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Is your premium too high? You might be getting ripped off

Loading could be incorrect for you, lead to overcharges

No one enjoys paying their hospital professional liability (HPL) premiums, but paying too much is even worse. Your premium might be too high if the insurer is loading based on a broad geographical area, and it's up to you to ask the right questions.

Hospitals and hospital groups should ask their insurers about the loading applied to premiums to account for claims inflation, says **Nat Cross**, head of the healthcare team for Beazley, which insures many of the most highly ranked hospitals in the United States. The insurer's claims database is one of the most extensive in existence and covers more than 455,000 claims made against more than 1,400 hospitals since 1998.

Overcharging on premiums can occur when the insurer doesn't differentiate between hospitals in the same area and, instead, treats them all the same, Cross explains. Applying an across-the-board annual percentage loading to account for claims inflation could result in some hospitals being overcharged by a large margin, he says.

Unless it has access to data showing the actual experience of a hospital or group, it is likely that an insurer would have to apply a single percentage loading for anticipated claims inflation when renewing coverage, no matter where the hospital is located. The figure typically levied is 6%, and Beazley's research confirms that median inflation on claims of more than $500 in the period 2001-2010 was 6%, Cross says. However, this figure concealed a

EXECUTIVE SUMMARY

Risk managers should insist that their professional liability insurers are correctly applying the loading to their premiums, because many are overcharged. The problem often is traced to loading for a broad geographical area that is unfair to your facility.

- Hospitals with low claims costs are most at risk for overcharging.
- Risk managers might be the one to raise the alarm.
- Overcharging based on loading might be prevented during contract negotiations.

wide divergence from the median in some states.

The problem for the hospital is that it might be facing a premium increase based on artificially inflated claims experience — one that may look at all facilities nationwide, or over a specific geographic area — rather than one focusing on the specific hospital or location, cautions **George B. Breen**, JD, an attorney with the law firm of Epstein Becker Green in New York City. For example, a provider may be located in a state with a cap on damages for pain and suffering, but its premium adjustment might be based on damages payments made in states without any such cap, or even nationwide.

In Cook County, IL, for example, Beazley data show that median claims over the period grew by 9.5% annually. That growth means an insurer charging local hospitals a burning cost premium (i.e. just sufficient to cover the actuarial expected cost of claims) and increasing that premium by only 6% annually would be charging a sum that fell short of the expected cost of claims in Cook County by 25% a decade later.

In contrast, hospitals in Cuyahoga County, OH, saw the median cost of claims actually fall between 2001 and 2010 by 5% annually. A hypothetical insurer applying a standard 6% claims inflation loading to the premiums paid by hospitals in Cuyahoga County would be charging over 2.5 times the burning cost after a decade.

Across Michigan, median claims inflation from 2001 to 2010 rose at only 2.5%, less than half the national rate. In this case, an insurer applying a 6% claims inflation loading over the period would be charging 35% more than the burning cost by the end of the period. "As in all markets, prices move over time toward an equilibrium that reconciles supply with demand," Cross explains. "But in hospital professional liability insurance, the information held by a number of the suppliers of insurance is very imperfect and can lead to lasting and widespread price distortions."

Ask how your loading is determined

The money involved can be substantial if your hospital is being overcharged for premiums, notes **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI. Trosty previously worked for an insurance company.

The difference between the loading you really deserve and the loading applied by the insurer could be as high as 9%, he says, so it behooves the risk manager to inquire about exactly how its loading is determined. *(See the stories on p. 15 for more advice on how to get the best deal.)*

One thing you can do is to look at your claims experience, he says. If you see that claims have been going down but you find yourself with a significantly increased percentage, the risk manager needs to ask the insurer or the broker why. The answer might be geographic loading that is not specific enough, Trosty says.

"Risk managers need to be more proactive in asking for explanations and justifications," he says.

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"That doesn't happen nearly as often as it should. They just accept it."

Insurers do take some account of the impact of tort reform on anticipated claims inflation, which has had a significant impact in Cuyahoga County, OH. But there are other, subtler differences between states and even more so between individual hospitals that mean that claims inflation can vary quite widely from the median, Cross says. This situation puts new entrants to the insurance market at grave risk of adverse selection as they herd toward inadequately priced risks that better informed insurers avoid.

Hospitals are frequently better off insuring with well-established, data-rich insurers for two reasons, Cross says. If they are in a low claims inflation region, they are less likely to be penalized by a claims inflation loading that is based on a market-wide median. If they are in a high claims inflation region, they might benefit for a short while, but they will also run a far greater risk that losses will drive their insurer to pull out of writing HPL insurance altogether

"When this happens, the claims that the insurer is still responsible for are unlikely to receive the care and service they require," Cross says. "Given that HPL insurance claims take an average of 2.2 years to be settled after the incident occurred, this is a real danger."

SOuRCES

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Probe load calculation, show your own data

To avoid being overcharged on load premiums, you have to ask the right questions and provide the data showing why you deserve better than the typical load for your area.

Question the insurer's loading policies and formulations up front, advises **George B. Breen**, JD, an attorney with the law firm of Epstein Becker Green in New York City.

"Providers need to be asking carriers how their load premiums are calculated," Breen says. "What are the sources of the information the carrier uses to determine the load? How up to date is that information the carrier uses, and how is that information tested? They should, to the extent possible, be comparing carriers in this regard."

Providers should make an effort to be judged, from a premium perspective, based on their own claim statistics, rather than an artificial average of statistics that might not appropriately take into account what is going on at its hospital or its geographic region, he says. To that end, the hospital needs to be monitoring its claim history, looking at it over time and as part of its overall risk management program.

"The efforts the hospital makes in risk management can have a direct impact on its insurance costs, but the hospital needs to monitor what its exposure is and why and look for ways to reduce its risks in those areas it identifies," Breen says. "The risk manager also ought to be following litigation trends, including verdicts, in its location and contiguous locations, as he or she looks to evaluate the proposal carriers make."

Hospitals also need to be sure not to look at claims history in a vacuum, Breen cautions. Don't focus on one "good" year while ignoring two or three previous "challenging" ones. "The risk manager's goal is to protect the hospital, and it is critical that a realistic assessment is made so as accurate a projection as possible can be forecast," he says. ■

Don't leave insurance to finance department

Risk managers should have an active role in purchasing and managing insurance, says **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI, and a former insurance company executive.

"It should not be just the financial individuals in the healthcare organization who are involved with insurance," Trosty says. "Risk managers have a greater knowledge of the claims, the risks, the medical errors that are occurring. There should be an active involvement in insurance issues."

Much of the interaction with the insurer should involve the risk manager, possibly with financial professionals also, he says. "If the hospital's interactions with the insurer are left entirely to the financial people, then the risk management program is not as comprehensive as it should be," Trosty says.

"As you look to moving more toward enterprise risk management, that becomes even more true. One cannot have enterprise risk management without having involvement with the insurance component."

Inaccurate claims loading often is the result of the risk manager not being involved enough in the procurement and management of insurance contracts, Trosty says. Risk managers can focus so intently on preventing and responding to medical errors, for example, that they are content to leave the intricacies of insurance to their financial colleagues.

"There is far too little understanding among risk managers of these insurance questions and the role they can play," Trosty says. "A risk manager who wants to build his or her worth in the organization has a lot of opportunity if they get involved in these issues." ■

More MD hires means more tail insurance

Hospitals are bringing more self-employed physicians on board as employees, which can bring benefits to both parties, but it brings a potential problem for risk managers. What do you do about tail insurance?

The easy answer is to have physicians take care of their own med mal tail and prior acts exposure. But hospitals often sweeten their recruiting offer by agreeing to pay for the tail exposure, especially for highly sought specialists, says **Mary Anne Hilliard**, JD, BSN, CPHRM, chief risk counsel with Children's National Medical Center in Washington, DC, and president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

"The tail coverage problem often comes up in negotiations around hiring," Hilliard says. "The doctor wants the job, and the hospital wants to hire, but someone has to cover the tail liability."

The physician's own coverage usually has an option for tail coverage with stated terms, typically a percent of the annual premium, notes **John Geisbush**, placement leader for the healthcare practice of Marsh, an insurance broker and risk adviser based in Phoenix, AZ. If you want to obtain the tail coverage through that policy, you're stuck with those terms, he explains.

The hospital might have alternative risk vehicles — captives and self insureds — that could absorb the tail liability for the physicians or physician groups, he says. Additionally, insurers are beginning to offer more tail-only policies for physician exposures, he says. "The fact that we have freestanding tail options is a positive development," Geisbush says. "We didn't have any freestanding options in the past. It's a limited market now, but I think we may see an expansion of those options."

The decision making might come down to how much risk the hospital is willing to take on and how much it is willing to pay to reduce that risk, Geisbush says. The risk can be transferred by paying for a tail policy, but that move reduces your cash flow. Taking the tail exposure into your own captive or self-insurance plan saves you that policy payment, but you could end up paying for a med mal case down the road. *(See the story on p. 17 for tips on deciding how to provide tail insurance.)*

"If you bite the bullet and invoke the tail provisions in the policies of the physicians being acquired, the issue just goes away at that point. There's nothing to negotiate, but you might be getting the best deal in terms of cost or coverage," Geisbush says. "If you take that risk into your own risk financing structure, you have to weigh what the actuary says could be the eventual cost to you, and it could turn out to be more than you bargained for."

As with any insurance decision, the risk manager and colleagues in finance will need to weigh the available options to determine what is most affordable and advantageous, he says. The financial expert might be best able to sort through the cost differences, but the risk manager is best suited to weighing the details of the coverage. "Unfortunately the risk manager is usually the last person to find out about these acquisitions," Geisbush says. "The person making these acquisitions should be reaching out to the risk manager very early to make him or her aware of the possibilities and to allow the risk manager to do due diligence."

The risk manager is critical for collecting infor-

EXECUTIVE SUMMARY

Hospitals are hiring more physicians on staff, and that makes tail insurance more of a concern for hospital risk managers. Buying the right tail insurance at the right price can be challenging.

- The physician's existing policy probably has a tail option, but the terms are fixed.
- Hospitals with captives and self-insurance might be able to absorb tail coverage.
- Some insurers are offering standalone tail coverage policies now.

mation about the doctor's past practice, Hilliard says. The risk manager also can learn about existing claims and the potential for unknown claims. That information can be used to help the parties weigh the pros and cons to different approaches and to strategize around solutions that mitigate risk and maximize opportunity.

"Finally, the risk manager can help the physician feel welcome in their new hospital by engaging in the problem and working toward an amicable solution," Hilliard says. "That builds trust and, before you know it, your new doctor is telling folks in your hospital to report and work with risk management because they are good problem-solvers."

SOURCES

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Weigh tail options when hiring MDs

Deciding who pays for a new physician's tail coverage usually hinges on who has the leverage in the hiring situation, says **Mary Anne Hilliard**, JD, BSN, CPHRM, chief risk counsel with Children's National Medical Center in Washington, DC, and president of the American Society for Healthcare Risk Management (ASHRM) in Chicago.

Hilliard has seen it go both ways. Sometimes the job offer is contingent on the doctor getting his or her own tail coverage. Other times the hospital pays for the coverage as part of the employment contract.

"I've also seen arrangements where the doctor has a duty to pay the hospital back with interest for the tail cost and that obligations goes away over time," Hilliard says. "So, for example, the doctor owes the whole amount back to the hospital, and that liability goes down by 20% each year that the doctor remains employed by the hospital until the entire amount is forgiven."

Covering a physician through a hospital's insurance program offers more flexibility around pricing and coverage. "The downside risk — and this is significant — is that the hospital did not manage the physician during the period at issue and, therefore, the relative risk is arguably unknown," Hilliard says. "Generally speaking, in my experience, hospitals prefer to not cover an old liability, and they would rather have the doctor come without pre-existing insurance exposures. No one wants to pay for problems that arguably belong to the last employer."

When paying an outside insurer for a physician's tail coverage, Hilliard says it is generally advisable to maintain coverage with the original insurer, unless circumstances arise that make that company unreliable. Carefully study the stability of the company selling you the insurance, the scope of coverage, and the limitations on coverage.

"You want to be sure, for example, that the coverage goes back far enough and that it covers the doctor for all his or her known and unknown exposures," Hilliard says. "In that regard, it's very important for the physician to disclose any known or suspected liabilities to the carrier. Failure to be truthful on the application could lead to denial of coverage." ■

Identified fall risks can be used in prevention

Investigators have identified factors that are associated with an increased risk of in-hospital falls after total hip or knee replacement surgery, and the findings can be useful to risk managers and fall prevention committees.

The study, which appears online ahead of print in the *Journal of Arthroplasty*, identifies risk factors using a national database of patients undergoing a joint replacement revision, explains **Stavros Memtsoudis**, MD, PhD, an anesthesiologist at Hospital for Special Surgery (HSS), who led the study.[1] *(See the story on p. 18 for details of the study.)*

"This study helps doctors know which patients to look out for," Memtsoudis says. "Some studies have shown that falls occur when patients get up from their bed to go to the bathroom. While it may be unreasonable to put a helper into every room to help patients go to the bathroom, it would certainly be feasible to identify a smaller group of patients at-risk and focus efforts on them."

The study is one of the first to look into patients that suffer falls during their hospital stay after undergoing total hip or knee replacement surgery, says **Alejandro Gonzalez Della Valle**, MD, an

EXECUTIVE SUMMARY

New research identifies key risk factors for patient falls. Risk managers are advised to incorporate these warning signs into their fall prevention efforts.

- Falls are increasing, possibly due to an aging patient population.
- The rate of patient falls in the study was 0.85%.
- At-risk patients should receive special attention from staff.

orthopedic surgeon at Special Surgery, who was also involved in the study. According to published data, in-hospital falls occur in 2% to 17% of patients during short-term hospitalization. While orthopedic surgeries can put patients at risk for in-hospital falls, only two published studies to date have evaluated the risk for these types of falls in orthopedic patients.

"We detected an alarming increase in the national prevalence of this potentially preventable problem and identified a number of patient factors that were associated with an increased risk of falling during a hospital stay," he says. "The information in our study can be used by health care professionals to design or perfect in-hospital fall prevention programs."

The researchers say they hope the study will provide risk managers a smaller target to focus on for fall prevention. "If a patient comes in for revision surgery or has certain comorbidities, we know they are at increased risk," Memtsoudis explains. "Thus patients with these characteristics could be tagged and awareness of staff to especially watch out for this population could be raised."

An additional interesting study finding was that the rate of falls is increasing. The incidence over time jumped from 0.4% to 1.3% within 10 years. "It could be because of more reporting, because it is mandatory to report these falls, or because the patient population that we see — and we have more and more evidence for this — is actually getting sicker and so may, therefore, be at a greater risk."

The new research results are useful because they validate what many clinicians knew from experience or suspected, says **Pamela E. Toto**, PhD, OTR/L, BCG, FAOTA, an occupational therapist at the School of Health and Rehabilitation Sciences at the University of Pittsburgh in Pennsylvania. Much of what clinicians know about fall prevention is anecdotal, Toto says, so hard data is useful in establishing the need for special precautions with some patients. *(See the story on p. 19 for more information on targeting at-risk patients.)*

"This research confirms that the more issues you have, the more likely you are to fall," Toto says. "The more evidence we have in justifying that patients in a certain group are at high risk for falls, the more likely we are to address that risk and change those factors."

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Comorbid conditions increase fall risk

To study the risk of falls in patients undergoing orthopedic procedures, researchers at the Hospital for Special Surgery (HSS) turned to the Nationwide Inpatient Sample, sponsored by the Agency for Healthcare Research and Quality (AHRQ).

The sample is the largest inpatient database available in the United States that includes information on patients of all ages. It collects data from about 20% of all hospitalizations in the United States. This large cohort of patient information is unparalleled and allows for the appropriate study of relatively rare events surrounding surgery, notes **Stavros Memtsoudis**, MD, PhD, an anesthesiologist at HHS, who led the study.

The investigators analyzed data between 1998 and 2007 to identify patients who had undergone a total hip or knee replacement. Using statistical modeling, they then compared characteristics of patients who had suffered in-hospital falls to those who had not suffered a fall. During the study period, the rate of patients that fell during their in-hospital recovery was 0.85%, representing 2.1 falls per 1,000 inpa-

tient days. The incidence of falls increased from 0.4% to 1.3% during the study period.

Patients were more likely to fall if they were male, older, belonged to a minority race, or were undergoing a revision joint replacement surgery. Patients also were at heightened risk if they had certain comorbid conditions, including congestive heart failure, a clotting or bleeding disorder, liver disease, neurologic disease, electrolyte/fluid abnormalities, and recent weight loss.

Pulmonary circulatory disease posed the greatest risk. Obesity, hypothyroidism, uncomplicated diabetes, and cancer were not associated with an increased risk of falling. Postoperative complications including deep vein thrombosis, adult respiratory distress syndrome, and pulmonary embolism also were associated with higher fall rates, although Memtsoudis says it remains unclear if they were the reason or the consequence for this event.

In line with other studies, patients who experienced falls had longer hospital stays and were more frequently discharged to other healthcare facilities, instead of their primary residence. ■

Target those most at risk of falls, but others too

Fall prevention efforts usually target those thought most likely to fall, but does that leave the other patients at risk if no one is paying attention to their potential for falling? A special focus on high risk patients doesn't have to shortchange others, says **Pamela E. Toto**, PhD, OTR/L, BCG, FAOTA, an occupational therapist at the School of Health and Rehabilitation Sciences at the University of Pittsburgh in Pennsylvania.

The highest risk patients should always get more attention to prevent falls, even when everyone else is still at risk to some degree, she says.

"If you look at the literature, I could make the argument that the majority of people in the hospital are at risk for falls," Toto says. "I could go to a nursing home and tell you that 100% of the patients are at risk for falls. But you can make them into high, medium, and low risks relative to that particular population, and that can still be useful in directing your efforts."

The extra attention to high risk patients is justified by the data that identifies risk factors, Toto says. That focused attention doesn't mean that other patients don't need the basic fall prevention efforts that can apply to anyone, such as keeping the room free of clutter and providing grab bars, she says. "We know, however, that certain patients at risk in certain ways or in certain conditions. If we know that a patient has urge incontinence, she is going to be in a hurry when she gets up, and that situation puts her at risk more than a patient without that condition," Toto says. "It's appropriate to provide more assistance and more education about that scenario even if you don't address that with everyone."

Healthcare providers are using increased knowledge about the risk factors for falls to prevent accidents in more practical and patient-friendly ways, Toto says. Rather than trying to keep patients in bed to avoid falls, the traditional approach, more hospitals are providing assistance to patients when they want to get up.

"It's not about limiting their ability to move, but rather providing them a safer way to move," Toto says. ■

Volunteer program cuts falls 46%

Some of the best ways to prevent falls require personal, hands-on attention to individual patients, but hospitals don't have enough staff to provide as much of that tending as they would like. One hospital has found that volunteers are eager to do the job, and it has cut falls by a whopping 46% as a result.

Overall compliance with fall-prevention protocol has improved significantly since the initiation of the program in April 2008, says **Christine Waszynski**, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program at Hartford (CT) Hospital. The volunteer program, which costs the hospital virtually nothing, started out with only two volunteers from a local job corps academy and has grown to 16 volunteers.

Volunteers are particularly well suited to ensuring compliance with fall prevention protocols, Waszynski says. Many of the volunteers are teen-agers who can be shy about interacting with patients in a way that requires them to strike up a conversation, but Hartford's Fall Prevention-Safety Monitor Volunteer Program provides them a specific set of factors to check with each patient. *(For a video showing how the program works, go to http://vimeo.com/user7284985/videos and choose the video titled Safety Volunteer Program at*

EXECUTIVE SUMMARY

A hospital program that relies on volunteers to check up on patient at risk for falls has reduced falls by 46%. The program costs virtually nothing and has proven successful for several years.

- Volunteers visit patients to assess the situation for fall dangers.
- They also verify that the bed or chair alarm is activated.
- Staff are held accountable for deficiencies in the fall protocol.

Hartford Hospital. For more on the results of the program and tips for replicating it, see the stories on p. 21 & 22.)

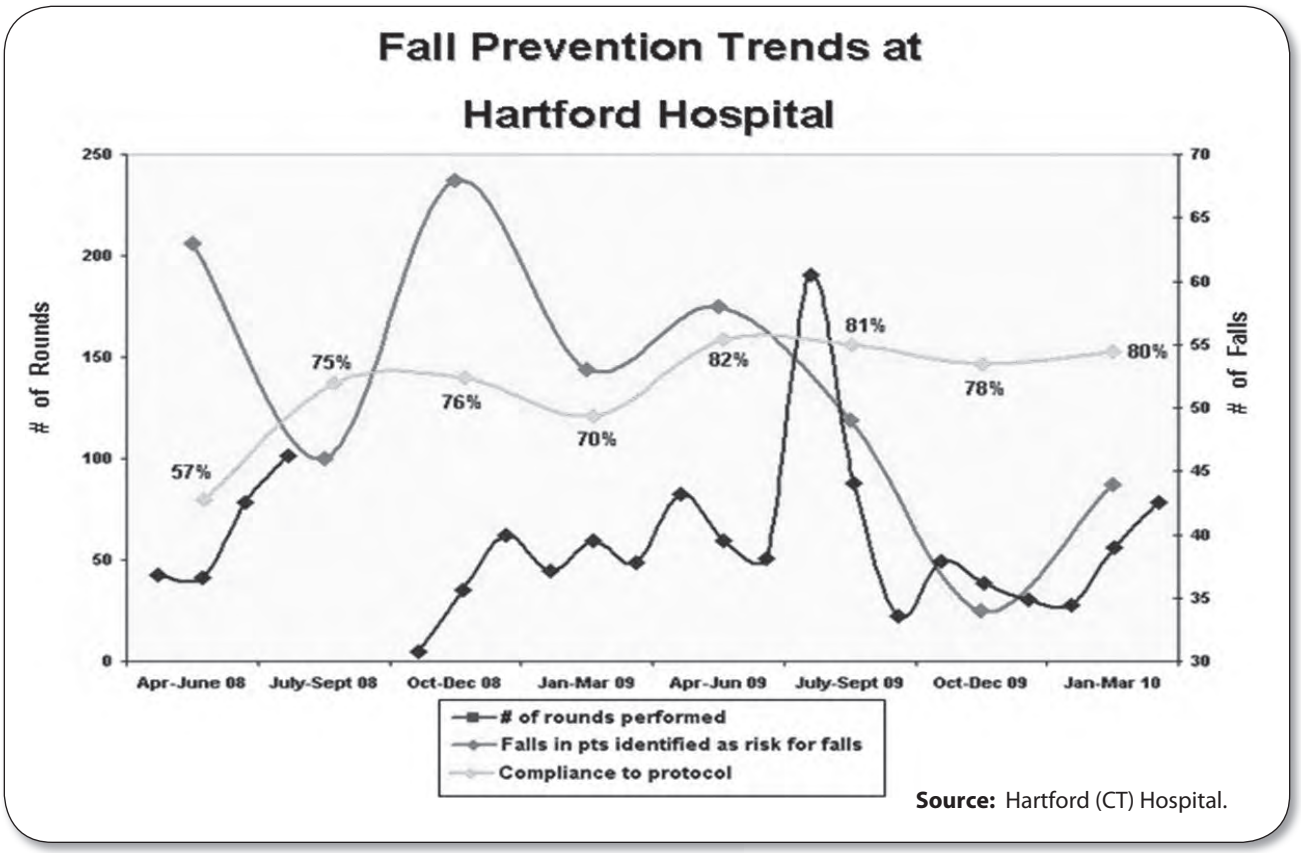
The program was developed to monitor and increase staff compliance with fall-prevention protocol measures, reduce patient falls, and increase involvement of patient and family in creating and maintaining a safe environment, Waszynski says. Volunteers are recruited and trained specifically for the program after completing the standard mandatory volunteer orientation. "We teach them to look for measures that should be in place for patients who are at risk for falls, and they correct any oversights they might find," Waszynski says. "They also remind patient and families about the risk of falling and their role in fall prevention."

The volunteers visit all patients who have been designated as a fall risk, which can include up to 80% of patients on some units. On each visit, the volunteer introduces himself or herself to the patient and family, and the volunteer explains that the purpose of the visit is to help reduce falls and keep the patient safe.

Using the hospital's fall safety screening tool, the volunteer confirms that the patient is at risk and then checks to see that all aspects of the fall prevention protocol are being followed. That includes verifying that the patient is wearing the hospital's green fall risk bracelet, there is a green triangle on the door, and the bed or chair alarm is activated. The volunteer also scans the room for fall hazards and improves safety however necessary, such as moving the phone to within the patient's reach, removing clutter, and making sure the patient knows how to call for assistance.

Each bedside check is recorded by the volunteer. At the end of the volunteer's shift, the results are reviewed with the unit's nurse manager or charge nurse. The findings also are sent to the fall-prevention team coordinator, who compiles the results for each unit monthly and presents them as a graph depicting compliance over time.

"We've used this program to help us change culture. When we started this program, the culture was 'patients fall, and there's nothing we can do



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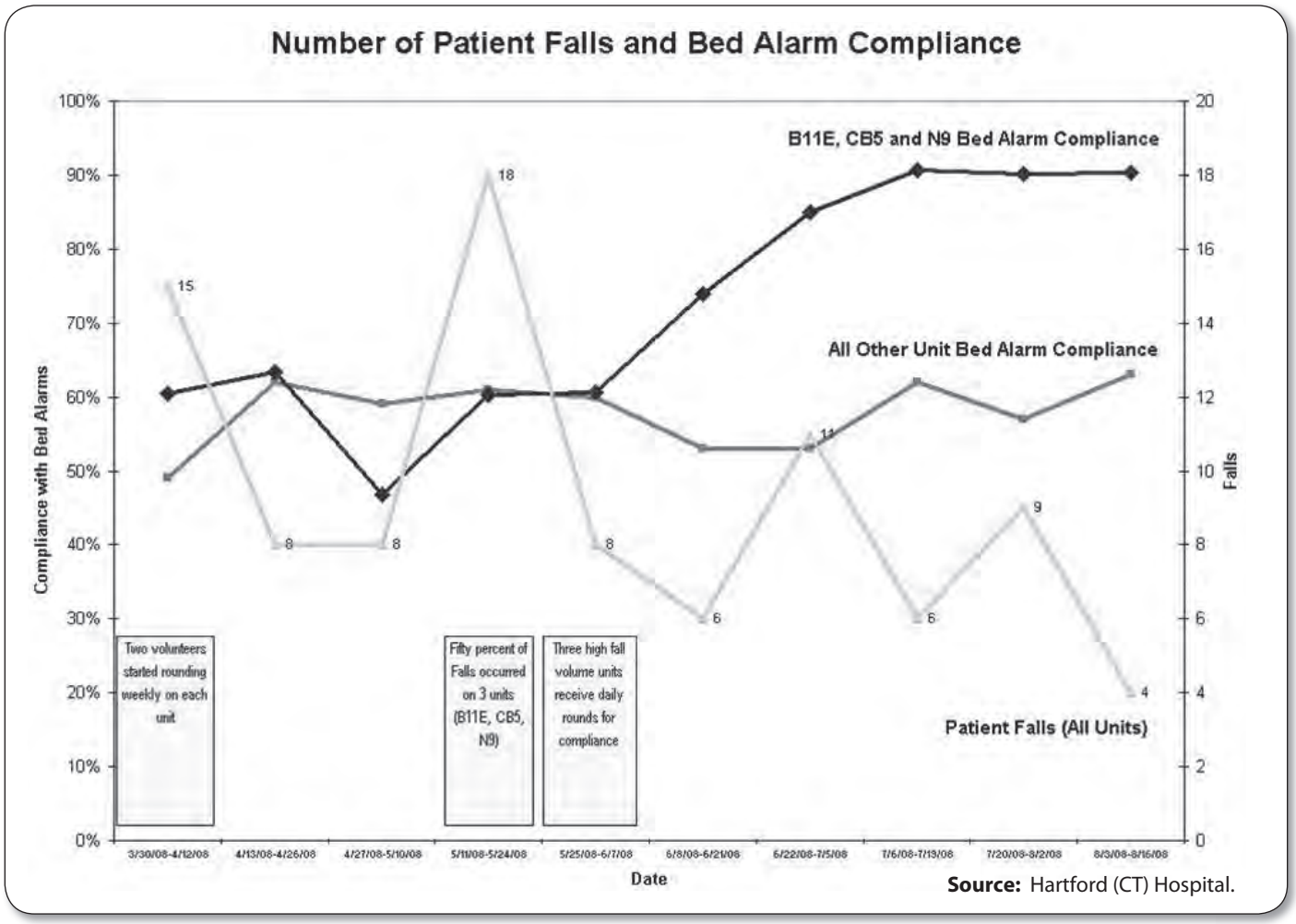

Source: Hartford (CT) Hospital.

about it,'" Waszynski says. "Our compliance with fall prevention was 50% at best. By talking about this all the time and using our volunteers, now our compliance is about 90%."

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More rounding means better fall compliance

Two years of the Fall Prevention -- Safety Monitor Volunteer Program at Hartford (CT) Hospital have yielded significant results, says Christine Waszynski, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program. *(See the charts above and on p. 20.)* In addition to reducing falls 46%, analysis of the bed check results shows these findings:

• There is a relationship between the frequency of volunteer rounding and the degree of staff compliance. The more often the volunteers visit, the better the staff complies with the fall prevention protocol.

• Nurses welcome the volunteers, seeing them as an extra set of hands to help with monitoring they don't have enough time to complete. Volunteers report that nurses thank them for helping keep patients safe and helping them do their jobs better.

• Staff members report that the volunteer rounding helps remind them to follow the fall prevention protocol at all times. Units even had unofficial competitions to see who could achieve 100% compliance more than the others. Staff sometimes use the volunteers' checklist to conduct their own fall safety rounds.

• The program gets high marks from volunteers, patients, and family members. Volunteers can see the results of their work and feel appreciated by the staff. Patients and family members are thankful that the hospital is looking out for the patient's safety.

Clinical champion is a must for falls program

Who wouldn't want to replicate a falls prevention program that cuts falls 46%? If you want the same results, here are some tips from **Christine Waszynski**, APRN, a geriatric nurse practitioner and clinical nurse specialist in the geriatrics program who works with the Fall Prevention-Safety Monitor Volunteer Program at Hartford (CT) Hospital:

• You must have a clinical champion.

The program can't be run solely out of volunteer services. A clinical professional from the fall prevention team needs to work closely with the volunteer coordinator to train the volunteers, monitor their work, and make good use of the data they collect.

• Give the volunteers concrete, specific instructions.

Don't educate them about fall prevention and then tell them visit patients to look for fall hazards. Provide a checklist with precise items to inspect, correct, and talk to the patient about. The volunteers will be much more comfortable with their roles and more effective.

• Involve the nursing department.

Part of the program involves providing feedback to the nursing staff and holding staff accountable for deficiencies found by the volunteers. To ensure that the volunteer program is seen as an aid to the nursing staff rather than anything punitive, the nursing department needs to be on board from the start. ■

Kaiser hospital fined for med storage error

The California Department of Health has fined Kaiser Permanente South San Francisco Medical Center $50,000 for failing to follow "policies and procedures for the safe and effective administration of medication," in relation to improper refrigeration. Thousands of patients received the potentially dangerous medications over almost three years.

The Department of Health's investigation linked the error to the deaths of two patients. According to the investigation, the hospital stored most medications needing refrigeration in one refrigerator in its pharmacy. The medications were supposed to be kept above freezing, but the refrigerator was set at freezing for a 32-month period between 2006 and 2009, investigators found.

EXECUTIVE SUMMARY

The state of California has fined a Kaiser Permanente hospital for improperly storing refrigerated medications. The potentially dangerous medications were administered to nearly 4,000 patients.

- The hospital was fined $50,000.
- Two patients died after receiving inoculations that might have been ineffective.
- The hospital notified only some of the patients initially.

The hospital stored 78 types of medications in the refrigerator, including vaccines used to prevent such diseases as Hepatitis B, tetanus, and pneumonia; skin tests; and insulin used to treat diabetes. The improperly stored drugs were administered to nearly 4,000 patients, according to the investigation.

The hospital discovered the cause of the error was that an engineer mistakenly had scheduled preventive maintenance checks on the refrigerator for every three years instead of every three months, and the hospital's pharmacy director told investigators that no staff member had been "responsible for monitoring refrigerator temperatures."

A spokesman for Kaiser did not reply to Healthcare Risk Management's request for comment but provided a statement from **Frank Beirne**, senior vice president and area manager for Kaiser Permanente South San Francisco Medical Center. "We immediately corrected the equipment problem and took steps to make sure it would not happen again," Beirne said in a statement.

Once the problem was discovered, the hospital reported it to the state, and it contacted some patients who had received the vaccines and tuberculosis tests — only those that hospital officials thought needed to be revaccinated or retested. "Our physicians worked with their patients to determine if any additional actions may have been needed, and if warranted, patients received re-vaccinations or retests at no charge," according to Beirne's statement.

That step was not sufficient for the Department of Public Health. It's investigation chided the hospital for failing to notify all the patients who had received the vaccines and tests. The hospital failed to contact some patients who had received a compromised dose of the pneumococcal vaccine, which is used to prevent pneumonia. The investigators noted that two patients who had received compromised doses later died after contracting pneumonia, and one of them had never been notified of the need to be re-vaccinated.

The hospital also failed to contact two other patients who received compromised doses of the vac-

cine and who later contracted pneumonia, according to the investigation.

The Department of Health instructed the hospital to notify all the patients who had been affected and still were living, and the hospital complied. The full investigative report can be found online at http://tinyurl.com/6pqe7vr. ■

Failure to communicate test results adds risks

Because clinical evaluation often depends on diagnostic tests, diagnostic physicians have a responsibility to notify referring clinicians when test results reveal urgent or unexpected findings. According to a report in the Journal of the American College of Radiology (JACR), the rapid growth of diagnostic testing appears to be placing physicians at greater risk for medical malpractice claims for test communication failures.

During the past decade, clinicians have ordered dramatically greater numbers of diagnostic examinations, according to the article by **Brian D. Gale**, MD, MBA, assistant professor of radiology at SUNY Downstate Medical Center in Brooklyn, and colleagues.[1] They also cite a study demonstrating that between 1996 and 2003, malpractice payments related to diagnosis increased by about 40%.

Contributing factors in malpractice cases associated with communication failures include, for example, failure of physicians and patients to receive results, delays in report findings, and lengthy turnaround time, the report notes.

Using data from the National Practitioner Data Bank (NPDB), the authors found that the total indemnity payout across all medical specialties for U.S. claims related to the three types of communication failures they studied increased from $21.7 million in 1991 to $91 million in 2010. Linear regression analysis of data from 1991 to 2009 indicated that communications-related claims payments increased at the national level by an average of $4.67 million annually.

Over the same period, NPDB data showed that communication failure awards accounted for an increasing proportion of total U.S. malpractice awards for all providers. The proportion increased by a factor of 1.7, from 0.93% in 1991 to 2.31% in 2009.

Gale and his co-authors write that the advent of semi-automated critical test result management systems might improve notification reliability, improve work flow and patient safety, and, when necessary, provide legal documentation. They recommend that when reportable test results arise, healthcare organizations need clear policies that define the responsibility of reporting and referring providers to ensure patient follow-up.

REFERENCE

1. Gale BD, Bissett-Siegel DP, Davidson SJ, et al. Failure to notify reportable test results: Significance in medical malpractice. *J Amer Coll Radiology* 2011; 8:776-779. ■

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

- Phones, other devices distract
- Long ED waits pose med mal risk
- Can staffing agencies ensure HIPAA compliance?
- Getting rid of verbally abusive docs

CNE QUESTIONS

1. Beazley determined that that the median inflation on claims of more than $500 in the period 2001-2010 was 6.0%. Why then, is 6% loading on premiums not always fair to a hospital?
   A. The figure conceals a wide divergence from the median in some states.
   B. The figure is based on claims from previous years and the current year claims may be different.
   C. There is no evidence that the increase in claims cost is the hospital's fault.
   D. The increased premium must be passed on to the patient.

2. In the fall prevention program that reduced falls by 46% at Hartford (CT) Hospital, who is responsible for checking patient rooms to ensure compliance with the fall protocol?
   A. The unit's director of nursing
   B. Physician interns
   C. Volunteers
   D. Family members of patients

3. In the study led by Stavros Memtsoudis, MD, PhD, an anesthesiologist at Hospital for Special Surgery (HSS) in New York City, what was found regarding the rate of falls?
   A. The rate is increasing.
   B. The rate is decreasing.
   C. The rate is holding steady.
   D. There was no finding regarding the rate of falls.

4. When Kaiser Permanente South San Francisco Medical Center investigated why refrigerated medications were stored improperly, what did it find to be the cause?
   A. The refrigerator was in a clinic that was closed on weekends, and power outages were not monitored.
   B. An engineer had mistakenly scheduled preventive maintenance checks on the refrigerator for every three years, instead of every three months.
   C. Staff frequently disconnected the refrigerator to use other equipment.
   D. An improper type of refrigerator was supplied by mistake.

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

ED treatment delayed — 14-year-old could have been saved by surgery, family claims

By **Leslie E. Mathews**, Esq., MHA
Buchanan Ingersoll & Rooney
Tampa, FL

Suzanne Gruszka, RN, MAS, CLNC, LHRM
Administrator, Clinical Support Services
Health Central
Ocoee, FL

News: A 14-year-old boy was taken to a local hospital emergency department (ED) with complaints of sharp pain on the right side of his face and his right shoulder after being kicked in the head by his mother. The boy reported that his pain level was 10 on a scale of 1-10; however, the triage nurse indicated his was a "non-urgent" case. The patient reportedly vomited more than once, continued to demonstrate signs of discomfort per his family, and had visible swelling of the neck and upper chest. The patient's heart rate continued to rise as time went on, and a soft tissue x-ray revealed "a lot of soft tissue swelling pushing the trachea out of position."

After several delays, the ED physician consulted vascular and thoracic surgeons; however, the surgeons recommended transferring the patient to a level 1 trauma center. Before he could be transferred, the patient heart rate plummeted, and he bled out into his chest. Surgeons could not save the patient's life. He went into cardiac arrest and died on the operating room table. The patient's family members sued the hospital and physicians. They claimed the doctor's negligence delayed surgery that could have saved the patient's life. The jury awarded the patient's family $2.4 million in malpractice damages.

Despite a pain level of 10 and vomiting, nurses in the ED determined that the boy's case was "non-urgent."

Background: A 14-year-old boy, who was kicked in the head and neck area by his mother, presented to the ED with severe pain and swelling in his neck in August 2003. Despite a pain level of 10 and vomiting, nurses in the ED determined that the boy's case was "non-urgent."

The ED physician evaluated the patient and admitted being "baffled by the lack of bruising or associated injuries." The physician's examination revealed significant swelling, stable vital signs, a "comfortable" patient, and a small hemorrhage in the white of one eye. He ordered a soft-tissue X-ray to determine the cause of swelling. After an hour had passed and the patient vomited again, the physician reviewed the X-ray, which revealed soft tissue swelling pushing on

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. **Suzanne Gruszka,** guest columnist, has no relationships to disclose.

the trachea. The physician then consulted a head and neck surgeon, gave the teen morphine for pain, and ordered a CT scan.

As time passed, the patient's condition worsened, and his heart rate began to rise. A radiologist read some of the CT scans from home, reporting the patient might have a "jugular injury with venous hemorrhage," and left her home to attend a wake before reading all of the scans. Several hours after his admission to the ED, the patient's blood work was ordered and revealed that he had lost two or more pints of blood. Eventually the radiologist read the entire CT and amended her report indicating that one of the patient's arteries was bleeding.

Upon seeing the result of the CT scan and just prior to finishing his shift at the hospital, the physician consulted vascular and thoracic surgeons. The vascular surgeon did not have the training to treat the patient. She recommended a thoracic surgery consult, and the thoracic surgeon did not come to the hospital or return calls for more than an hour. When the thoracic surgeon eventually evaluated the patient, he determined the patient should be transferred to a level 1 trauma center for treatment by a pediatric thoracic surgeon.

Several hours after his admission to the ED, the patient's blood work was ordered and revealed that he had lost two or more pints of blood.

Just after the patient's father gave permission to transfer him, his condition worsened. His pain level shot up, and he began to scream. A short time later, his heart rate plummeted, and he bled out into his chest. The thoracic surgeon attempted to save his life; however, the bleeding was too great to control, and the patient died on the operating table.

The plaintiff and the defendants provided conflicting expert testimony attempting to convince the jury of whether treating the patient's injuries in a timely manner could have saved his life. The plaintiff's expert testified that blood was the only thing that could cause this kind of swelling and the patient's situation was a "major emergency." The expert testified that the ED physician should have ordered blood pressure monitoring, blood work, a CT scan, and vascular surgery right away. The defendant's experts testified that the injury was unusually rare and difficult to diagnose, and that the physician's treatment of the patient was appropriate. The defendant also presented testimony that even if the patient's injuries had been treated sooner, his condition was so grave and complex that the early treatment would not have changed the outcome.

The jury found that the physician's delay in appropriately treating the patient resulted in the patient's death and awarded the family $2.4 million. The defendant appealed; however, the appellate court found that the jury was capable of finding the physician's failure to adhere to the standard of care caused delays in treatment that could have saved his life.

Commentary: This case is a delay in diagnosis and treatment of a 14-year old patient who suffered from blunt neck trauma. There are few emergencies that pose such a challenge as neck trauma. The wounds or injuries might not manifest with clear signs and symptoms, and these potentially lethal injuries can be easily overlooked. The most significant risk is airway occlusion and exsanguinating hemorrhage. Direct force can shear the vasculature. The impact to the anterior aspect of the neck might crush the larynx or trachea.

Of all serious traumatic injuries, neck trauma accounts for 5-10%. About 3,500 people die annually. Neck trauma is more common in adolescent males. Arterial injuries are the major source of morbidity and mortality. About 7% of injuries to critical structures of the neck involve major arterial structures, including the subclavian, internal and external, and common carotid arteries.

The clinical symptoms range from patients who have no symptoms to those that have life-threatening airway obstruction or shock. A progressive airway obstruction can occur from an expanding hematoma, and the patient often presents with abnormal respiratory patterns, tachypnea, and cyanosis. The evaluation of blunt neck trauma begins with the assessment of the airway.

The clinical management of a patient with blunt neck trauma begins with the ED physician and staff assessing and securing the patient's airway. This process might include intubating the patient. Once the airway is secured, then X-rays of the neck and chest followed by a CT of the head, neck and chest would be recommended. Blunt neck trauma can cause vascular injuries

that result in the formation of pseudoaneurysm, dissection, arteriovenous fistula, complete transaction, and thrombus formation. Use of a CT or CT angiogram to identify these formations is preferred.

The challenge for ED physicians is to detect the subtle but significant injuries that require intervention. This group includes patients who appear to have no immediate indication for surgical intervention. Blunt vascular injuries to the carotid or the vertebral arteries are rare, and clinical presentation is often subtle and nonspecific. The patient in this case presented with pain on the right side of his face and right shoulder. He had visible swelling of the neck and upper chest, and his X-ray of that area revealed "a lot of soft tissue swelling pushing the trachea out of position." This is a medical emergency, and his airway was compromised. There is no mention that his airway was managed by intubation.

There appears to be a real communication issue with this case from the time the patient presents through the time when he expires. There is no sense of urgency with the healthcare providers.

The ED physician noted that there was significant swelling in the area and that he had stable vital signs. The patient reported vomiting several times at home, and he is noted to have vomited once in the ED. The ED physician did order a CT scan, as well as a consult with a head and neck surgeon. The physician also administered morphine for pain. This use of morphine might be questionable in a patient with decreased respiratory function.

It appears that the radiologist read a portion of the CT scans and reported that the patient might have a "jugular injury with venous hemorrhage." It is unclear whether that information was communicated to the ED physician prior to the radiologist leaving to attend a wake. Ordinarily when an abnormal result is identified, the radiologist contacts the ordering physician immediately. Such communication might have had an impact on the outcome of this patient. The case information states that the radiologist eventually returns to the report of the CT scan and amends it to indicate that one of the patient's arteries is bleeding. It is at this point that additional consultants are called; however, the patient's condition rapidly deteriorates.

There appears to be a real communication issue with this case from the time the patient presents through the time when he expires. There is no sense of urgency with the healthcare providers. While the patient demonstrated significant signs of a potential life-threatening injury, the assessment, diagnosis, and treatment of his injures were treated as "routine."

The Joint Commission has identified communication as the number three most frequently identified root cause of sentinel events for 2009, 2010, and 2011. Since 2004, communication has been the number one root cause for delays in treatment, followed by assessment as the number two root cause for delay in treatment. Of the most frequently reported sentinel event categories, delay in treatment has been number two for 2009 and 2010. The data shows a rapid increase in delay in treatment events since 2000. The Joint Commission released a Sentinel Event Alert (http://bit.ly/iglWsH) in 2002 identifying this as a serious issue especially for hospital EDs.

This patient's outcome might have been a positive one if he were triaged and treated in a more timely and emergent manner. The delay in treatment severely impacted his chances at survival.

REFERENCE

Superior Court of New Jersey, Appellate Division, Docket No. A-5330-07T15330-07T1 ■

$10 million settlement in toddler amputations

Group A Streptococcus care delayed 5 hours

News: A 2-year-old patient presented to the emergency department (ED) with a high fever, skin discoloration, and weakness. Despite her parent's numerous requests for treatment, the patient waited for five hours before being evaluated by medical staff. By the time she was evaluated, her condition had worsened. She was flown to another hospital, where she was diagnosed with septic shock. She lost both of her feet, her left hand, and part of her right hand as a result of the shock. The hospital has agreed to

a $10 million settlement.

Background: The parents of a 2-year old little girl brought her to the ED of a local hospital with a high persistent fever, skin discoloration, and weakness. The parents reportedly begged the doctors and nurses to see the girl as they watched her condition deteriorate. After a five-hour delay in care, the treating physicians determined that her condition required treatment at another medical center.

Upon arrival at the academic medical center, physicians diagnosed her with septic shock secondary to an aggressive strain of Group A Streptococcus bacteria that had entered her bloodstream. Surgeons had to remove the patient's feet, her left hand, and part of her right hand. She spent three months in the hospital and later was transferred to another hospital in the area. She continues to undergo therapy and will need expensive medication, custom prosthetics, special garments, and wheelchairs for the rest of her life.

The patient's family filed a lawsuit against the hospital and medical staff. They sued for compensation for their daughter's past, present, and future medical bills. The hospital and physicians have agreed to a $10 million settlement.

Commentary: Septic shock occurs most often in the very young and very old. There are many types of bacteria that can cause septic shock. The toxins that are released by the bacteria can cause tissue damage and result in poor organ function and/or death. In some instances gangrene can occur, possibly leading to amputation.

The symptoms of septic shock differ in children and can be difficult to diagnose. It is one of the most common and often life-threatening conditions in infants and children. The incidence of septic shock is highest among children with special healthcare needs, and this special population of children continues to expand.

While our body of knowledge on septic shock continues to grow, our overall recognition of pediatric septic shock by healthcare practitioners remains low. To improve outcomes for these children, there must be early recognition and treatment. The treatment must be aggressive and goal-directed. Each additional hour of persistent shock increases the mortality risk twofold. Healthcare practitioners need to become aware of the warning signs of pediatric septic shock. They should be aware of changes in key vital signs such as age-appropriate heart rate, respiratory rate, and blood pressure. The signs and symptoms include fever, tachycardia, altered mental status, and poor perfusion to extremities noted by cool skin or decreased capillary refill. The occurrence of hypotension would be a late finding.

The ED failed to assess and take action when the child presented with all the symptoms of septic shock.

In this case, the child presented to the ED with a high fever, skin discoloration, and weakness. The background states that they waited five hours before the treating physician determined that her condition required treatment at a facility that could deliver a higher level of care.

The use of treatment protocols and strategies that include the delivery of rapid, aggressive fluid resuscitation and early antibiotic and oxygen administration could have improved her outcome. The ED failed to assess and take action when the child presented with all the symptoms of septic shock. The skin discoloration was a prime indicator that there was a decrease in circulation and should have been further assessed. There was a clear delay in treatment, which resulted in the loss of tissue and ultimately the loss of both feet, her left hand, and part of her right hand.

The $10 million settlement the providers and the patient agreed upon is reasonable. While $10 million is a significant sum, the patient is only 2 years old and will require ongoing care, expensive prosthetics and a great deal of therapy in the future.

SELECT REFERENCES

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2. The Huffington Post. Family of Malyia Jeffers, whose limbs were amputated after long ER wait, settles with Methodist Hospital. Oct. 28, 2011. Accessed at http://huff.to/x5J0dN.
3. Hubert C. Family of Sacramento girl who needed amputations after ER delay is awarded $10 million. T*he Sacramento Bee*. Oct. 28, 2011. Accessed at http://bit.ly/umvCbd. ■

HIPAA Regulatory Alert

Supplement to *Healthcare Risk Management* and *Hospital Access Management*

Data breaches attributed to business associates increase

Covered entities review responsibility for monitoring BAs

Three scenarios that no hospital security or privacy officer wants to experience:

• A hospital billing spreadsheet with details about patient identities and payment information posted on a public homework review web site for over a year (Stanford [CA] Hospital and Clinics);

• A computer maintenance vendor who forgot to enable security controls, which enabled a virus to breach a database and transmit data to an unknown location (Beth Israel Deaconess Medical Center, Boston);

• An unencrypted hard drive stolen from the back seat of an employee's car that affected two health systems in two states (Saint Barnabas Health Care System in New Jersey and Cook County Health & Hospitals System in Chicago).

All of the hospitals affected by these three situations in the past year were not responsible for these data breaches. Their business associates (BAs) were responsible. A study conducted by the Ponemon Institute in Traverse City, MI, shows that 46% of the data breaches that occurred at respondents' organizations were the result of third parties, including BA, mistakes.[1] *(See story on p. 4 for more findings from the study.)*

Although HITECH rules increase the business associate's responsibility for protection of patient data and reporting breaches, these situations raise the question: To what extent should covered entities actively monitor their BA's privacy and security programs?

> ***"Even if the data breach is the result of a business associate's action, the liability for the breach affects the covered entity because it affects the relationship between the covered entity and the individual."***
>
> ***Andrew Martin, Attorney***

"Even if the data breach is the result of a business associate's action, the liability for the breach affects the covered entity because it affects the relationship between the covered entity and the individual," says **Andrew Martin**, an attorney with Scott & Scott, an intellectual and technology law firm in Southlake, TX. Although the business associate agreement should require specific policies and activities related to privacy and security of data, it is important that the covered entity also include a program to monitor the BA's program, he recommends. *(See p. 3 for privacy and security items you should require in a BA agreement.)*

EXECUTIVE SUMMARY

With the number of data breaches that are the result of business associates' actions increasing, covered entities are reviewing their responsibility for monitoring a business associate's (BA's) privacy and security program.

- The BA agreement should clearly define expectations for compliance with HITECH regulations.
- The type of and extent to which a hospital monitors the business associate's program can be determined by the level of risk that exists with that particular relationship.
- Limit the type and amount of protected health information shared with the business associate to limit the risk of a breach.
- Evaluate the business associates methods for sharing, accessing, storing, and destroying data.

If the BA is not in compliance with privacy and security regulations, it might face fines as a result of the breach, Martin points out. If the covered entity can demonstrate that it has taken steps to require and monitor compliance, it is not at risk for non-compliance fines, he adds. The BA and covered entity, however, are liable for other costs related to the breach, including notification costs, he warns.

Before determining how often and in what manner you'll monitor a business associate's privacy and security program as it relates to your data, start with a risk assessment that will help you determine the details you must address in the agreement, suggests **Christine Leyden**, RN, MSN, senior vice president of client services and chief accreditation officer at URAC, a Washington D.C.-based nonprofit accreditation, education, and quality measurement organization. "Understand the flow of protected health information from your organization to the business associate and from the business associate to others," Leyden says. "The risk assessment should also address physical safety of the data."

> ***"Understand the flow of protected health information from your organization to the business associate and from the business associate to others."***
> ***Christine Leyden, RN, MSN***

Although data might be encrypted, or access to electronic data is limited to specific people, be sure you know if there are paper records handled by mail room personnel, fax machines that receive information in unsecured areas, or backup tapes or hard drives that are taken off site by employees, she suggests. By identifying all of the points at which a breach can occur, the covered entity and the business associate can take steps to reduce the risk of a breach and determine how often the covered entity should audit the program, she adds.

The idea of monitoring or auditing business associates' programs can seem overwhelming for hospitals and health systems due to the large number of business associates, admits **Anupam Sahai**, president of eGestalt Technologies, an information security company in Santa Clara, CA. A covered entity can ask some basic questions of every BA and use the responses to prioritize the list of associates that should be monitored, Sahai suggests. Evaluate the amount and type of data the BAs will handle as well as their development of policies that address privacy and security; training programs for employees; and methods of storing, accessing, and destroying data, he suggests. "Business associates should also be asked if they conduct employee background checks, use subcontractors, require subcontractors to meet same privacy and security standards as the business associate, and will agree to an onsite review of their privacy and security processes," Sahai says.

Once a covered entity has reviewed the information about data that business associates handle and the answers to questions about the privacy and security program, a list of the business associates that prioritizes the organizations that represent the highest risk can be developed. "These high risk relationships are the ones that a covered entity should monitor," says Sahai. Because a covered entity should limit data shared with a business associate to only the information needed to perform the job for which they are contracted, organizations that receive limited data or data that will be used for a short, specific timeframe subsequently pose less risk, he points out. Efforts to monitor and audit a BA's privacy and security program should focus upon organizations that receive a high volume of protected patient information on a regular, ongoing basis, he suggests.

Monitoring a business associate can be handled differently for each BA, says Martin. "The review can be yearly or quarterly and can be an onsite evaluation, a paper audit, or an evaluation by a third party evaluator," he says. "It is a good idea to review all business associates' policies and procedures related to privacy and security annually."

A quality management committee also can be used to monitor BAs' performance, suggests Leyden. "The risk assessments of business associate relationships can be reviewed by the committee prior to signing a business associate agreement," she says. "It helps to have an extra set of eyes that can look for vulnerabilities in the process."

The quality management committee also should receive quarterly updates on privacy and security indicators identified by the privacy and security officers of the covered entity, recommends Leyden. In addition to collecting information that is obviously related to privacy and security and business associates, be sure to include items such as patient complaints about not receiving bills, she says.

"When patients don't receive their bills, it may indicate that they are being sent to the wrong address, which means patient information is disclosed to someone who should not have it," Leyden says.

REFERENCE

1. Poneman Institute. 2011 Benchmark Study on Patient Privacy and Data Security. Traverse City, MI; 2011.

Source S

For more information about monitoring business associates, contact:

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• **Anupam Sahai**, President, eGestalt Technologies, 3080 Olcott St., Suite No. 200-B, Santa Clara, CA 95054. Telephone: (408) 689-2586. ■

BA `must haves' for privacy, security

Agreements spell out CEs' expectations

A hospital privacy and security compliance officer knows exactly what policies and programs within the organization are designed to protect patient information (PHI), but what should be expected of a business associate (BA)?

Cyber insurance coverage is one item that all BAs should have, recommends **Andrew Martin**, an attorney with Scott & Scott, an intellectual and technology law firm in Southlake, TX. "The cost is not prohibitive, especially compared to the costs associated with a breach," he says. "If a business associate refuses to obtain cyber insurance coverage to the appropriate limit for the protected health information for which they handle, the covered entity should stop negotiations."

While cyber insurance can help cover the financial aspects of a breach, it is a supplement to, not a replacement for solid privacy and security policies and procedures, Martin says. "A covered entity should also expect the ability to perform a non-intrusive audit of the business associate's policies and technology," he says.

When auditing or monitoring a business associate's program, look for the following:

• Policies that clearly define process for handling PHI.

The policies should define the flow of information, who is responsible for reporting a data breach back to the covered entity, the physical safeguards for information, and the employee training program, says **Christine Leyden**, RN, MSN, senior vice president of client services and chief accreditation officer at URAC, a Washington D.C.-based nonprofit accreditation, education, and quality measurement organization.

• Names of the business associate's privacy and security officials.

"Be sure you have all of their contact information, as well as contact information for the people who serve as their backup in their absence," says Leyden.

• Documentation of employee information.

Look for proof that the BA conducts background checks on new employees and that all new employees receive training on privacy and security policies and procedures, says Leyden.

"In addition to new employee training, all employees should undergo privacy and security training annually," she points out. Business associates should also include compliance with privacy and security protocols as part of an employee's annual evaluation.

• Results of periodic risk assessments.

Make sure your business associates are routinely evaluating their procedures and how they handle or update your data, suggests Leyden.

"Patients change insurance and healthcare organizations merge or change, so your business associates need to make sure they are sending information to the appropriate people," she says.

A risk assessment also should address the type and amount of data shared with the business associate, suggests Martin. Although it is easier to share entire records, the data should be restricted to only what the BA needs, he points out. If too much data is shared, the BA and covered entity should work together to identify what is needed, he adds.

Be sure that the risk assessment addresses such as the use of mobile devices and how data is destroyed when no longer needed, adds Anupam Sahai, president of eGestalt Technologies, an information security company in Santa Clara, CA.

• Use of subcontractors

If your BA will share your data with subcontractors to perform contracted tasks, verify that the BA requires the subcontractors to protect the privacy and security of PHI, says Sahai. ■

Study: Breaches of data up 32%

Sloppy mistakes, unsecured devices cited

The second annual benchmark study by Ponemon Institute in Traverse City, MI, sponsored by ID Experts, finds that the frequency of data breaches in healthcare organizations surveyed has increased by 32%.

Employee negligence is the primary culprit. According to 41% of healthcare organizations surveyed, data breaches involving protected health information (PHI) are caused by sloppy employee mistakes. Half of respondents do nothing to protect mobile devices that are in use in 80% of healthcare organizations.

> ***Based on the experience of the healthcare organizations surveyed, data breaches could be costing the U.S. healthcare industry an estimated $4.2 billion to $8.1 billion annually.***

Based on the experience of the healthcare organizations surveyed, data breaches could be costing the U.S. healthcare industry an estimated $4.2 billion to $8.1 billion annually.

Key findings of the research:

• Data breaches at hospitals and healthcare providers are rising, due to employee mistakes.

— Compromised patient records in benchmarked organizations increased an average of 46%.

— Fifty-five percent of healthcare organizations say they have little or no confidence they are able to detect all privacy incidents.

— Sixty-one percent of organizations are not confident they know where their patient data is physically located.

— Third-party mistakes, including business associates, account for 46% of data breaches reported in the study.

— According to 49% of respondents, lost or stolen computing or data devices are the reason for healthcare data breach incidents.

• Widespread use of unsecured mobile devices is at the core of hospital data breaches.

— More than 80% of healthcare organizations use mobile devices that collect, store, and/or transmit some form of PHI.

— Fifty percent of all respondents do nothing to protect these devices.

• Federal regulations and policies are not reducing data breaches.

— Twenty-two percent of organizations say their budgets are sufficient to minimize data breaches.

— Eighty-three percent of hospitals have clearly written policies and procedures to notify authorities of a data breach, but 57% don't believe their policies are effective.

— The research indicates that the closer the personnel are to the data, such as billing and information technology, the higher the probability of not following policies and procedures.

— Forty-two percent of respondents say administrative personnel in their organizations do not understand the importance of protecting patient data.

• More healthcare providers say data breaches are leading to medical identity theft.

— Twenty-nine percent of respondents say their data breaches led to cases of medical identity theft.

— The number of cases of medical identity theft represents a 26% increase compared to 2010.

— Ninety percent of organizations say data breaches cause harm to patients, yet only 25% offer basic monitoring services following a breach.

— Thirty-five percent of healthcare breaches are discovered by a patient complaint.

• Data breaches are likely to increase, given lack of resources.

— Seventy-three percent of respondents reported lacking sufficient resources to prevent or detect unauthorized patient data access, loss, or theft.

— Fifty-three percent of organizations cite lack of budget as their biggest weakness in preventing data breaches.

— Sixty-nine percent of organizations say that they have little or no confidence in business associates ability to secure patient data.

For a free copy of the *2011 Benchmark Study on Patient Privacy and Data Security*, go to http: www2.idexpertscorp.com/ponemon-study-2011. ■