Healthcare RISK MANAGEMENT

September 2012 | Vol. 34, No. 9 Pages 97-108

Attorneys debate whether ACA will lead to more or fewer malpractice cases

Will increase in coverage lead to more patient care, thus more lawsuits?

Risk managers and malpractice defense and plaintiffs' attorneys are divided over whether the implementation of the Affordable Care Act (ACA) will have a direct impact on the number of malpractice cases. Some say the future will bring a frightening increase in lawsuits because more people — many of them not cooperative in their own healthcare — will enter the system. Others, however, say the ACA could result in a decrease in malpractice allegations.

Malpractice claims might increase if the ACA creates unrealistic expectations on the part of patients, says **James Ron Kennedy**, MHA, ARM, AIC, vice president for risk management and patient safety at Louisiana Medical Mutual Insurance Co. (LAMMICO) in Metairie. "Expectations of equal access, equal quality, and increased satisfaction at little or no cost will set the stage for unhappy customers," Kennedy says. "When an untoward medical event occurs, even known risks previously discussed with the patient, the probability of a claim will likely increase dramatically."

> *"... I worry about the influx of 20-30 million users, as has been predicted, into the system."*

Some attorneys worry that the insurance coverage required by the ACA will result in more people seeking healthcare and that the sheer increase in patients will result in more malpractice claims. If the rate of malpractice claims per patient stayed the same, the number inevitably would rise, says **James A. Comodeca**, JD, a partner with the law firm of Dinsmore in Cincinnati, OH.

The increase in patients also could emphasize the healthcare system and jeopardize patient safety, he says. "While safety and the provision of quality health services will remain the top priority of all healthcare providers and organizations, I worry about the influx of 20-30 million users, as has been predicted, into the system," he says. "Just from a statistical

INSIDE

Enclosed:

Legal Review & Commentary: Excessively strong birth contractions lead to $3.75 million settlement

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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. **Radha V. Bachman**, guest columnist, has no relationships to disclose.

perspective, this influx of users can lead to issues that can result in increased claims."

James A. Hoover, JD, a partner in the Birmingham, AL, office of the law firm Burr Forman, says the risk is increased by "the law of large numbers." If you have one patient, the risk of being sued for malpractice is lower than if you have 100 patients, Hoover says. "I think probably there will be more claims because there will be more people getting healthcare," he says. "There are more factors involved, of course, so it's not really that simple. But I think in the end that the number of people will trump."

Improving quality and patient safety can counter some of that increase in malpractice claims, Hoover says, but there is a limit to how much you can fight the math. "If you have 100 patients and typically 10% will file a medical malpractice claim, that's 10 claims," Hoover explains. "If you work and reduce your percentage to 5% through improved quality of care, safety, and communication, when your number of patients rises to 300, you're still looking at more malpractice claims than before."

Executive Summary

The Affordable Care Act (ACA) might lead to an increase in malpractice cases, according to some trial attorneys. Others, however, say they expect no increase or possibly even a decrease in malpractice allegations.

- ✦ One theory holds that the ACA will bring more people into the health care system, inevitably leading to more lawsuits.
- ✦ Others contend that those patients already are in the system and having insurance coverage will not increase the number of patients.
- ✦ A decrease in malpractice allegations is possible if the ACA leads to more preventative care and therefore fewer serious illnesses.

If any increase, how much?

Kennedy agrees that the increase in patient care could lead to more claims, but he expects a smaller effect than some attorneys predict. *(See the story on p. 99 for speculation on how the ACA could cause a decrease in claims.)*

"Some increase in medical malpractice exposure will naturally occur as a result of the increase in exposure units. But this should be a relatively small increase because of the fact that poverty level patients already had coverage available via Medicaid and all uninsured patients already had access to emergent care via EMTALA," Kennedy says. "In addition, many of the 'new' people covered will come from a healthy population of young people who, previous to ACA, had elected to forgo health insurance coverage."

The number of new patients introduced to the healthcare system might be overestimated, says **Kevin Troutman**, JD, an attorney with the law firm of Fisher and Phillips in Houston, TX. The law already prohib-

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

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

AHC Media is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

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

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

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Editorial Questions

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its hospitals from turning away most emergency cases, so it is not as though these folks have had no access to care, he says. "If anything, they may not have been receiving adequate preventive care. This is significant because women who deliver babies after receiving little or no prenatal care tend to have more complications and bring more malpractice claims," Troutman says. "Because hospitals are already seeing emergency cases involving patients who have not been receiving preventive or maintenance care, malpractice claims from this area seem less likely to increase."

Still, Troutman acknowledges that increases in patient encounters might arise in the form of those who will have greater access to screenings or preventive care, if the newly insured use those services. "Many won't, but a significant number will," he says. "Statistically, such increases in volume are bound to increase the volume of malpractice claims."

Increase is logical, but not certain

The ACA will stress a healthcare system that already is dealing with staff shortages and budget cuts, Comodeca points out. The influx of patients might require hiring additional physicians and staff to maintain quality care, he says. *(See the story on p. 100 for advice on how risk managers can prepare for ACA implementation.)*

"Until providers can better understand new staffing needs, there exists a risk of being understaffed and, as we know, understaffing can lead to potential problems," Comodeca says. "There are studies that have shown a significant risk factor for claims arise from patient dissatisfaction, from a provider simply not spending enough time with a patient and establishing a bond. With the number of new users in the system and the looming physician shortage, the combination is concerning."

"More bad outcomes mean more claims and potential lawsuits, so strictly by logic, one could rightly assume there will be a greater number of claims."

The larger pool of potential plaintiffs also might include patients who are sicker and less compliant than the current patient population, says **Martin C. Foster**, JD, a partner with the law firm of Foster & Eldridge in Cambridge, MA. "You're going to have more bad outcomes," Foster says. "More bad outcomes mean more claims and potential lawsuits, so strictly by logic, one could rightly assume there will be a greater number of claims."

However, Foster cautions that, although logical, such an increase might never appear. He points to similar fears in 2008 when Medicare announced it would not reimburse for costs associated with "never events" and certain hospital-acquired conditions. Many risk managers and defense attorneys feared that the number of malpractice claims would increase because Medicare's written refusal to pay could be used as proof of malpractice.

"But that hasn't manifested itself yet," Foster says. "There are a number of possible reasons why, but the point is that we don't know until everything plays out how the many factors will come together and affect claims. It's too soon to know about the effect from the ACA, but my guess is no, we're not going to see a considerable number of new claims."

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Medical malpractice claims could decrease under ACA

It is possible that the increased preventative care provided by the Affordable Care Act (ACA) could even reduce the number of patients seeking emergent or late-term medical care, thereby reducing medical malpractice claims, but that situation is far from certain, says **James Ron Kennedy**, MHA, ARM, AIC, vice president for risk management and patient safety at Louisiana Medical Mutual Insurance Co. (LAMMICO) in Metairie.

"The promise of global decrease in costs as a result of preventative care, in the medical malpractice arena, just like the healthcare arena, has yet to be empirically validated," Kennedy says. "However, I am of the opinion that it will likely be an unfulfilled promise."

The ACA is likely to change the nature of medical malpractice claims even if it does not affect the number of claims filed, Kennedy says. As healthcare moves toward the accountable care organization (ACO) model, the possibility of entity exposure

becomes more likely, he says. Liability that previously might have fallen on an individual caregiver can be applied to the entities participating in the ACO because, by their nature, ACOs involve integrated care, he says.

In addition to the ACO model, the ACA requires nonprofit hospitals to perform annual community needs assessments, develop a written implementation plan to address community health needs, or declare why they are not addressing identified needs. "The assessment and implementation plan must be publically available — fertile ground for consumer activists and plaintiff attorneys," Kennedy says. "This is a developing corporate liability exposure for the nonprofit hospitals. Add to this the potential of anti-trust allegations, all of which could be used by plaintiff attorneys to leverage a quick settlement even with an otherwise weak medical malpractice claim."

Another possible positive effect for hospitals is fewer emergency department (ED) visits for uninsured patients, notes **Robert Allen**, senior vice president for medical professional liability with Torus, an insurer based in Jersey City, NJ. The many uninsured patients currently seeking care in the ED should be able to seek more appropriate care when they are insured, he says, which will take pressure off of overworked EDs. That situation, in turn, could improve ED care and result in fewer malpractice claims.

Additionally, those previously uninsured patients might seek help earlier than when their only option was the ED, which would result in less critical care, Allen says. That change also could result in fewer claims, he says. "I'm actually of the opinion that ED activity will actually go down," Allen says. "You won't see the child with the mild fever coming through the ED, so you'll get some relief there."

The ACA also could change the way damages are awarded in malpractice claims, says **James A. Farrell**, JD, a partner with the law firm of Shutts & Bowen in West Palm Beach, FL, and formerly general counsel for a hospital.

"Plaintiffs have used the future cost of care as a way to pump up the value of the case significantly, and if everybody has health insurance, why are there any medical damages?" Farrell asks. "At most the medical damages should be limited to the cost of the premium to continue their coverage."

SOURCES

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What risk managers can do now to prepare for ACA impact

The key to survival in the post-Affordable Care Act (ACA) world is to make sure the organization has a vigorous corporate enterprise risk management process, says **James Ron Kennedy**, MHA, ARM, AIC, vice president for risk management and patient safety at Louisiana Medical Mutual Insurance Co. (LAMMICO) in Metairie.

New risks must be identified and assessed, their potential severity scored, and appropriate risk management interventions initiated and monitored, he says.

"The corporate risk manager and corporate counsel should actively engage their board of directors in risk mapping and provide reports regarding the impact of risk management interventions," Kennedy suggests.

Analyzing and updating staffing will be critical in meeting the requirements of the ACA, says **James A. Comodeca**, JD, a partner with the law firm of Dinsmore in Cincinnati, OH. Hospitals and clinics must begin immediately to recruit and retain physicians and other providers, and the risk manager must ensure that standards are not lowered or corners cut in the vetting process, he says.

Unfortunately, hospitals simultaneously will be dealing with increasing budget pressures, notes **Kevin Troutman**, JD, an attorney with the law firm of Fisher and Phillips in Houston, TX

"These budget pressures will make it more difficult to acquire new equipment, implement new systems, and provide training as frequently as the hospitals would prefer," Troutman says. "Nevertheless, hospitals should prepare by anticipating some increases in patient volumes and re-emphasizing effective documentation, including medical histories, especially for patients who are new to their healthcare systems." ✦

Long-term care liability loss rates and severity at a high

Long-term care liability loss rates and claim severity have reached an eight-year high and are expected to grow steadily in 2013 against a backdrop of healthcare provider budget constraints and uncertainty about healthcare reform, according to a new report from Aon Risk Solutions, the global risk management business of Aon.

Aon Global Risk Consulting released its "2012 Long Term Care

General Liability and Professional Liability Actuarial Analysis" in partnership with the American Health Care Association (AHCA) in Washington, DC.

Since 2005, the annual loss rate (liability costs relative to occupied long term care beds) has grown from $1,040 to a projected $1,480 in 2012 and is expected to increase again in 2013 to $1,540, according to the report based on 19,500 individual claims from long-term care facilities. Claim severity (claim size) also has grown from a low of $109,000 per claim in 2005 to a projected $168,000 per claim in 2012 and $175,000 in 2013. Claim severity and loss rates have been growing consistently since 2009 at a rate of 4% annually, even though claim frequency has been stable since 2008, Gov. **Mark Parkinson**, president and CEO of AHCA, said in a statement released with the report.

"Long-term care and skilled nursing centers strive to provide quality care each day, but they also must find ways to cope with the ever-increasing cost of doing business and multiple rounds of funding reductions at the state and federal level," Parkinson said. "This report underscores the need to continue to utilize tools like voluntary arbitration agreements, a cost-effective option for long term care providers and their residents to resolve legal disputes."

Long-term care providers faced high loss rates in the late 1990s and early 2000s, Parkinson said. Over the years, they answered this challenge by reinvesting in patient safety, developing liability defenses, advocating for limits on tort damages, and implementing arbitration. While these efforts helped providers control the growth of liability costs, reductions in Medicare reimbursement rates and healthcare reform have had an impact on long-term care provider revenue and budget, says **Christian Coleianne**, associate director and actuary at Aon Global Risk Consulting in Washington, DC.

"With reduced revenue, providers may have difficulties funding expansion and improvements, maintaining facilities, and hiring and training qualified caregivers," Coleianne says. "These competing priorities have the potential to impact liability costs. By providing access to this invaluable data, we are enhancing our clients' ability to better understand and more effectively manage these risks."

The Affordable Care Act (ACA) encourages closer coordination of care with additional healthcare providers with the expectation of reduced costs, Coleianne notes. Interaction between long-term care providers and dependence on other healthcare providers might increase exposure as the new system is expected to operate at a lower cost, he says.

State laws and the state judiciary have a tremendous influence on liability costs, Coleianne says. As a result, state loss rates vary considerably. For example, the report notes that tort limits on awards are constitutionally prohibited in Kentucky, which has the highest loss rate in this study ($5,120 per bed for 2012). In contrast, Texas amended its constitution to protect its tort limits and has the lowest projected loss rate ($320 per bed for 2012).

Kentucky's loss rate has increased dramatically over the past eight years. The 2012 projected loss rate of $5,120 is the highest projection of any of the profiled states. Kentucky's constitution prevents limitations on tort awards, which makes the state an attractive venue for tort, the report says.

Providers become more willing to settle for higher amounts to avoid trials when the potential for unlimited judgments exists, according to the report. The projected 2012 claim frequency of 1.64%, which has been increasing since 2007, is the highest of the profiled states. Claim severity in Kentucky, projected at $313,000 for 2012, is twice that of the overall average claim severity in this study and the second highest of the profiled states.

These are some other state results:

• West Virginia's loss rate exhibits a strong upward trend. The 2012 forecast of $4,430 per occupied bed is the second highest of the profiled states. West Virginia has the third highest claim frequency among the profiled states, with a 2012 forecast of 1.36%. The state has the highest projected claim severity at $326,000, showing persistent growth since 2005.

• Tennessee's loss rate has increased in recent years from $1,560 in 2008 to a projected $3,380 in 2012. Tort limits recently were enacted in the state, and Aon's study shows an increase in claim frequency as claimants move to assert their claims before the limits become effective. This pattern is typically followed by a decrease in claim frequency as the caps reduce the upper bound

Executive Summary

Loss rates and claims severity are at an eight-year high. They are expect to continue rising in 2013.

- ✦ The annual loss rate is projected at $1,480 in 2012.
- ✦ State laws and local judiciaries have a strong effect on liability costs.
- ✦ Liability loss rates and severity can determine whether long-term care providers operate in certain states.

of claim sizes and lessen the incentive to pursue claims. Claim frequency in Tennessee is projected at 1.13% in 2012. Claim severity drives Tennessee's loss rates relative to other states. At $300,000, Tennessee's 2012 claim severity forecast is third highest among the profiled states.

• Texas's loss rate, projected at $320 per bed in 2012, is the lowest loss rate of the profiled states, as are its claim frequency and claim severity. Texas enacted tort reform in 2003 and shortly thereafter saw remarkable reductions in loss rates, from an estimated $5,500 per occupied bed before the tort reform to under $1,000 in 2004. The 2012 claim frequency forecast is 0.43%, and the 2012 claim severity forecast is $73,000.

The free full report can be downloaded at http://tinyurl.com/bs4sedv. ✦

IT security requires more than producing a long policy

IT security is becoming more important in healthcare every day, but the old ways of educating employees and physicians on this topic are insufficient, say leading IT security experts. Risk managers should consider entirely revamping the way IT security is taught and monitored, they say.

Unless IT security is a core element of someone's job, it is not necessarily considered in their ongoing development needs, says **Dominic Saunders**, senior vice president of the NETconsent business unit at the London office of Cryptzone, a technical security company based in Gothenburg, Sweden. All too often employees receive merely an initial presentation from the IT department when they start and are expected to remember it, keep up to speed with changes, and adhere to ever-changing IT security policies and procedures.

"Without an ongoing systematic and proactive user-awareness program, a strong security posture is in jeopardy," Saunders says. "There is no cure for stupidity or genuine human error, but you can educate your workforce to help them make the right decisions and avoid unnecessary mistakes. What are you doing to make sure your workforce is security aware?"

Eileen Buck, MD, an IT security specialist with the Cogo Agency in London, is working with IT security in the National Health Service (NHS) and says the IT security concerns are nearly identical in American hospitals. "We find that hospitals do the basics with IT security, but they cannot keep up with the new information about security risks and prevention," Buck says. "The nurses on the ground are running around trying to take care of patients, and the ones at the top sometimes think they're too important to be told this. So the e-mails don't get read, and the new information is lost."

Most commonly, the biggest failing in a healthcare IT policy is that it is written to satisfy regulators and not to actually educate staff about protecting data security, Buck says. "When I ask what is in their policy, the hospital always tells me 'it has everything in it, everything we're supposed to have,'" Buck says. "That makes me wince. That means that it's likely to be 40 pages long, it covers everything, and people are asleep by page three. They don't understand it, and there is no focus on specific essentials."

Most IT security policy and procedure manuals are written in a language to impress the regulators, lawyers, and auditors who will be checking its existence, Saunders says. "The average employee doesn't stand a chance," he says.

Instead, employees should be educated about the specific areas in which they work, under the umbrella of the overall IT policy, Buck says. Provide examples of situations in which they might actually face a security issue and explain how it should be handled. The goal, Buck emphasizes, is to actually educate the employee about IT security rather than being able to say you gave the employee the entire IT policy and therefore any violation is the employee's fault, not yours.

"Auditors are not impressed anymore with looking at a huge policy," Buck says. "They want to see that the risks and procedures are so clear that the employee should understand them."

Specificity in IT training also can eliminate the folly of forcing employees to agree to a policy with which they cannot comply. For example, most IT policies forbid employees from downloading software to their work computers and require everyone to agree to that provision along with the rest of the entire IT policy. "And then the IT professionals violate that agreement on the first day, because they have to download software to do their jobs," Buck explains. "When you force people to agree to something that they can't do, you're telling them that the policy is not really intended to provide security but is there for another reason."

Executive Summary

Hospitals might be falling short on IT security because they are more focused on satisfying regulators and attorneys rather than actually educating employees. Chances are good that your policy and education need to be revamped.

- ✦ Strive for a policy that explains risks and requirements in plain English.
- ✦ Educate staff members about IT security issues that apply specifically to their work, not necessarily the entire IT policy.
- ✦ Make the learning process interactive, and use real world examples.

Employees should receive a copy of the written materials, but most actually learn better and faster from practical experience, Saunders says. *(See the story below for more on how to improve IT security.)*

"Staff need multi-sensory input if they're going to fully appreciate relevant policies and procedures and understand exactly what their responsibilities are," he says. "If you expect them to play their part in protecting the organization, don't they deserve to be shown how to do it? Online videos and interactive training that can be viewed at their convenience do the job very well."

Risk managers also must watch for the creeping emergence of a systematic disregard for IT security, cautions **Beverley Stonehouse**, UK marketing manager for Cryptzone in London. If an IT policy is poorly developed and does not take into consideration the practical needs of employees, or if they are not properly educated on the policy, employees might dismiss it as unworkable. "You can get nurses and others who say among themselves that they know what the policy is, but if they follow it they'll never get their jobs done," Stonehouse says. "That can be devastating to the effectiveness of your security program."

An employee's ability to take appropriate actions if, and when, a security incident arises is paramount, Saunders says. Think about how anyone in your organization would react when discovering a breach. If it were something they'd done that had caused the problem, would they put their hand up and come clean, or try to cover it up?

It is imperative to make sure employees understand the risks of leaving any security breach unreported and are not scared of reporting potential issues, he says. Employees also respond better to seeing that right behavior is expected and it is what everyone else does, rather than simply being told that is what employees 'have to do,' Saunders says.

"Every single person in your organization needs to understand the part they play in defending your organization and keeping it secure," Saunders says. "Don't just assume that because you've got written policies and procedures to follow that the people in your organization are security aware."

SOURCES

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Seven steps to improving IT security among staff

If you're serious about creating awareness among your workforce to the security risks that healthcare providers face, **Dominic Saunders**, senior vice president of the NETconsent business unit at the London office of Cryptzone, a technical security company based in Gothenburg, Sweden, offers this seven-point action plan:

- **Action 1: Rewrite your IT security policies and procedures.** Use a language that actually will be understood and not just impress an auditor. Spell out the risks the organization faces for non-compliance.
- **Action 2: Consider changing the way you introduce security as part of the induction process.** Smaller, more manageable documents are easier not only for the recipient to grasp, but also for the organization to review and update. In addition, by drip feeding the information, people are more likely to find time to read it and build a deeper awareness of security issues while reinforcing elementary security fundamentals.
- **Action 3: Review and update processes regularly, and that includes regularly reminding your colleagues.** Just because John in accounts had a security briefing when he joined the company 10 years ago doesn't mean he knows what the risks are today. Educate staff regularly to make sure they still understand what's expected of them and especially when things change.
- **Action 4: Consider using an automated system to deliver policies and associated documentation directly to employees at their workstations.** This makes the whole process manageable for you both.
- **Action 5: Introduce testing, either for all or a proportion of users.** This will help to identify where policies aren't understood so they can be rewritten to make sure everyone knows what they are doing and, as importantly, why. You'll also be able to identify weaknesses and therefore focus training energies to the necessary areas.
- **Action 6: Get your employees to agree in writing to key policies so you know that they're onboard.** As part of the process, include the consequences if they break the rules. That said, make sure that they understand that genuine errors are expected and should be reported, not ignored or covered up.
- **Action 7: Take action against offenders.** If people see policies being enforced consistently at all levels within an organization and where appropriate disciplinary action is taken against those who willfully neglect corporate rules, people are more likely to take notice of security information. When employees realize the circumstances and the consequences of security policy violations for them as well as for the organization, it nudges them to choose the right course of action and perhaps be more prepared to encourage others to conform to standards of behavior within the acceptable governance framework. ✦

Hospital changes procedures after child's death

NYU Langone Medical Center, part of New York University, has changed its procedures for handling potential cases of septic shock after the death of a 12-year-old boy who was misdiagnosed.

Rory Staunton was sent home from the hospital's emergency department with a diagnosis of viral gastroenteritis, but three hours later a laboratory test at the hospital showed that his blood had extraordinarily high levels of cells associated with bacterial infections, according to information confirmed by the hospital. He subsequently went into shock and experienced organ failure. He died three days later, on April 1.

His parents issued a statement saying they were not told about the lab results and were unaware of how seriously ill their son was, having been assured that he was suffering from a typical stomach bug. In fact he was suffering septic shock brought on by an accident few days earlier when he cut his arm while diving for a basketball at his school gym.

Lisa Greiner, a spokeswoman for the hospital says that emergency physicians and nurses would be "immediately notified of certain lab results suggestive of serious infection, such as elevated band counts." The child's bands, a type of white blood cell, were nearly five times as high as a normal level. *(See the story below for information on how hospitals are addressing septic shock.)*

The hospital has developed a new checklist to ensure that a doctor and nurse have conducted a final review of all critical lab results and patient vital signs before a patient leaves, according to a hospital statement.

"Following our review of the events that led to this tragic loss, we have implemented corrective actions and are in the process of designing additional care processes to address the delivery of care to our ED patients," the statement says. "We developed a new ED Discharge Checklist to make certain that the treating physician and nurse conduct a final review of all critical lab results and patient vital signs prior to the patient being discharged. Additionally, we are designing a process by which the attending ED physician is immediately notified of certain lab test results suggestive of serious infection, such as elevated band counts.

"In the unlikely occurrence that a clinically relevant test is only available after the patient is discharged from the ED, the patient will be called and the information will be shared with referring physician. Keeping our patients safe is our first priority, and we want to prevent this situation from happening again." ✦

Executive Summary

A New York City hospital has altered its discharge policy for possible cases of septic shock and other serious infections. The move was in response to the death of a 12-year-old boy.

- ✦ The child was discharged with a diagnosis of stomach flu when had septic shock.
- ✦ Lab reports suggested septic shock, but they were not reviewed until after discharge.
- ✦ The hospital now uses a checklist to ensure a final review of lab results.

Hospitals trying for better diagnosis of sepsis in kids

The Greater New York Hospital Association (GNYHA) is leading a consortium of 55 hospitals in developing tactics for early diagnosis of sepsis. The association is focusing on pediatric patients because identifying and treating sepsis can be especially challenging with that population. *(More on the association's sepsis effort is available online at http://www.gnyha.org/6653/Default.aspx. Registration is required but free.)*

Sepsis is the 10th leading cause of death in the United States, the GNYHA reports. With an estimated 750,000 cases annually and a nearly 40% mortality rate, severe sepsis is also one of the most common causes, and possibly the number one cause, of death in hospital critical care units. In addition to its high mortality rate, severe sepsis also bears a huge price tag, with a national estimate at $16.7 billion annually.

To address this challenge in the New York metropolitan area, GNYHA launched a new initiative in 2010 focused on the early identification and treatment of sepsis at hospitals. The initiative is STOP Sepsis Collaborative, with STOP being an acronym for Strengthening Treatment and Outcomes for Patients. The central goal of the initiative is to reduce mortality in patients with severe sepsis and septic shock by implementing a protocol-based approach to case identification and rapid treatment. This effort will

entail improving communication and patient flow between the emergency department and intensive care units (ICUs).

Critical care and emergency medicine leaders from throughout the region spent months developing model protocols, checklists, and data collection tools for the initiative. Fifty-six hospitals from throughout the region are participating in the STOP Sepsis Collaborative. ✦

Hospital reduces med errors to 0.1 per 1,000

Operating a small hospital doesn't mean you can't think big. Ellenville Regional Hospital (ERH), a 25-bed rural hospital in Wawarsing, NY, is enjoying success with a medication reconciliation and patient safety project that would be the envy of any large teaching institution by reducing medication-related events to a very low 0.1 occurrences per 1,000 doses dispensed.

As a result, Physicians' Reciprocal Insurers (PRI), the second largest medical malpractice insurer in New York state, presented Ellenville Regional Hospital with its 2012 Best Practices in Risk Management and Patient Safety Award.

The program was born in 2008, says **Michael Stearns**, RPh, director of pharmacy. Stearns and others at the hospital had been eager to address medication safety issues, particularly the number of admissions due to unsafe medication practices, after the 2001 "To Err is Human" report.

"There were therapeutic duplications of medicine, overdoses of therapeutic medicines, underdoses, and things like that. They were all preventable," Stearns says. "So we thought if we implemented some education protocols and sat down to really spend time with people, this could really be beneficial to our patients."

Along with Stearns, **Ashima Butler**, CPMSM, CPCS, vice president of quality, compliance, and medical staff management, was worried about patient safety being compromised by medication errors. Those errors included those brought on by patients not fully complying with or understanding their medication use. "Being a small hospital, we weren't having a significant amount of medication errors but enough that we really started to worry about where the gap was, why our staff were missing some key information and not getting the right medication to the patients," Butler says.

> *Stearns found that even meeting with a patient just once could produce significant improvement in medication compliance and safety.*

The resulting program involves having Stearns, the hospital's only pharmacist, see patients by appointment to discuss their medications. He also visits inpatients in the hospital. In addition, the program was taken outside the hospital to the hospital's senior living center and family physician practice. "I've seen over 1,500 patients, and they all walked away with more knowledge than they came with," Stearns says.

The number of medications was a first concern, but Stearns also considers issues such as how many doses per day the person was supposed to take of all the medications. "We found that some people were supposed to take 30, 40, 50 doses of their medications a day, and that was not feasible," Stearns says. "We redesigned their programs to make them more achievable. Patients became more aware of their healthcare and were able to interact more effectively with their doctors and nurses."

Patients often were counseled multiple times, but Stearns found that even meeting with a patient just once could produce significant improvement in medication compliance and safety. In what he refers to as "getting the pharmacist out of the pharmacy," Stearns began interacting more directly with the physicians and staff during patient care, visiting to perform medication reconciliation at the bedside. "The doctor prescribed the medication, but instead of just hav-

Executive Summary

A small, rural hospital has used a medication reconciliation and patient safety project to reduce medication errors that reach the patient to 0.1 per 1,000 doses dispensed.

- ✦ A medication reconciliation program sought to improve patient education and avoid dangerous drug combinations.
- ✦ The hospital pharmacist meets with individual patients to discuss their medications.
- ✦ Medication records in the hospital are scrutinized daily for any possible gaps.

ing it delivered, he would sit with the patient and discuss what it was, how it worked, what kind of reaction they might have, how and when to take it," Butler explains. "Mike also started reviewing the MARS [medication administration records] on a daily basis to make sure nursing wasn't leaving any gaps, like a missed dose."

The effort has changed the role of the hospital's pharmacist from dispensing to consulting, says **Steven L. Kelley**, FACHE, president and CEO.

"The patient is working with the patient and the provider to make sure we have the best possible medication regimen," Kelly says. "In the future I see the pharmacist becoming more the decision-maker, much more so than now, in recommending which medications to use. The provider will be focused on diagnosing and recommending treatment, and the pharmacist will be much more active rather than just dispensing on someone else's order."

SOURCES

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- **Steven L. Kelley**, FACHE, President and CEO, Ellenville Regional Hospital. Telephone: (845) 647-6400. Email: skelley@ellenvilleregional.org.
- **Michael Stearns**, RPh, Director of Pharmacy, Ellenville Regional Hospital. Telephone: (845) 210-3037. Email: mstearns@ellenvilleregional.org. ✦

Medmal payments lowest ever in 2011, advocacy group says

Medical malpractice payments in 2011 were at their lowest level on record by almost any measure, according to a report by the consumer advocacy group Public Citizen in Washington, DC.

In the report, "Malpractice Payments Sunk to Record Low in 2011," Public Citizen analyzed data from the federal National Practitioner Data Bank (NPDB), which tracks malpractice payments on behalf of doctors. The report found that the number of medical payments and the inflation-adjusted value of such payments were at their lowest levels since 1991, the earliest full year for which such data is available. *(The full report is available online at http://www.citizen.org/npdb-report-2012.)*

The findings dispute the arguments of some physician groups and policymakers that high malpractice claim costs are a key driver in the rise of healthcare costs, says Taylor Lincoln, research director of Public Citizen's Congress Watch division and author of the report. "Instead, malpractice victims and ordinary patients end up absorbing significant costs for uncompensated medical errors," Lincoln says.

The report found that in 2011:

- The number of malpractice payments on behalf of doctors (9,758 payments) was the lowest on record, having fallen for the eighth consecutive year.
- The inflation-adjusted value of payments made on behalf of doctors ($3.2 billion) was the lowest on record. In actual dollars, payments have fallen for eight straight years and are at their lowest level since 1998.
- The average size of medical malpractice payments (about $327,000) declined from previous years.
- Four-fifths of medical malpractice awards compensated for death, catastrophic harm, or serious permanent injuries.
- Medical malpractice payments' share of the nation's health care cost was the lowest on record (0.12% of all national health care costs).
- The total costs for medical malpractice litigation for doctors and hospitals (as measured by liability insurance premiums paid) have fallen to their lowest level in two decades. They amounted to 0.36% of national health care expenditures in 2010, the most recent year for which such data is available. ✦

Few adverse events reported to state systems

Many adverse events in hospitals are never reported to state adverse event reporting systems, according to a recent report by the Department of Health and Human Services Office of Inspector General (HHS OIG).

Previous OIG work found that an estimated 27% of Medicare beneficiaries hospitalized in October 2008 experienced harm from medical care, either serious adverse events (defined as events resulting in prolonged hospitalization, permanent disability, life-sustaining intervention, or death) or temporary harm events (defined as events requiring intervention but not

resulting in lasting harm).

To determine this rate of adverse and temporary harm events (referred to collectively as events), OIG investigators examined medical records for a nationally representative sample of 780 hospitalized Medicare beneficiaries in October 2008. Prior OIG work also found that in 2008, about half of states operated adverse event reporting systems to monitor the occurrence of events in hospitals.

Typically, these states required hospitals to report only specific types of events and analyzed the events in aggregate. The investigators found that an estimated 60% of adverse and temporary harm events nationally occurred at hospitals in states with reporting systems, yet only an estimated 12% of events nationally met state requirements for reporting.

"We also found that hospitals reported only 1% of events. Most of the events that states required to be reported but that hospitals did not report were not identified by internal hospital incident reporting systems," they wrote. "This suggests that low reporting to state systems is more likely the result of hospital failure to identify events than of hospitals' neglecting to report known events."

The full report is available online at http://tinyurl.com/cu6voo2. ✦

ASHRM joins the FDA in surgical fire prevention effort

The American Society for Healthcare Risk Management (ASHRM) in Chicago is partnering with the Food and Drug Administration (FDA) to help prevent surgical fires. The groups are offering fire prevention resources to hospitals.

An estimated 550 to 650 surgical fires occur in the United States each year, the FDA reports. Professionals involved with the initiative recommend that healthcare organizations conduct a fire risk assessment at the beginning of each procedure. The procedures at highest risk of fires include head, neck, or upper chest surgeries since they involve an ignition source, delivery of supplemental oxygen, and the operation of the ignition source near the oxygen.

Communication among the surgical team is critical, the groups advise. In particular, the anesthesia professional must communicate with the surgeon controlling the ignition source and the clinician applying the skin preparation agent.

For more information on the Surgical Fires Prevention Initiative, go to http://tinyurl.com/6sq3l6s. ✦

COMING IN FUTURE MONTHS

- ✦ Restricting early cesarean sections
- ✦ Promoting patient safety to staff
- ✦ Hospitals forgoing liability insurance
- ✦ Fall prevention in the ED

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 healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

CNE INSTRUCTIONS

Nurses participate in this CNE 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 QUESTIONS

1. What is one reason James Ron Kennedy, MHA, ARM, AIC, vice president for risk management and patient safety at Louisiana Medical Mutual Insurance Co. (LAMMICO), says the Affordable Care Act (ACA) could lead to a rise in malpractice claims?

A. Expectations of equal access, equal quality, and increased satisfaction at little or no cost will set the stage for unhappy customers.

B. The ACA relaxes the standards under which a patient may sue for malpractice.

C. The ACA sharply increases the potential payout on malpractice claims.

D. Physicians will not be obligated to some current patient safety practices.

2. Why does Robert Allen, senior vice president for medical professional liability with Torus say the ACA could result in fewer malpractice claims?

A. The ACA imposes restrictions on the ability to sue in some of the most common types of claims.

B. The many uninsured patients currently seeking care in the ED should be able to seek more appropriate care when they are insured, which will take pressure off of overworked EDs.

C. The ACA imposes caps on some medical malpractice claims.

D. Patients will be less inclined to sue when they have insurance because they not feel excluded from the system.

3. According to Aon Global Risk Consulting's "2012 Long Term Care General Liability and Professional Liability Actuarial Analysis," which of the following is true of long-term care liability loss rates and claim severity?

A. They have reached an eight-year high.

B. They have reached an eight-year low.

C. They have remained steady for eight years.

D. They have remained steady for 18 years.

4. What does Eileen Buck, MD, an IT security specialist with the Cogo Agency, say is most commonly the biggest failing in a healthcare IT policy?

A. The policy leaves out some material that regulators want to see.

B. The policy is too brief and concise.

C. The policy is written for individual departments or roles in the hospital instead of providing the same blanket information to all employees.

D. The policy is written to satisfy regulators and not to actually educate staff about protecting data security.

Healthcare Risk Management

Confidential Salary Survey

This confidential salary survey is being conducted to gather information for a special report later in the year. Watch in coming months for your issue detailing the results of this survey and the overall state of employment in your field.

Instructions: Select your answers by filling in the appropriate bubbles completely. Please answer each question as accurately as possible. If you are unsure of how to answer any question, use your best judgment. Your responses willbe strictly confidential. Please do not put your name or any other identifying information on this survey form.

1. What is your current title?

- ◯ A. Director/CEO
- ◯ B. Administrator
- ◯ C. Ambulatory Surgery Mnaager
- ◯ D. Nurse Manager
- ◯ E. Other

2. What is your annual gross income from your primary healthcare position?

- ◯ A.< $30,000
- ◯ B. $30,000 - $39,999
- ◯ C. $40,000 - $49,999
- ◯ D. $50,000 - $59,999
- ◯ E. $60,000 - $69,999
- ◯ F. $70,000 - $79,999
- ◯ G. $80,000 - $89,999
- ◯ H. $90,000 - $99,999
- ◯ I. $100,000 - $129,999
- ◯ J. $130,000 or more

3. Where is your facility located?

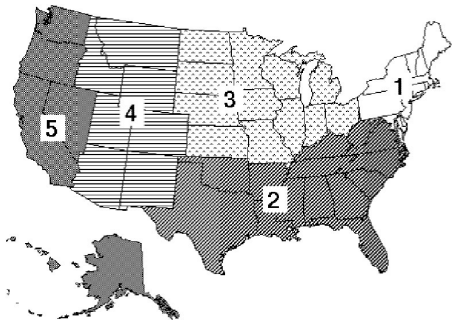
- ◯ A. Urban area
- ◯ B. Suburban area
- ◯ C. Medium-sized city
- ◯ D. Rural area

4. In the last year, how has your salary changed?

- ◯ A. Salary decreased
- ◯ B. No change
- ◯ C. 1% - 3% increase
- ◯ D. 4% - 6% increase
- ◯ E. 7% - 10% increase
- ◯ F. 11% - 15% increase
- ◯ G. 16% - 20% increase
- ◯ H. 21% increase or more

5. Please indicate where your employer is located.

- ◯ A. Region 1
- ◯ B. Region 2
- ◯ C. Region 3
- ◯ D. Region 4
- ◯ E. Region 5
- ◯ F. Canada
- ◯ G. Other



6. Which best describes the ownership or control of your employer?

- ◯ A. College or university
- ◯ B. Federal government
- ◯ C. State, county, or city government
- ◯ D. Nonprofit
- ◯ E. For profit

7. How long have you worked in healthcare?

- ◯ A. Less than 1 year
- ◯ B. 1-3 years
- ◯ C. 4-6 years
- ◯ D. 7-9 years
- ◯ E. 10-12 years
- ◯ F. 13-15 years
- ◯ G.16-18 years
- ◯ H. 19-21 years
- ◯ I. 22-24 years
- ◯ J. 25+ years

8. Which certification best represents your position?

- ◯ A. ARM
- ◯ B. CHPA
- ◯ C. FASHRM
- ◯ D. MSM
- ◯ E. DFASHRM
- ◯ F. Other

9. If you work in a hospital, what is its size?

- ◯ A. < 100 beds
- ◯ B. 100 - 200 beds
- ◯ C. 201 - 300 beds
- ◯ D. 301 - 400 beds
- ◯ E. 401 - 500 beds
- ◯ F. 501 - 600 beds
- ◯ G. 601 - 800 beds
- ◯ H. 801 - 1,000 beds
- ◯ I. > 1,000 beds
- ◯ J. I don't work in a hospital

Deadline for Responses: Oct. 15, 2012

Thank you very much for your time. The results of the survey will be reported in an upcoming issue of the newsletter, along with an analysis of the economic state of your field. Please return this form in the enclosed, postage-paid envelope as soon as possible.

If the envelope is not available, mail the form to: AHC Media, P.O. Box 105109, Atlanta, GA 30348.