tend to be really righteous people, but they go overboard because they thought it was necessary. I'm horrified when they come to me with these documents." ■

# Federal, state laws protect whistleblowers

Many states offer protection to whistleblowers, and a federal statute protect whistleblowers reporting false claims, explains **Amy S. Leopard**, JD, partner with the law firm of Walter & Haverfield in Cleveland, OH. If the court finds that the employer terminated the employee because of the whistleblowing, the employer will be required to reinstate the employee and provide double back pay for the period in question.

Gag orders written into settlement agreements also will be difficult or impossible to enforce when the employee is trying to report wrongdoing to the government, she says. "All the government has to do is get wind of the false claim, and they will subpoena the person who knows about it," Leopard says. "You can't enforce any type of confidentiality agreement if the employee or former employee is subpoenaed for a government interview."

Employees' concerns about impropriety are not always well founded, of course. The employee might be mistaken about the facts or the law, Leopard says, but the provider still should take the employee seriously. It can be a costly mistake to casually dismiss the employee's concerns or even indicate annoyance that the employee is trying to stir up trouble over nothing, she cautions. That response can prompt the employee to feel righteous indignation and investigate the matter independently, then take the concerns to outside regulators.

"You always are best advised to listen to any complaint seriously and express that this is exactly what you want people to do if they are concerned something might be wrong," she says. "If you determine that, in fact, there is no problem, then you can explain that to the person without making them feel like you're blowing them off."

**SOURCE**

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# Hospital sues ex-worker who instigated probe

The overlap of whistleblowing and confidentiality requirements was highlighted recently in a lawsuit filed by North Carolina Baptist Hospital (NCBH) in Winston-Salem, NC, against whistleblower **Joseph Vincoli**, a former administrative director who alerted state officials that the State Health Plan (SHP) was overpaying the hospital.

According to the complaint filed by the hospital, Vincoli was terminated by the hospital in October 2007 and signed an agreement that provided more than $10,000 in compensation, with the stipulation that the former employee would not "speak in a disparaging manner concerning NCBH to any person who was not a party to the Agreement."

Vincoli subsequently "prompted the investigation by providing disparaging and/or confidential information about NCBH to the Plan in breach of his Agreement," the complaint said. NCBH argued that Vincoli had no legitimate reason to involve himself in the SHP contract issue because he was a private citizen. The hospital sought damages of more than $10,000 to recover the more than $10,000 it paid Vincoli in the settlement. It also wanted to prevent Vincoli from further breaches of the agreement.

Forsyth Superior Court dismissed the complaint without prejudice on Oct. 18, 2011, which left the door open for the hospital to refile the lawsuit if it chooses. NCBH and Vincoli declined requests for comment.

The complaint by the hospital outlined why it sued the whistleblower: SHP is a self-insured plan that uses taxpayer money and employee premiums to provide coverage to more than 663,000 teachers and state workers, and in January 2009 Vincoli alerted the state that NCBH was collecting more than it was due.

A state auditor's report released Sept. 7, 2011, validated Vincoli's complaint and said that NCBH received $1.34 million in reimbursement rate overpayments from July 1, 2003, through June 30, 2008. ■

# Be quick, proactive to avoid whistleblowing

When an employee has concerns about fraud or other wrongdoing within your organization, that person can take two paths: either report it internally, or report it to regulators and become a whistleblower.

You always will fare better by having the person report internally, says **Dave Scher**, JD, a principal with The Employment Law Group in Washington, DC, who specializes in representing whistleblowers. However, if you don't respond properly, the person still might turn into a whistleblower. Here is Scher's advice:

1. As soon as an employee voices a concern about possible fraud or other improper activities, sit down with him or her to discuss the situation. Do not delay. Listen carefully to the employee's concerns, and indicate that you are glad he or she reported them. Tell the employee that you will research the matter further and report back with more information.

2. Have the compliance department conduct a thorough investigation. Do not minimize the employee's concerns or dismiss them as unfounded. Every allegation should receive a thorough investigation. Even if the conclusion is that the concerns are unfounded, the healthcare provider has performed due diligence and created a paper trail showing that it responded in a responsible way. When a legitimate problem is uncovered, the provider's actions will show regulators that it responded in a proactive way as soon as it was notified of potential trouble.

3. If the concerns are well founded, the organization should consider publicly disclosing the problem through the media and explaining what steps are being taken to fix it.

4. Thank the employee for bringing the issue to your attention. Most importantly, protect the employee from retaliation. Remember that the retaliation might not originate with your office or the executive suite. The employee's line level supervisor and coworkers might retaliate if they see the whistleblower as a troublemaker, so go directly to the supervisor and emphasize that any sort of retaliation is inappropriate and will not be tolerated. Consider reassigning the whistleblower, supervisor, or coworkers if necessary. ■

# Doctor claims firing for poor EMR use

A case from Illinois has risk managers wondering just where to draw the line when an employee can't keep up with new technology. The answer might be different in each case, experts say, but there has to be a point where dismissal is an option.

**Steven Kottemann**, MD, was placed on a paid leave of absence for deficiencies including a failure to adequately use the electronic medical record (EMR) adopted in the past year by his employer, Memorial Health System in Springfield, IL, according to information provided by Memorial. The 63-year-old doctor was a family physician at Family Medical Center of Lincoln, part of the Memorial system.

Kottemann did not respond to requests for comment by Healthcare Risk Management, but he told The State Journal-Register newspaper in Springfield that he had "no computer skills" before Memorial went live with its EMR on Jan. 12, 2011. When he fell behind on handling electronic records for his patients, Memorial told him he was creating "a liability for the clinic," he told the newspaper.

Patients have rallied to Kottemann's defense and launched a Facebook page to support him. (The Facebook page is at http://tinyurl.com/88l9vq9.) In material on the Facebook page and in the newspaper article, Kottemann says he fell behind because the new system wouldn't always accept his dictated notes and sometimes deleted notes after dictation. The doctor also says a minor stroke in 2008 makes it hard for him to write or type for long periods of time.

A spokesman for the health system, **Michael Leathers**, tells Healthcare Risk Management that the doctor was suspended for more than just the allegedly poor adoption of the EMR. The hospital CEO, **Ed Curtis**, declined HRM's request for an interview. *(See the hospital's statement on p. 6.)*

Though the facts are in dispute, a healthcare employer is right to draw the line somewhere regarding an individual's ability to learn and use new technology, says **Grena Porto**, RN, MS, ARM, CPHRM, principal with QRS Healthcare Consulting in Hockessin, DE, and former president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. "I think it's perfectly reasonable to expect a physician to use an EMR. This is the 21st century, after all," Porto says. "I suppose one question could be how hard they worked with him, but if every other member of the medical staff adopted the system and he can't, then he just doesn't have a key occupational qualification, and they're within their legal rights to tell him he has to find somewhere else to work."

Adapting to new technology can be a challenge for some healthcare employees, but employers should not lower their expectations, Porto says With nearly everyone using computers at home and at work, an employer is not asking too much by expecting

## EXECUTIVE SUMMARY

A physician claims he was fired for not adequately adapting to his employer's new electronic medical record (EMR). The case raises questions about how to respond to poor EMR adoption.

- The doctor suffered a minor stroke and had difficulty with the technology.
- The employer says it worked with the doctor to help him with the new EMR.
- Risk managers will have to determine when enough assistance has been provided.

employees to learn a new computer system, assuming you provide adequate training, she says. *(See below right for more advice on how to implement new technology.)* "This has been a problem in the past, but I think we've gotten past the point where it is a serious reason for someone not to meet your performance standards," Porto says. "The systems in use today are fairly user-friendly, and I don't think we're asking too much of people."

The health system claims that it worked with Kottemann to help him overcome his difficulties with the EMR long before placing him on leave. To keep his job, the physician should seek intensive training on his own or hire an assistant to handle the EMR data input out of his own pocket, Porto says. The alternative would be maintaining a separate paper record system for this physician, which would be unsafe and unreasonable, she says.

Any lingering difficulty from the doctor's stroke would not change the expectations for the doctor, Porto says. The Americans with Disabilities Act requires employers to make reasonable accommodations for disabilities, but education is the only reasonable accommodation for adopting the new technology, she says. Allowing the physician to only partially use the EMR system or not use it all would be a reasonable option, she says.

"It sounds to me like they've met their obligation to help him get on board," Porto says. "There comes a point where it is not reasonable to expect more assistance and, if this is a bona fide occupational qualification, if you can't get it, then you can't work here."

**SOURCES**


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# Hospital says more than EMR in dispute

Memorial Health System in Springfield, IL, provides this statement regarding the physician who claims he was placed on leave for failing to adequately adapt to the system's new electronic medical record (EMR):

Steven Kottemann, MD, has been on a paid leave of absence since Sept. 16 from Family Medical Center of Lincoln. Prior to that, clinical and administrative leadership at Family Medical Center had been working with Dr. Kottemann for several months to address mutual concerns regarding his medical practice. Those mutual concerns were not limited to computer use for patient health records. They extended to other matters regarding safe, high-quality care. Our health system's network of physician practices includes nearly 70 physicians and 20 nurse practitioners. There has been no other instance of a provider having difficulty making a transition to our electronic health record. We will decline to elaborate further on the circumstances surrounding Dr. Kottemann's medical practice. Some situations, such as those associated with Dr. Kottemann, must be treated confidentially. ■

# EMR requires patience, relaxed workload at first

Even though electronic medical records (EMRs) are here to stay, there always will be a percentage of physicians who are resistant to using a system and don't want to change, says **Stephen Martinez**, PhD, CEO of MTS Healthcare, a company in Pasadena, CA, that implements EMRs for hospitals, medical groups, and other healthcare organizations.

"Unfortunately, physicians that are not computer literate often have a difficult time," Martinez says.

When implementing a new EMR system, it is critical that physicians' workloads be reduced for a few weeks so that they have the time to improve their speed in using the system, Martinez says. "Unfortunately, practices are under financial pressure to see as many patients as possible. This often results in providers not being able to reduce their schedules after the go-live date," he says. "Ultimately, it takes even longer for providers to be able to increase their speed in using the system, not to mention the increased stress they feel in trying to use the system."

It typically takes months before physicians are fluent enough in an EMR system to see patients in the same amount of time as when they did not use an EMR, Martinez says. "The power of repetition should not be understated, and the importance of training cannot be overstated," he says. "A good trainer will recognize when a physician is having a problem learning a system during the training sessions. Ideally, the trainer should have notified the physician's superior or someone from the EMR project so that additional training or coaching could be provided to this physician."

Extreme cases might require solutions such as having the physician dictate notes to a staff member who enters them into the EMR, but Martinez says that additional person must have sufficient medical training and that can make the personnel costly. Dictating to a voice recognition system also can work, but physicians with strong accents might have trouble.

"Probably the most effective solution is to offer more training or coaching," Martinez says. ■

# EMRs could increase malpractice risk

The continuing adoption of electronic medical records (EMRs) might result in increased malpractice liability risk and higher insurance premiums, according to a new report from a health IT research firm.

Many leaders in healthcare focus on how EMRs can reduce the medical liability for certain errors, but they also "create new forms of medical liability and expose existing liability issues in the healthcare environment that might otherwise remain unknown," says a white paper published by the AC Group, a Montgomery, TX, health IT research and consulting firm.

Co-authors **Mark Anderson**, CEO of the AC Group, and **Larry Ozeran**, MD, associate clinical professor of health informatics at University of California, Davis, pushed for the government to slow the pace of the federal Meaningful Use incentive program to get medical practices and hospitals to use EMRs. In response to similar concern throughout the healthcare industry, the Department of Health and Human Services recently moved the start date for Stage 2 of the Meaningful Use program from 2013 to 2014. The longer deadline could help avoid a situation in which "artificially short deadlines" for implementation would raise malpractice risks by spurring vendors to cut corners on developing products and rushing users through training, the authors say. *(The full report is available online at http://tinyurl.com/85u9nlg.)*

The report is based on a study of 65 ambulatory EMRs that were certified to meet federal 2011 Meaningful Use standards. More than 90% did not offer "adequate medico-legal training," and 95% raised specific legal issues, the authors say. "Either could increase the potential risk of a liability claim and would hamper its defense," they write. "As is often the case, technology is advancing more rapidly than our ability to identify and address the medico-legal issues. The result of this uneven progression is that physicians and other stakeholders may be unknowingly exposed to medical liability risk."

Shortfalls in EMR functionality also could contribute to increased liability risk, since the Office of the National Coordinator for Health Information Technology's (ONC) certification criteria doesn't require EMRs to check drug orders against laboratory results or take into account social and family medical history in creating alerts, the report says.

As more providers adopt new EMR technology, "software design flaws will be identified as the systems are tested," the report says. "Data coding errors, implementation challenges, and operational failures will occur as the systems are utilized. These errors should decrease over the long term as vendors, providers, and medical liability carriers monitor the new systems and develop process improvements, but there will be early challenges that will also serve to develop case law through legal action."

Medical liability claims also might increase as patients gain easier access to their electronic data and discover that their provider might not have followed one or more treatment protocols that are embedded therein, the report says. The authors expect that the cost of defending against these claims will increase as more attorneys use electronic legal discovery for the data and the metadata.

"Until these challenges are addressed, medical liability insurance costs are likely to increase even faster than their historical controls in order to compensate the liability carriers for their increased professional liability payouts," the authors say. ■

# Poorly designed records said to threaten safety

Poorly designed, hard-to-use electronic medical records (EMRs) are a threat to patient safety, according to a new federal study that also calls for an independent agency to investigate injuries and deaths linked to health information technology.

The report by the Institute of Medicine (IOM) cautions that the billions of dollars in incentive payments to encourage doctors and hospitals to adopt EMRs could undercut patient safety if the technology is not designed and used well. The Department of Health and Human Services (HHS) requested the study, in response to concerns from some doctors and public health experts that the drive for digital records might bring a wave of technology-induced medical errors. *(The study is available for download online at http://*

*tinyurl.com/7882h6w. The PDF download is free, and a printed copy costs $32.40.)*

A new investigative agency should be modeled after the National Transportation Safety Board, which examines airline safety and accidents, says **Gail L. Warden**, MHA, president emeritus of Henry Ford Health System in Detroit and chair of the committee that wrote the report. The Institute of Medicine committee also called for tracking the safety performance of electronic health records in use. Results from studies done so far, the report said, are mixed. Success stories are offset by reports of patients harmed.

The advisory group also recommended that electronic health record suppliers drop "hold harmless" clauses from their sales contracts. The group says the language often limits the freedom of doctors and hospitals to publicly raise questions about software errors or defects.

The secretary of the HHS should publish a plan within 12 months to minimize patient safety risks associated with health IT and report annually on the progress being made, the report says. The plan should include a schedule for working with the private sector to assess the impact of health IT on patient safety. However, if the secretary determines that progress toward improving safety is insufficient within a year, the Food and Drug Administration should exercise its authority to regulate these technologies. Concurrently, the FDA should begin planning the framework needed for potential regulation so that the agency is ready to act if necessary.

"Just as the potential benefits of health IT are great, so are the possible harms to patient safety if these technologies are not being properly designed and used," Warden says. "To protect patients, industry and government have a shared responsibility to ensure greater transparency, accountability, and reporting of health IT-related medical errors."

The federal government is investing billions of dollars to encourage hospitals and other healthcare providers to adopt health IT so that all Americans can benefit from the use of electronic health records by 2014, but demonstrated improvements in care and safety are not yet established, the report says. Some of these technologies have significantly improved the quality of healthcare and reduced medical errors. However, concerns about potential harm are emerging as healthcare providers increasingly rely on health IT to deliver care.

Little published evidence exists that quantifies the magnitude of the risk associated with health IT problems, partly because many technology vendors discourage the free exchange of safety-related information in their contracts with healthcare providers. But serious errors involving these technologies — including medication dosing errors, failure to detect fatal illnesses, and treatment delays due to poor human-computer interactions or loss of data — have led to several reported patient deaths and injuries, the report says.

HHS should establish a mechanism for technology vendors and users to report health IT-related deaths, injuries, or unsafe conditions, the report says. Reporting events related to patient safety should be mandatory for vendors and voluntary, confidential, and nonpunitive for care providers. In addition, Congress should establish an independent federal entity to investigate patient deaths, injuries, or potential unsafe conditions associated with health IT, Warden says. Based on those investigations, the entity could make nonbinding recommendations, allowing flexibility for HHS, healthcare organizations, vendors, and other experts to determine the best course forward.

Health information technology researcher **Dean Sittig**, PhD, presented information to the panel that developed the IOM report. He is a professor at The University of Texas Health Science Center at Houston School of Biomedical Informatics and a member of the faculty of The University of Texas — Memorial Hermann Center for Healthcare Quality and Safety. Sittig says the IOM's recommendations are in line with the improvements sought by many health IT leaders, particularly the call for a government agency to investigate errors. *(See the story on p. 9 for more advice from Sittig.)*

"Right now we when we have these accidents, we're not learning from them. One organization is not telling others what they have learned and what they're doing in response," Sittig says. "Nobody thinks an accident like this is going to happen to them, but accidents happen. Backhoes cut power lines, coding errors cause havoc, and we need to know how to deal with these problems when they

## EXECUTIVE SUMMARY

The rapid adoption of electronic medical records (EMRs) could threaten patient safety, according to a report from the Institute of Medicine (IOM). A new government agency might be needed to oversee the performance of EMRs.

- The report was requested by the Department of Health and Human Services (HHS).
- Safety data has been scarce so far.
- The Department of Health and Human Services (HHS) is calling for better reporting of healthcare IT-related safety data.

happen."

Sittig notes that risk managers have not been greatly involved with healthcare IT in a direct sense, and he urges risk managers to take an active role because of the potential for meaningful intervention.

"IT people don't really understand risk management. They understand how to make sure the system doesn't fail, but they don't understand the larger picture of how IT affects patient care and safety," Sittig says. "The risk manager can bring that perspective and help people understand the ramifications of IT issues, that they have a direct impact on patients. I think a lot of times when we have an accident or bad outcome, there's a role that health IT played in that."

**SOURCES**


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# Monitor EMRs for effect on safety

Even under the best of circumstances, implementing an electronic health record system is difficult, costly, time-consuming, and fraught with unintended adverse consequences, says **Dean Sittig**, PhD, who presented information to the panel that developed a recent report by the Institute of Medicine (IOM) on the dangers of information technology. Sittig is a professor at The University of Texas Health Science Center at Houston School of Biomedical Informatics and a member of the faculty of The University of Texas — Memorial Hermann Center for Healthcare Quality and Safety.

Evaluation of these systems following implementation shows that some do not meet safety standards established in other industries such as the airline and pharmaceutical industries, he says. "We are building this huge health information technology system that we don't know how to monitor properly," Sittig says. "These electronic interventions can adversely affect patient safety and quality of care."

Borrowing from the safety practices of other industries, Sittig and his colleague **David Classen**, MD, associate professor of medicine at the University of Utah School of Medicine in Salt Lake City, have created this five-stage proposal to monitor and evaluate these systems.

**1. Report electronic health record safety issues.**

It is unclear who a healthcare practitioner would call to report a problem with an electronic health record system. According to Sittig, some electronic health record vendors discourage the release of such information. A reporting system could be created under the new Patient Safety Organizational Statute utilizing Agency for Healthcare Research and Quality reporting formats.

**2. Enhance electronic health record certification.**

Vendors developing the software should be required to "demonstrate that their applications have been designed for safety, developed correctly, work as designed, and had all their defects fixed," Sittig says.

**3. Encourage self assessment of electronic health record use.**

Each organization should perform and document an extensive review of its clinical information systems on a yearly basis. This review should include hardware and software, clinical content, user interfaces, user training and authorization procedures, clinical workflow and communication, organizational policies and procedures, compliance with state and federal rules and regulations, and periodic measurements of system activity.

**4. Conduct unannounced on-site inspections.**

Sittig and Classen propose random, on-site inspections by The Joint Commission.

**5. Implement a national electronic health record adverse event investigation board.**

Much like the National Transportation Safety Board investigates accidents, the Office of the National Coordinator for Health Information Technology could create a board to investigate electronic health record problems, Sittig says. ■

# Patient, nurse injuries linked, approach similarly

A safe working environment for nurses is also a safe environment for the patients in their care, according to a new study led by public health researchers at Drexel University in Philadelphia.

Researchers, led by **Jennifer Taylor**, PhD, an assistant professor in Drexel's School of Public Health, found that safety climate was associated with patient and nurse injuries, which suggests that patient and nurse safety might be linked outcomes.[1] For each 10-point increase in the average safety climate score, the odds of decubitus ulcer declined

by 44-48% and the odds of nurse injury declined by 40-45%.

Patient and nurse injuries are both cause for increasing concern in the healthcare industry, Taylor says, not only due to the pain and suffering experienced by those directly affected, but also because both types of injuries contribute to the rising cost of healthcare due to the need for extended hospital stays for patients and hiring temporary staff to replace injured nurses. However, most research considers patient safety and occupational safety in isolation.

"Our findings suggest that patient safety and occupational safety for nurses may be related by common causes and should be considered together in future studies," Taylor says. "We've always looked at patient safety and occupational safety as two separate issues, but everything we do in a healthcare organization is a continuum. Start looking at patient safety and occupational safety together, because they're directly related."

One example is the installation of lifting devices that simultaneously prevent lifting injuries for nurses but also help avoid falls for patients, Taylor says. Less obvious is an improvement such as computerized physician order entry (CPOE). The CPOE might improve patient safety and reduce adverse drug events for patients, but it also can reduce stress on providers. It reduces stress-related effects including injuries that can occur when employees are too harried or tired to use proper procedures.

Another example would be making changes to employee policies, such as allowing nurses more autonomy to choose their own schedules. That change could lead to happier employees, which in turn could result in more attentive care for patients, Taylor explains.

The study included data from a large urban hospital, including 28,876 patient discharges on 29 nursing units employing 723 registered nurses. For each nursing unit, researchers collected nurses' responses to a survey of safety attitudes (a measure of safety climate) as well as hospital-reported nurse and patient injury data collected the following year. Patient injury data included commonly-preventable hospital injuries: falls, pulmonary embolism/deep vein thrombosis (PE/DVT), and decubitus. Nurse injury data included needlesticks, splashes, slips, trips, and falls.

### Turnover increases nurse, patient injuries

The findings also indicate that increased turnover of nurses should be considered a risk factor for nurse and patient injuries: With each 10% increase in a unit's nurse turnover rate, researchers observed a 68% increase in the odds of nurse injury, as well as increased patient risk for PE/DVT.

The researchers note that a study of this type could not identify the specific causes of the associations found between factors of safety climate and nurse turnover, and reported injuries. Future studies should track injuries and safety factors over time and in different types of hospital environments, Taylor says. "This is one of few studies that have identified predictors of both nurse and patient injury in the hospital setting," she says. "We need to look deeper into hospital organizations to understand the cause and effect relationship."

Risk managers should factor occupational safety effects into patient safety improvements, and vice versa, Taylor says.

"When you're assessing the potential for improvement in length of stay and adverse events, you might want to assess what the workforce thinks about the change and if you are seeing any benefits to them in terms of increased productivity, less time away from work for illness and injuries," Taylor says. "What you put in place for patients may also have unexpected benefits for employees."

## REFERENCE

1. Taylor JA, Dominici F, Agnew J, et al. Do nurse and patient injuries share common antecedents? An analysis of associations with safety climate and working conditions. *BMJ Qual Saf* 2011. Doi:10.1136/bmjqs-2011-000082. ■

**SOURCE**

• **Jennifer Taylor**, PhD, MPH, Drexel University School of Public Health, Philadelphia. Telephone: (215) 762-2590. Email: jat65@drexel.edu. ■

## EXECUTIVE SUMMARY

Patient safety and nursing safety are directly linked, according to researchers. Improvements efforts for both areas of concern should be linked and cooperative.

- The researchers used a safety climate score to assess patient and employee safety.
- Better safety climate scores were associated with fewer decubitus ulcers and nurse injuries.
- Increased turnover is a risk factor for employee injuries

# Group: TX health system worse after liability caps

A new report from Public Citizen claims that the imposition of medical liability caps in Texas in 2003 has not reduced medical costs or curbed the ordering of expensive diagnostic tests, and instead, healthcare is less available and has become more expensive compared to national averages.

The report, "A failed experiment: health care in Texas has worsened in key respects since state instituted liability caps in 2003," analyzes the costs and availability of healthcare since Texas imposed a $250,000 cap on the amount of non-economic damages that injured patients could recover from negligent doctors. Since the cap was implemented, malpractice litigation in the Lone Star state has plummeted dramatically, but Medicare spending has soared, says **Taylor Lincoln**, research director of Public Citizen's Congress Watch division and author of the report.

Lincoln says this finding contradicts the "defensive medicine" theory, which holds that fear of litigation is to blame for stark increases healthcare costs. Since the caps were instituted in Texas, health insurance costs have outpaced the national average, and the percentage of residents lacking health insurance has risen, he says. *(The full report is available free at http://www.citizen.org/a-failed-experiment-report.)*

"Despite the sales campaign to promote Texas as an exhibit of the merits of limiting doctors' liability for mistakes, the real world data tell the opposite story," Lincoln says. "Healthcare in Texas has become more expensive and less accessible since the state's malpractice caps took effect."

The findings of the report were disputed by **Jon Opelt**, executive director of the Texas Alliance for Patient Access, which supported the 2003 liability caps. Opelt released a statement saying that lowering the cost of healthcare was never the purpose of the tort reform law. Rather, it was intended to improve access to care and has been successful in that regard, he says.

The caps have kept payouts lower. The number of payments made on behalf of Texas doctors to compensate patients for medical errors fell more than 50% between 2003 and 2010, and the value of those payments fell by nearly 65%, without adjusting for inflation. But insurance companies have cut doctors' malpractice insurance premiums more slowly.

The report cites these changes since Texas instituted its liability limits:

- Per-enrollee Medicare spending in Texas has risen 13% faster than the national average.
- Medicare spending specifically for outpatient services in Texas has risen 30.7% faster than the national average.

Medicare diagnostic testing expenditures in Texas have risen 25.6% faster than the national average.

Premiums for private health insurance in Texas have risen faster (51.7%) than the national average (50%).

The percentage of Texans who lack health insurance has risen to 24.6.

The per capita increase in the number of doctors practicing in Texas has slowed to less than half its rate in the years leading up to the caps. ■

## CNE INSTRUCTIONS

Nurses participate in this CNE/ CME program and earn credit for this activity by following these instructions.

1. Read and study the activity, using the provided references for further research.
2. Log on to **www.cmecity.com** to take a post-test; tests can be taken after each issue or collectively at the end of the semester. *First-time users will have to register on the site using the 8-digit subscriber number printed on their mailing label, invoice or renewal notice.*
3. Pass the online tests with a score of 100%; you will be allowed to answer the questions as many times as needed to achieve a score of 100%.
4. After successfully completing the last test of the semester, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be e-mailed to you instantly.

## 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

- Sex scandals in healthcare: Certain to come
- Fleet safety and insurance
- Best suggestions for surviving an audit
- Analyzing your attorney's bill

## CNE QUESTIONS

1. What does Tammy Marzigliano, JD, partner with the law firm of Outten & Golden, advise regarding how to educate employees about reporting their concerns regarding fraud or other wrongdoing?
   A. Stress that they should fully investigate the matter and bring evidence when reporting their concerns.
   B. Remind them that it is their obligation to report their concerns but not to investigate the problem.
   C. State that they are subject to disciplinary action if they report mere suspicions without providing proof.
   D. Indicate that employees should report their concerns directly to outside regulators rather than trusting anyone within the organization.

2. What should be a top priority when an employee internally reports concerns about possible fraud or other wrongdoing?
   A. Warn the employee that disciplinary action may follow if the concerns are unfounded.
   B. Insist that the employee provide documentation to back up the claims.
   C. Thank the person for coming forward with the concern and reporting it through your organization's proper channels.
   D. Indicate to the person's supervisor that the employee should be watched carefully to ensure there is no prying into the area of concern.

3. Which of the following is true regarding the dispute between Steven Kottemann, MD, and Memorial Health System?
   A. The employer provided no training for physicians on its new electronic medical record (EMR) system.
   B. The employer provided training for physicians on its new EMR, but Kottemann still could not use the system adequately.
   C. Kottemann refused all efforts to learn the new system.
   D. Kottemann claims he had no difficulty with the new system and that the employer is using the EMR as an excuse to discipline him.

4. The report on EMRs from the Institute of Medicine suggests what type of new government agency to oversee investigate potential harm from EMRs?
   A. A new agency should be modeled after the Department of Education and primarily focus on educational resources.
   B. The new agency should be similar to the Department of Commerce and work closely with EMR vendors to protect their interests.
   C. The agency should be similar to the Department of Energy and award grants for EMR development.
   D. A new investigative agency should be modeled after the National Transportation Safety Board, which examines airline safety and accidents.

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

# Perforated intestine during lap case precedes death, $2.5 million settlement

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Leesburg, FL

**News:** A 45-year-old woman underwent surgery at a local university hospital to remove a cyst on her ovary. During the operation, surgeons found dense adhesions, and the patient experienced increased pain and pressure in her abdomen following surgery. By the time the medical staff diagnosed her with a perforated bowel, the patient was in critical medical condition due to sepsis. In preparation for a second surgery, the patient suffered a heart attack resulting in severe brain damage. The patient was removed from a ventilator and died when it was determined she had no meaningful brain function. The hospital and patient's family settled a wrongful death suit for $2.5 million.

**Background:** A 45-year-old legally blind woman underwent surgery at a local university hospital to remove a cyst on her ovary that was causing chronic pelvic pain. During the operation, surgeons found dense adhesions requiring a difficult dissection of the bowel. Following the surgery, the patient experienced increased pain and pressure in her abdomen overnight. The next day it was recorded that the patient was tachycardic, tachypneic, nauseated, and had a bloody emesis. The nurse also reported that the patient's abdomen was tender to the touch and distended.

Two days after her surgery, the patient's blood pressure dropped to dangerously low levels. At that time, a surgical consult was ordered. The surgeon immediately determined that the patient had a hole in her large and small intestines. Before the hospital staff could prepare her for a second surgery, the patient suffered a heart attack, leaving her with severe brain damage. The cardiac arrest left her ventilator dependent with no meaningful brain function. The ventilator was removed, and she died four days after her initial surgery.

The personal representative of the patient's estate brought an amended complaint against the university medical center and four of the physicians who oversaw her care at the hospital. The plaintiff sued the hospital as the doctors' employer. The plaintiff alleged that the surgeons who completed the initial surgery were negligent in injuring the terminal ileum mesentery during surgery, perforating the anterior wall of the lower sigmoid colon, failing to appropriately follow the patient in the recovery room, and failing to communicate to the postoperative caregivers the high likelihood of bowel injury. The plaintiff claimed that the other physicians on staff at the hospital failed to assume the patient had a bowel or urinary tract injury, failed to recognize and treat symptoms of sepsis, and failed to insist the patient be returned to the operating room for surgery.

The plaintiff's counsel argued that the medical team considered other possible causes of the patient's postoperative symptoms, instead of considering organ perforation, which is a better known complication of the surgery. For example, physicians called to exam-

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. **Leslie Mathews**, guest columnist, discloses that her husband is an employed physician at Bradenton (FL) Cardiology Center. **Barbara Reding**, guest columnist, has no relationships to disclose.

ine the patient ordered an arterial blood gas test and a ventilation/perfusion lung scan to rule out a pulmonary embolus. A CT scan of the patient's abdomen, performed the day after her surgery, showed fluid around the liver and spleen in the posterior cul de sac, as well as possible bowel obstruction.

The plaintiff also argued that the patient should have been examined by a doctor the day after her surgery, colon perforations are known complications of the type of surgery performed, the tests did not rule out a perforation, and tests showing a decrease in white blood cells were a sign of sepsis and should have prompted diagnosis and treatment of an infection. They argued that the delay in diagnosing the infection gave it time to spread and cause brain swelling, which resulted in the patient's death.

The plaintiff sought survival damages for the patient's conscious pain and suffering prior to her death, as well as wrongful death damages for loss of consortium. A settlement agreement was reached between the hospital and the plaintiff for $2.5 million. The patient's estate received $1.85 million for damages, the estate's personal representative received $20,039 for funeral and burial expenses, and the patient's sister received $1,038 for funeral and burial expenses. The remaining funds were paid out to a creditor and the plaintiff's attorney.

**What this means for you:** It is seen on almost every procedural consent form as alluded to in this case study: Intestinal perforation is a known, highly recognized complication of laparoscopic procedures, and it is addressed as such as part of the informed consent process. Common signs and symptoms of bowel perforation are severe abdominal pain (including a distended, firm, and/or "board-like" abdomen), chills, fever, nausea, vomiting, and fluid or air in the abdomen as noted on X-rays or CT scans. Signs and symptoms of septic shock also include a rapid heart rate, low blood pressure, rapid breathing, low or absent urine output, reduction in the white blood cell count and restlessness, agitation, lethargy, and confusion. Septic shock and intestinal perforation are medical emergencies, and timely assessment and intervention are critical. Intestinal perforation in and of itself is often successfully resolved through surgical intervention and antibiotic therapy. Septic shock has a high death rate, associated with rapid deterioration and organ failure, and it requires mechanical ventilation, medications, IV fluids, oxygen, and possibly surgery. With either diagnosis, early detection, diligent monitoring, and medical intervention must occur in an expedient manner.

In addition to the tragic outcome of this case, it is difficult to comprehend why a post-laparoscopy patient suffered for two days prior to a surgical consult being initiated. This female was symptomatic post-procedure. She continued to deteriorate over the next 24 hours. Where was the nursing intervention (monitoring and reporting) during that time? Where was the medical intervention in response? Ruling out a pulmonary embolus (PE) post-procedure might make some sense only after the severe abdominal pain has been addressed. While a rapid heart rate and shortness of breath are common symptoms of PE and septic shock, abdominal pain, nausea, and vomiting are not common signs and symptoms of PE. The risk of intestinal perforation following a laparoscopy is not uncommon or unexpected and, therefore, should be a primary consideration when signs and symptoms of perforation and septic shock are present in a patient post-procedure.

Knowledge of the patient's medical history and the procedure performed are of great benefit in assessing any patient post any procedure. In this case, knowing that dense adhesions were discovered during the laparoscopy and those adhesions required a "difficult dissection of the bowel" would have placed nursing personnel and attending physicians on high alert for the possibility of bowel perforation, requiring diligent monitoring for same. Knowing the patient had experienced chronic pelvic pain prior to the laparoscopy would provide a baseline for evaluating the patient's post-laparoscopic pain and would serve to alert clinical personnel that the post-laparoscopic pain was different and more intense. Unfortunately, in the "rush" of providing healthcare, nurses and physicians often do not have or take the opportunity to read the chart, do not know their patients' history and baselines, and therefore increase the risk of failure to monitor, assess and treat. This situation increases the risk of negative outcomes for the patient and financial risk for the healthcare providers.

The plaintiff's complaints regarding the care and treatment of the patient in this case are sound with the exception of negligence on the part of the surgeons in perforating the intestines. The plaintiff's counsel acknowledged the known and common complication of perforation associated with the laparoscopy, especially in light of the dense adhesions and difficult bowel dissection for this patient. The negligence in this case occurred in the follow-up, in timely assessment and diagnosis, and in the subsequent delay of critical intervention. The response in this case to a medical emergency resulted in failure to rescue a 45-year-old woman, which led to her untimely death.

The hospital should have conducted a thorough and effective root cause analysis that included the

physicians. The opportunities to learn from this case and other similar cases and to adapt care processes in light of what is learned will serve to minimize risks in the future for patients and providers.

REFERENCE:

Circuit Court of Illinois, Cook County Judicial Circuit, Case No. 10 L 2270 ■

# No removal of sponge nets $375,000 judgment

*Doctors are cleared of fault*

**News:** An 85-year-old woman underwent surgery for an aortofemoral bypass at a local medical center in 2004. In the four years following the surgery, the patient suffered from periodic severe abdominal and back pain, a foul odor coming from her body, weakness, lightheadedness, dizziness, loss of appetite, and nausea. In late 2008, the patient was admitted to the hospital with severe abdominal pain and a foul odor coming from her body. A CT scan revealed a mass near the patient's colon that was later identified as an old surgical sponge. A jury verdict was entered against the hospital, and the doctors who performed the surgery were cleared of fault.

**Background:** Prior to undergoing an aortofemoral bypass surgery in 2004, the 85-year-old woman was working part-time, living independently, driving herself to work, and taking trips with friends and members of her family. After the surgery, the patient reported periodic episodes of pain in her back and the lower left quadrant of her abdomen over the next four years. The patient also reported that at times she experienced weakness, lightheadedness, nausea, and loss of appetite. Her symptoms resolved when treated with antibiotics.

In December 2008, the patient was admitted to the same hospital with acute abdominal pain and a foul odor coming from her body. A CT scan revealed a mass near her colon. The patient underwent laparoscopic surgery to remove the mass, which was later identified as an old laparotomy pad. It was determined that the surgical staff members and the surgeons failed to remove the sponge and that they failed to conduct an accurate sponge count following her surgical procedure in 2004.

The patient eventually made a full recovery after her second surgical procedure. Immediately following the surgery, she was dependent on her daughter and was unable to return to her home for several months. She also returned to her part-time employment and regained independence in activities of daily living (ADL).

The patient filed a civil suit against the medical center and the surgeons alleging negligence and malpractice. Specifically, the patient claimed that the hospital's employees negligently failed to remove the surgical sponge and conduct a sponge count. The defendant argued that the hospital's staff met the standard of care, except when performing the sponge count. Expert witnesses for the patient and the doctors were called at trial. The experts disagreed as to how much responsibility the doctors had for the sponge count.

Initial offers to settle the case failed. The hospital first refused the patient's offer to settle for $250,000. The hospital then made an offer of judgment for $50,000. It claimed that the patient's routine recovery and her ability to return to work were evidence that she did not suffer significant damages. The parties also attempted mediation. All attempts at negotiation failed, and the case was presented to a jury.

The amount of damages was left up to the jury to decide. The patient's attorney did not ask for any particular dollar amount at closing. The patient's medical bills for her additional surgery already were paid by the hospital, and she did not lose a substantial amount of income during her recovery. After three to four hours of deliberation, the jury returned a verdict of $375,000 against the hospital and found that the surgeons were not at fault. The hospital has since filed a motion for a new trial based on the "excessiveness of the verdict."

**What this means for you:** Retained surgical objects reflect serious health risks for patients and severe financial, quality, and reputational risks for healthcare providers. This case is interesting from several perspectives: the patient's, the hospital's, the surgeons', the attorneys, the patient outcome, best practices, accountability, and risk management. It encompasses several areas of risk management concerns, including but not limited to, policy, procedure, and regulatory compliance, culpability, and claims management. The judgment rendered in this case is fascinating because the end result could have been more costly had the patient's ultimate outcome been less than satisfactory. It is noteworthy that the hospital has filed a new trial motion related to an "excessive" verdict. It is our opinion the hospital should consider the verdict to be reasonable based on a posi-

tive outcome in an elderly patient, an outcome that had the costly potential for permanent harm or even sepsis-related death. It is curious the surgeons were not held accountable or responsible in light of the patient safety requirements and initiatives in position today. I can only surmise the physicians involved in this case were not informed of an incorrect count at the time of the event.

The American College of Surgeons (ACS), in their Statement on the Prevention of Retained Foreign Bodies after Surgery, "recognizes patient safety as being an item of the highest priority and strongly urges individual hospitals and healthcare organizations to take all reasonable measures to prevent the retention of foreign bodies in the surgical wound." The ACS offers guidelines to various practice settings for the prevention of retained foreign bodies and recommends "performance of a methodical wound exploration before closure of the surgical site." This recommendation is not only for the healthcare organization but for those individuals who comprise the surgical team and who serve as the last line of defense for the patient.

"Nothing Left Behind," a national initiative conceived in 2004 and implemented in January 2005, provides tools and guidelines to improve processes of care in handling surgical instruments, needles, and sponges to prevent the retention of foreign bodies post surgical or invasive procedures. Achieving a goal of nothing left behind requires team commitment of accountability and responsibility for anesthesiologists, surgeons, nurses, surgical techs, radiologists, and the healthcare organization's leadership. It requires, per the initiative, "good communication among perioperative personnel and the consistent application of standardized processes of care," such as clear and concise sponge count policies that apply not only to staff nurses and scrub technicians but to the behavior of surgeons, anesthesiologists, and radiologists as well. Without commitment to the nothing left behind campaign, surgical foreign bodies will continue to be retained postoperatively, will continue to harm those who trust in our provision of and dedication to safe care, and will prove costly to the healthcare provider(s).

In 2007 the Institute for Clinical Systems Improvement (ICSI) published an extensive health care protocol for the Prevention of Unintentionally Retained Foreign Objects in Surgery that aligns with the recommendations of the ACS and Nothing Left Behind initiative, as well as AORN guidelines. It holds all team members and the organization accountable. Although the jury did not find the surgeons responsible, it would be prudent for the hospital, as a long-term risk reduction strategy, to hold the surgeons accountable. They are part of the team providing the care and who are responsible for recognizing and supporting patient safety as the highest priority. It is disconcerting to learn an 85-year-old woman experienced pain and a foul odor for four years, not to mention being treated and placed at risk for chronic infection, because due diligence was not initially performed by those she trusted to heal her. It is fortunate for the organization that this patient's eventual outcome was one of temporary, not permanent harm.

The claims management of this case is also of interest. The hospital clearly evaluated this case as low risk, as evidenced by its perception of minimal and temporary patient harm, a positive patient outcome, and its refusal to settle at mediation for $250,000, which mean taking a chance on a jury verdict. Its offer to settle at $50,000 made it clear to the plaintiff that leaving a sponge behind, while not causing permanent harm, placed little value on her health status during the four post-op years that the laparotomy pad remained "left behind." Although the hospital covered all medical costs, clearly the jury was sympathetic and held the hospital responsible for its care practices and policies. It is remarkable the trial experts disagreed as to physician (surgeon, anesthesiologist, radiologist) responsibility for sponge count. Why would a physician wish to be placed at personal litigation risk for not accepting team member responsibility for correct surgical counts? It is the physician who performs the methodical wound exploration when a surgical count is deemed incorrect.

Currently, healthcare consumers (including those who serve as members of the jury) continue to receive education in patient safety initiatives and regulatory compliance. Healthcare consumers are encouraged to participate in their plan of care, to speak out, speak up, and ask questions regarding their safety and well-being in all avenues of healthcare provision. Information publicly abounds regarding retained foreign objects and healthcare teams' ability to achieve a level of zero events. Clear, concise communication, compliance with surgical counts policies and procedures, and a consistent team mentality will serve to end cases such as this one and eliminate excessive verdicts. Most importantly, it will prevent patients from experiencing the event of a retained surgical object.

## REFERENCE:

State Court of Dekalb County, Georgia, No. 09A21762-6. ■

Healthcare Risk Management™

# The changing healthcare field means challenging opportunities for risk managers

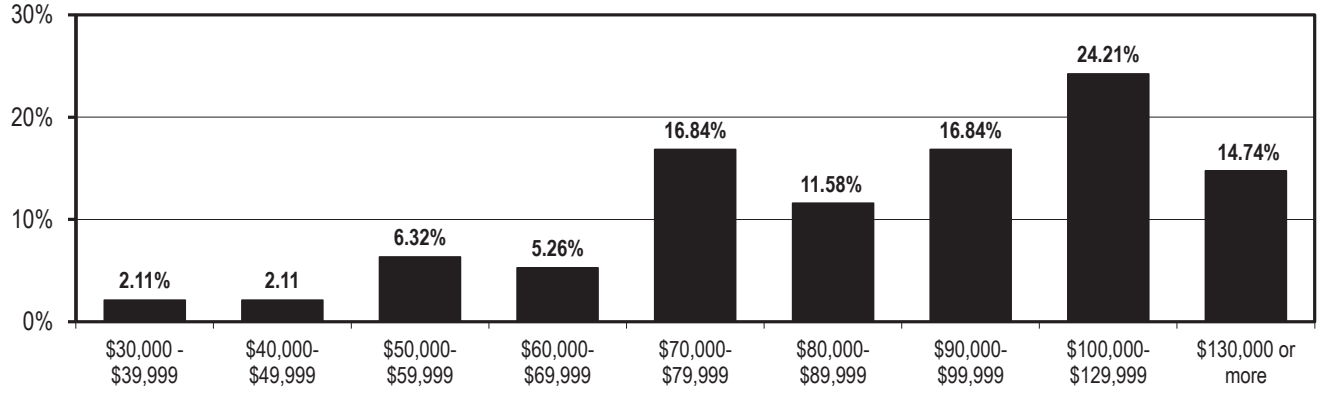
*Seek certification, education to position yourself best*

With the healthcare industry still experiencing some of the most significant changes in decades, risk managers will continue to be in demand, says **Mary Anne Hilliard**, JD, BSN, CPHRM, chief risk counsel with Children's National Medical Center in Washington, DC, and president-elect of the American Society for Healthcare Risk Management (ASHRM).

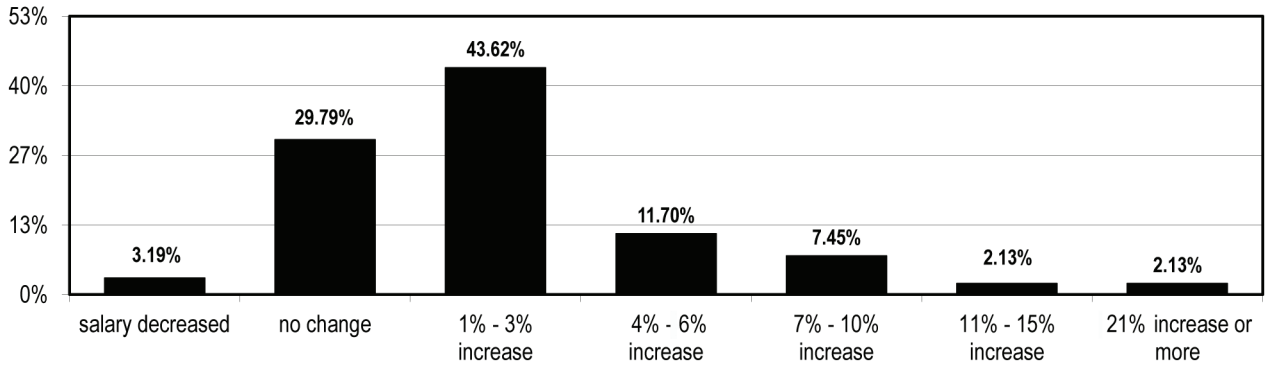
"It's never been a better time to be a healthcare risk manager," Hilliard says. "With all the changes in healthcare, the need to prevent, detect, and correct the risk management process is more important than ever. Today we are challenged to be involved in almost every aspect of healthcare operations, and we respond with vigor."

When Hilliard queried the ASHRM board members on behalf of Healthcare Risk Management, they replied with positive outlooks for the coming year. ASHRM board members told Hilliard that the field is "strong, relevant, and engaged," and that from clinical exposures to facilities management, from contract review and vendor management to claims studies and social media policy, "the healthcare risk manager of 2012 is more diverse and a greater asset to

## What is Your Annual Gross Income from Your Primary Healthcare Position?



## In the Last Year, How Has Your Salary Changed?




the enterprise than ever before." *(See the story on p. 3 for the results of the* Healthcare Risk Management 2011 Salary Survey.*)*

Hilliard expects to see risk managers getting involved in more of the financial and cost savings goals of the organization than in the past. "I think the next big wave of risk management is taking that risk management competency around decision making and helping the company make better economic and strategic decisions," she says. "The ability to make those decisions, to steer the organization in the right direction, will be enhanced by the risk management process."

It is true, however, that as with much of healthcare, there is much uncertainty over what risk management will look like in the near future, Hilliard says. The industry is encountering challenges and opportunities. For example, every sector of the healthcare system is learning to respond to new regulatory pressures, reimbursement tightening, and consumer demands all which pose new and recurrent risks.

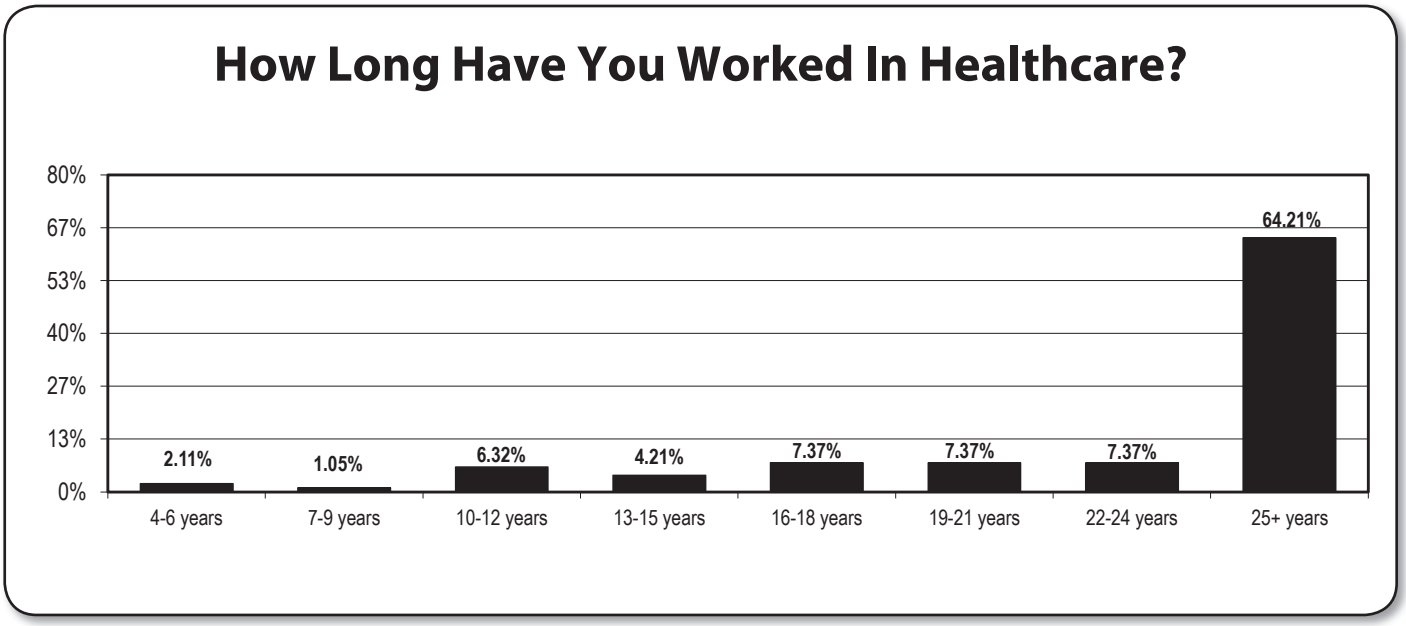
New exposures will develop as the result of those environmental changes, Hilliard says, but that change means the industry will need risk management skills more than ever before. "This is a time for innovation and creativity on the front lines," she says. "Don't wait for others to drive the changes that are needed." For example, there is a lot of consolidation in the healthcare market, Hilliard says. "Have you made recommendations to assist with that transition as it relates to your risk function? Can you create opportunity by doing more for less?" she says.

So is this a good time or not so good time to be a risk manager? Hilliard says yes. The healthcare delivery systems in the United States are taking inventory of strengths and weaknesses, and making decisions impacting clinical best practices and financial best practices in providing services. "The challenge for risk managers is we have to be ready to reinvent ourselves," Hilliard says. "We can't just rely on our past to carry us through, because I think the future is going to demand more."

Healthcare risk managers have a golden opportunity to provide front-line guidance to the decision makers in these areas. "Our leaders need our expertise, guidance, and resources," Hilliard says. "While our government works on regulation, we need to focus on improvement. Right now is the best time to be a healthcare risk manager due to the maturing landscape. It's a fabulous time to be a risk manager."

Hilliard advises risk managers to concentrate on the challenges and opportunities in the coming year. She suggests these focus points:

- Continue the "journey to zero." This phrase refers to the prevention of serious safety events and elimination of waste, a primary ASHRM initiative.
- Getting a seat at the table and persuading decision-makers to seek out the advisement of the healthcare risk manager remains the challenge and the opportunity.
- Demonstrate expertise and provide sound guidance to protect the clinical outcomes and the assets of the enterprise, which will cause decision-makers will seek you out.
- Get yourself involved internally as much as you can, and get out of your office.
- Improve your visibility, confidence, expertise,




and influence.

• Identify the changing role of the healthcare risk manager.

• Create a meaningful partnership with the other members of the healthcare delivery team that is patient-focused.

Making the most of those opportunities will require a dedication to continuing education and a willingness to be involved beyond the confines of your own office, Hilliard says. To that end, she encourages risk managers to seek credentials such as CPHRM, DASHRM, and FASHRM, and to think big. "Do you have an enterprise risk program that can offer decision support to strategic decisions? Maybe now is the time to think of your risk management function as more than just clinical risk," Hilliard says. "Don't be afraid to move your organization toward a more holistic risk management approach that includes finance, strategic planning, and systemwide crisis management."

Hilliard also urges risk managers to get in front of their organization's board of directors, or at least other executive leaders, on a routine basis.

"Step up. Be creative in your solutions," she says. "Stay current with healthcare reform and related topics. Get involved with your local state chapter and ASHRM. Don't be passive."

## SOURCE

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# Income holding steady in bad economy

Risk managers are seeing little or no growth in their income lately, no doubt a reflection of the continuing economic difficulty across the country. That is the key finding in this year's *Healthcare Risk Management's Salary Survey*.

The exclusive 2011 Healthcare Risk Management Salary Survey was sent to 775 readers in the June 2011 issue. A total of 95 were returned, for a response rate of 12%. The results were tabulated and analyzed by AHC Media, publisher of *HRM*.

The median income for health care risk managers in this year's survey is $125,000, the same as last year and the year before. *(See the chart, p. 1.)* Income levels had been rising from 2006 to 2009 but then leveled off as the bad economy took hold. About 25% of respondents reported income in the $100,000 to $129,999 range, and 15% reported income of $130,000 or more. Another 17% reported income in the $90,000 to $99,999 range.

The median salary increase over the past year was 1% to 3%, the same as last year and the year before, but lower than the 4% to 6% reported in 2008 and 2007. *(See the chart, p. 2.)* About 44% of respondents report salary increases in the 1% to 3% range, slightly down from the 47% figure last year. Twelve percent report increases in the 4% to 6% range, and 7% report increases in the 7% to 10% range.

Two readers, or 2% of the sample, reported increases of 11% to 15%, and two more reported increases of 21% or more.

Thirty percent report that their salaries had not changed this year, and three readers report a salary decrease in 2010.

Sixty percent of respondents work for non-profit healthcare organizations, and 28% work for for-profit providers, with the remainder in educational or government settings. The great majority of readers, 64%, have worked in health care for more than 25 years. ■