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2 infant abductions show strengths of security systems, but also process failure

One stopped by alarm system — Band already removed in other case

Infant abduction is a constant threat to hospitals with obstetrics units, and many facilities have implemented sophisticated technology in recent years to lower that risk. The strengths of the technology were illustrated in one recent abduction, but another revealed a process failure that allowed a baby to be taken for five hours.

Both infants were recovered, and in one case the hospital reports that the alarm system designed to prevent the unauthorized exit with a baby worked perfectly. In the other, *Healthcare Risk Management* has learned that the mother and infant had been discharged and the monitor tag removed, but the family did not leave the unit immediately. In the short time they remained, the baby was kidnapped.

In the first case, the Garden Grove Police Department in Florida reports that 48-year-old Grisel Ramirez wore hospital scrubs and a visitor pass when she entered the room of a mother and her newborn baby girl at Garden Grove Medical Center. Posing as an employee, Ramirez suggested the mother take a shower and she would watch the baby, police say. While the mother was in the shower, Ramirez is reported to have put the baby in a large tote bag and left the fifth floor room.

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Ramirez was about to leave the unit when an electronic monitor on the infant's right ankle sounded an alarm that alerted staff members, says Garden Grove Police Lt. **Jeff Nightengale**. A nurse and other staff members questioned Ramirez and discovered the infant in the bag, he says.

Ramirez was arrested and charged with suspicion of kidnapping. There is no relationship with between the accused and the mother, Nightengale says. As in many past infant abduction cases, Ramirez had told her husband and others that she was pregnant with a girl, he says.

Authorities believe Ramirez is the same woman who was reported approaching several expectant mothers at Western Medical Center — Anaheim

INSIDE

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and asking questions about when they were due and the sex of their babies. Staff at the hospital also reported a woman calling several times to ask about the status of expectant mothers.

The ankle sensor worked exactly as designed, according to **Sofia Abrina**, RN, MBA, chief nursing officer and administrator at Garden Grove Hospital Medical Center. Abrina spoke at a news conference after the incident to explain that the hospital applies the security band to the infant's ankle as soon as it is born. The sensor triggers an alarm if it is tampered with and if it comes close to a unit door.

The alarm activates the hospital's Code Pink protocol, which alerts staff to block doors and prevent anyone from passing through without first being checked for the missing infant, Abrina explained. The hospital also conducts regular Code Pink drills. *(See the story on p. 112 for more on Code Pink protocols.)*

The hospital official did not indicate how Ramirez obtained a visitor badge, and Abrina confirmed that before the kidnapping, a hospital employee questioned Ramirez in another area of the hospital because she seemed to be in the wrong place. *(See the story on p. 111 for more on limiting access by visitors.)*

Executive Summary

Two recent infant abductions at hospitals reinforce the need for security, but they also reveal an unexpected weakness. One hospital reports that the proximity alarm functioned perfectly.

- ✦ Both babies were recovered.
- ✦ The sensor tag had been removed from one infant during the discharge process.
- ✦ Technology always must be paired with staff vigilance.

Sensor removed during discharge

In the other recent incident, police and media reports initially indicated that an infant's sensor tag had been cut off, somehow without causing the sensor to trigger the alarm and allowing the baby to be taken from the unit. *Healthcare Risk Management* has learned, however, that the alarm system's monitor had been removed from the infant during the discharge process.

That information was discovered in the investigation by **John Rabun**, ASCW, director of infant abduction response for the National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA. He spent 28 years as executive vice president and CEO of NCMEC before semi-retiring in February 2012. *(See the story on p. 111 for data on the frequency of infant abductions.)*

Nineteen-year-old Breona Moore first paid $16.19 for scrubs with a hospital logo at a store across the street from Magee-Women's Hospital, and she claimed a 10% discount as a hospital employee, Rabun says. Moore then posed as a nurse to take a three-day-old infant from the mother, he says.

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Though discharged, the family had not yet left the unit. During that time, Moore is reported to have told the mother she needed to take the baby for one last exam. She left the unit and the hospital without being stopped, according to police.

The baby was missing for five hours before police found Moore hiding in a stairwell in a nearby building, police report. She was charged with kidnapping.

The technology worked as intended in both cases, says **Cathy Nahirny**, senior analyst for infant abduction cases at the NCMEC. "This was not a technology failure in Pittsburgh, and the California case shows how important it is to have a protocol for responding to the alarms. When the alarm sounded there, the staff knew what to do and stopped the kidnapper trying to leave with the baby," Nahirny says. "There was no alarm in Pittsburgh because the tag had been removed, so the staff had no notice of a problem."

Nahirny does note, however, that the kidnapper was not a familiar face in the unit and did not have a staff identification badge. There was a missed opportunity to spot her and realize she did not belong on the unit, Nahirny says. The mother also did not protest the woman's lack of proper identification, she says.

SOURCES

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Limit access, urge parents not to linger after discharge

Limiting access to hospital units is one strategy for reducing the risk of abductions and other threats to children, notes **Dan Yaross**, director of security at Nationwide Children's Hospital in Columbus. Nationwide uses a system that provides visitors with a hotel-type card key that provides unit access after they have registered and been cleared for visiting a certain patient. *(See the story on p. 112 for more on Nationwide's system.)*

The kidnapper's success in the Pittsburgh case reveals a previously unknown weakness in the use of infant security technology, says **John Rabun**, ASCW, director of infant abduction response for the National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA. He spent 28 years as executive vice president and CEO of NCMEC before semi-retiring in February 2012. The hospital uses the Hugs infant protection system from Stanley Solutions in Framingham, MA, which Rabun says is one of the more advanced and reliable technology options.

"The more we think that we have every angle covered, the more we're shown that infant security is a moving target," Rabun says. "Who would have thought this could happen in the few minutes after the tag is removed?

Sensor tags should be removed from the baby at the last possible moment during the discharge process, Rabun says. Most hospitals follow that procedure, he says, though there is no formal protocol for removal. Most families leave the unit and the hospital as soon as the discharge process is complete, but inevitably some will return to the room for forgotten belongings, make a visit to the gift shop, or otherwise delay, he says.

"After talking to a lot of staff around the country, after the Pittsburgh incident, I realized this may happen a lot more than we think. But it's kind of non-observable to outsiders who make a lot of the security recommendations," he says.

Because the risk of abduction and liability remains as long as the infant is on hospital property, Rabun suggests that the family be made aware that the baby is no longer a patient and no longer protected by the sensor technology.

That discussion will take some finesse, however. Urging the family to leave the hospital immediately makes sense, but you must avoid the impression that you are hustling people out the door the minute they are no longer customers, Rabun says. Instead, focus on the fact that the baby's care is now complete. He suggests using language such as this: "We're removing the baby's sensor tag, so that means we won't be able to monitor his location anymore. Now that you're discharged, remember that no staff member will ask to take the baby away from you for any reason." ✦

287 infants abducted since '83 – Many are from mom's room

A total of 287 infants have been kidnapped in the United States since 1983, and 12 still are missing, according to information provided by **John Rabun**, ASCW, director of infant abduction response for the National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA. Seven abductions occurred in 2012.

The following list of abductions since 1983 includes all abductions by

non-family members from healthcare facilities, homes, and "other places" of newborns and infants (birth to six months).

• Abducted from healthcare facilities — 132 (46%):

– from mother's room: 77 (58%);

– from nursery: 17 (13%);

– from pediatrics: 17 (13%);

– from other healthcare premises: 21 (16%);

– with violence to the mother or caregiver: 11 (8%).

• Abducted from homes — 116 (40%).

• Abducted from other places — 39 (14%).

For comparison, there are approximately 4.3 million births in the United States yearly at more than 3,500 birthing facilities. ✦

Hotel-like card keys restrict access to high-risk units

Hospitals are taking a closer look at visitor access, especially in units such as obstetrics where visitors should be monitored closely, and one hospital is finding success with a key card similar to those used in hotels.

Nationwide Children's Hospital in Columbus uses a visitor management system that provides authorized guests of patients a hotel-type key card that permits them uninterrupted access to the patient's room, explains Director of Security **Dan Yaross**. The system is integrated with the door access control system.

Yaross describes how the system works:

• Guests must provide a code (given to the patient when admitted) for the patient they would like to visit.

• Each guest provides identification at the welcome desk.

• The guest's identification is checked in a database to ensure that any potentially unsafe or unauthorized visitor is properly managed.

• If authorization is granted, a hotel-type visitor key card is issued to provide access to the patient's clinical unit.

• The card key is time-limited. Guest passes will be valid for one day and expire at the conclusion of already established visiting hours, which is 9:30 p.m. Parent passes will be valid for seven days and can be extended longer if necessary.

• Authorized guests also are issued badges with their photos that must be worn above the waist at all times.

Providing specific access only to the patient's unit increases the security of the patient from abduction and reinforces visitor restrictions, Yaross says. It also helps prevent elopements, since the critical doors will not open without a staff or visitor key card.

Implementing the system, however, required changing the culture of the hospital, in which staff and visitors were accustomed to open doors throughout the facility. Staff members were educated about the need for better visitor management, and the purpose of the system is explained to visitors when they register, Yaross says.

"The key cards are very limited in their authorization. We only put on the card access to the doors, and it's usually just one door that they need to get through to visit that patient," he explains. "Getting a key card doesn't mean you have access to all the locked unit doors."

On a related note, Nationwide Children's Hospital also recently has installed a magnetometer, commonly known as a metal detector, at the entrance to the emergency department (ED). Anyone entering the ED has to walk through the metal detector.

In the first two months of operation, the use of the magnetometer has prevented the entry of 596 knives, 59 box cutters, 134 cans of mace or pepper spray, and two guns. Some were detected by the magnetometer, and some were handed over when people realized the metal detector was in use. The items are held by the hospital and returned to visitors when they leave. ✦

Do you use Code Pink for a missing older child?

Most hospitals with an obstetrics unit have a protocol for announcing a missing infant, often named a Code Pink, but what do you when an older child is missing? Do you still sound a Code Pink?

You can, but with a modification, suggests **John Rabun**, ASCW, director of infant abduction response for the National Center for Missing and Exploited Children (NCMEC) in Alexandria, VA, and previously executive vice president and CEO.

The missing child could be a pediatric patient or perhaps the sibling or child of a patient, Rabun says. Some hospitals restrict the use of Code Pink to newborns so that there is no doubt about the meaning and what action should be taken, Rabun says. For older children, those hospitals often use a general announcement that a child is missing, which might not produce the same response as a Code Pink.

"If you want to use Code Pink for the 8-year-old oncology patient who wandered away to the gift shop without permission, you can use 'Code Pink, 8' so that everyone knows you're not looking for an infant," Rabun says. ✦

More hospitals 'going bare,' taking big gamble on med mal

With a tough economy and mounting pressures on healthcare providers, more hospitals are going bare and foregoing medical malpractice insurance coverage in the hopes that they can cover any judgment on their own. While such a step usually does not violate any laws or state requirements, going bare should be the last resort for a hospital in crisis, sources say.

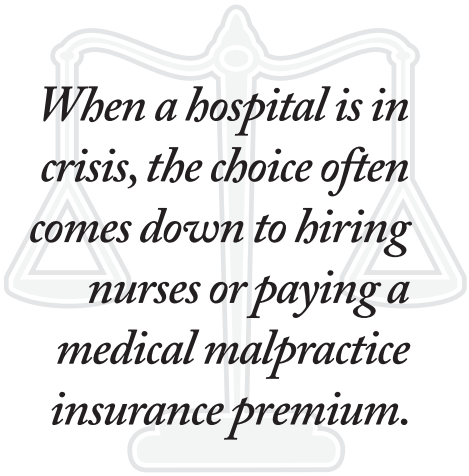
Many states do not require hospitals to carry malpractice insurance, and self-insured hospitals are more likely to be found in regions with a history of large malpractice verdicts, notes **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI. Trosty previously worked for an insurance company.

"I think we are seeing an increase in hospitals going bare," Trosty says. "Part of it has to do with the economy, but part of it has to do with the increase in frequency and severity – especially severity, and particularly in large urban areas."

Hospitals also find themselves facing tough decisions about how to spend a sometimes shrinking or static pool of money while the cost of healthcare increases steadily, he says. When a hospital is in crisis, the choice often comes down to hiring nurses or paying a medical malpractice insurance premium, he says.

When the choice is that desperate, many hospitals choose to hire the nurses and try to convince themselves that going bare is a legitimate, if risky, strategy. *(See the stories on p. 114 for the risks associated with going bare.)* "Going bare should be a last resort. This is not a creative budgeting strategy that might help you manage your finances better," Trosty says. "You do this when you don't have any other choice, because there is the risk that you're taking a bad situation and making it worse."

Going bare or self-insured is not something to undertake without considerable study, Trosty says. Simply dropping the insurance premium and socking that money away for self-insurance is not enough. It is crucial to have accurate actuarial studies to determine how much money should be set aside for self-insurance, for example. The goal is to set aside as much as you need, but not considerably more, Trosty explains. "If you don't set aside adequate funds, it becomes an exercise in futility," Trosty says. "If you go this route to avoid closing your doors and you don't do it right, ultimately it can end up forcing you to close your doors."



When that happens, that doesn't mean the crisis is over, notes **Gary Patterson**, MBA, CPA, CEO of FiscalDoctor, a financial consulting firm in Alpharetta, GA. Even if the hospital is out of business, the board of directors can be held liable for a malpractice award, he says. *(See the story on p. 114 for risks to board members and executives.)*

For-profit hospitals are at somewhat less risk of having a malpractice payout bring them to their knees because they sometimes can obtain support from a parent organization, Patterson says. Non-profits often are on their own, he says.

"How many board members are going to quit when you announce you're going bare?" Patterson says. "After a big loss, the plaintiff's attorney is going to bring in a financial expert like me who will claim that you could have afforded that malpractice insurance if you hadn't given the CEO such a large bonus or you had cut physician pay 5%. Then it becomes an issue of board governance."

Patterson advises risk managers to document that they advised board members to obtain a legal opinion of their personal exposure from going bare, so that there can be no claims later of dereliction of duty.

"Your personal brand reputation is at stake as a risk manager," Patterson says. "If the hospital closes because of financial problems, that is not going to look good on the resume of any administrator. At a minimum, you need to be able to show that you saw trouble coming and tried to warn them."

SOURCES

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Executive Summary

More hospitals are foregoing medical malpractice insurance and just hoping they can cover the loss of a major malpractice case. "Going bare" is almost always a last resort as hospitals face tough economic choices.

✦ Without adequate self-insurance reserves, going bare still can result in the hospital closing down.
✦ Bankruptcy is only one potential risk, as going bare can damage the hospital in other ways.
✦ Board members and executives might be personally liable if the hospital cannot pay a claim.

Going bare is like 'playing Russian roulette'

While legal in most communities, going bare has to be "a last resort when you're holding on by your fingernails," says **Douglas Grimm**, JD, partner and chair of the healthcare practice for the law firm of Stradley Ronon in Philadelphia. He represents healthcare providers.

"It's like playing Russian roulette," Grimm says. "It's like something out of The Deer Hunter. One bad claim and boom, you're done."

Grimm also raises the question of whether a hospital without malpractice insurance should notify patients, physicians, staff, and others who might be affected in the event of a malpractice loss. It is reasonable for people to assume that a hospital is insured, he says. "If they're going bare and the people there don't know it, that compounds the problem. When plaintiffs turn to those people for money, things are going to get ugly," Grimm says. "But the idea of a hospital sending out a memo saying 'We don't have insurance, so please be careful,' is not very practical."

SOURCE

• Douglas Grimm, JD, Partner and Chair of the Healthcare Practice, Stradley Ronon, Philadelphia, PA. Telephone: (215) 564-8539. Email: dgrimm@stradley.com. ✦

Bankruptcy not the only risk when going bare

Having to pay a major medical malpractice award out of pocket is the obvious downside to foregoing malpractice insurance, but it is far from the only one, says **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI.

Trosty lists these potential risks with foregoing medical malpractice insurance:

• Bankruptcy is a real possibility. The hospital might not be able to provide adequate care under bankruptcy conditions, and it might cease to exist.

• Loans might be difficult to obtain. If the hospital is in difficult financial trouble, especially bankruptcy, because of going bare, banks might be reluctant to loan money. If they do, they might insist on exorbitant interest rates. Obtaining annuities to pay out a malpractice award might be similarly difficult.

• Attracting and maintaining physicians and staff can become a challenge. Going bare can signal financial struggles, so physicians and staff might be reluctant to work with a hospital that might not be able to provide adequate equipment, staffing, quality of care, and liability protection. Physicians, in particular, might fear that plaintiffs will look for a deeper pocket if the hospital lacks adequate insurance.

• Certification by The Joint Commission and Medicare can be threatened. Providing adequate liability protection is a factor considered by both groups, so the exact structure or self-insurance and cash reserves for a payout will be studied.

• The hospital's reputation and brand can be damaged. Publicity about the hospital going without insurance, particularly if it is unable to pay a malpractice award, will signal to the community that the organization is in deep trouble and that care might be substandard. ✦

Board members, C-level execs at risk from going bare

In addition to risking financial calamity for the hospital, going bare or self-insured can put individual board members at risk, says **James W. Satterfield**, president and CEO of Firestorm, a financial and risk management consulting firm in Roswell, GA. Satterfield worked for many years as a hospital administrator. Board members often are misled by the idea that they are serving their community and will not be held personally liable, he says.

"If board members are under the impression that good Samaritan laws will protect the personal liability of the board, I would feel they are largely mistaken," Satterfield says. "Board members and the C-level officers in all likelihood will end up with personal liability. It will be their homes, their checking accounts, their IRAs that are indemnifying them in this area."

When hospitals go bare as the last resort short of closing the doors, the reasoning often is that they will just take the risk of a big malpractice verdict, and if the hospital cannot pay it, the hospital will be forced to close, Satterfield notes. That situation would be a regrettable outcome for any facility, but administrators and board members often do not realize that closure would not be the end of the story, he says.

"Yes, they will close, but the leadership in that hospital has a very high likelihood of being held personally accountable within it," he says. "We saw the same thing in the banking industry when financial institutions closed down but the key players there were still responsible because they had a fiduciary and governance responsibility."

SOURCE

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BYOD: It's not a party invite, but a hospital problem

Providers are increasingly faced with the dilemma of whether to ban all personal electronic devices — such as iPads and BlackBerrys — in patient care areas or allow clinicians to use them. If you let clinicians bring their own devices, how do you let them connect to the network without risking data loss or a violation of the Health Insurance Portability and Accountability Act (HIPAA)?

A bring-your-own-device (BYOD) policy is necessary because clinicians expect to have information at their fingertips all the time, at work just as they do anywhere else, says **Tom Murphy**, chief marketing officer of Bradford Networks in Concord, NH, which provides BYOD support to healthcare providers. BYOD used to be less common, but now it is inevitable that physicians and staff will bring their personal devices to work, Murphy says.

Trying to stop BYOD would be futile and counterproductive, so managing the risk is the better strategy, he says. "Hospitals are studying what devices are accessing their networks and deciding what information that device and that person should have access to," Murphy says. "Network access control is about determining the risk profile of the device — whether it is owned by the hospital or by an individual, for instance — and then providing different levels of access."

A doctor's iPad, for example, might be allowed a certain level of access to information, Murphy explains, but a nurse logging in to the network using that same device might be allowed less access. Either the doctors or the nurses might be granted deeper access if they log in using a hospital-owned computer on the unit.

Audit use of BYOD, educate staff

The hospital policy on who can access what and with what device must be accompanied by extensive staff education, Murphy says. Auditing and usage reports should be maintained and distributed to key administrators and staff leaders, he says.

Protecting patient information on personal devices is a major concern, and there are frequent reports of laptops and other items with sensitive data being lost or stolen. Encryption of the data is one of the best safeguards against that potential loss of data, but Murphy also suggests the use of remote wipe technology. With remote wipe, a signal can be sent to the lost device that automatically deletes data.

BYOD items also should have a timeout feature that triggers the password protection after a short time of inactivity, Murphy suggests.

"Doctors are driving the BYOD initiative," Murphy says. "They come to work and say 'I'm going to use this iPad, so you need to figure out how to keep the information safe.' IT can leverage some of the policies that they apply to in-house workstations, applying that to mobile devices, but I would recommend that risk management oversee this because there is a lot at stake if the precautions are not adequate."

SOURCE

• **Tom Murphy**, Chief Marketing Officer, Bradford Networks, Concord, NH. Telephone: (603) 228-5300. Web: www.bradfordnetworks.com. ✦

Executive Summary

With more hospital employees and physicians bringing their own electronic devices to work, risk managers must deal with the security and liability issues posed by those computers, tablets, and smart phones. A formal Bring Your Own Device (BYOD) policy may be necessary.

✦ Users should be able to connect to the hospital network without risking data loss.

✦ It is inevitable that people will want to bring their own devices, so it is better to manage the risk than to try to prevent it.

✦ Some limitations on the use of personal devices will be necessary.

Checklist helps hospital curtail early c-sections

Elective deliveries before 39 weeks, often performed as a convenience to the patient or the physician, have long been known to threaten patient safety and risk hospital liability. One hospital is reporting great success with a checklist and firm refusal to permit early deliveries without a good reason.

The policy is tough but accepted practice at Vanderbilt University Medical Center in Nashville, says **Bennett Spetalnick**, MD, director of labor and delivery.

The hospital's current policy is the culmination of about five years' effort to discourage elective deliveries before 39 weeks, Spetalnick says. Clinical leaders at Vanderbilt decided five years ago that they wanted to adhere strictly to guidelines from The American Congress of Obstetricians and Gynecologists (ACOG) that say such procedures should not be performed without solid clinical indications.[1]

"We got the rate down very low so that we only got down to an appeal here and there for the case where the father is going to Afghanistan or Iraq, and the fetal lung maturity is good," he says. "But over the last five years, even those outlier situations have almost entirely gone away. We don't get requests because the mother-in-law will be in town or dad's going on a business trip. Those situations have totally disappeared."

Trying to avoid elective deliveries before 39 weeks is nothing new, but it is still a challenge to many hospitals. ACOG has long discouraged elective deliveries prior to 39 weeks. The group notes that evidence suggests that non-medically indicated obstetrical procedures such as elective inductions performed prior to 39 weeks have risen sharply in the United States over the past 20 years, with associated increases in cesarean and late preterm births.

The reported rate of labor induction in the United States more than doubled between 1990 and 2006, rising from 9.5% to 22.5%, according to ACOG. The group also states that a fetal lung test before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is alone not an indication for elective delivery prior to 39 weeks.

Furthermore, The Joint Commission Set Measure PC-01 focuses on patients with elective vaginal deliveries or elective cesarean sections at 37 to 39 weeks of gestation completed. *(See "Resources on p. 117.)* The rationale for the measure states, "For almost three decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative." The Joint Commission (TJC) rationale goes on to say that a survey conducted in 2007 of almost 20,000 births in hospitals throughout the United States revealed that almost one-third of all babies delivered in the country are electively delivered, with 5% of all deliveries violating ACOG guidelines. "Most of these are for convenience, and result in significant short-term neonatal morbidity (neonatal intensive care unit admission rates of 13- 21%)," the TJC explains.

Trying to avoid elective deliveries before 39 weeks is nothing new, but it is still a challenge to many hospitals.

The clinical literature is clear that, compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay, Spetalnick says. The American Academy of Family Physicians notes that elective induction doubles the cesarean delivery rate.[2] Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis, and hypoglycemia for the newborns, Spetalnick says.

"We use a hard stop. When people try to schedule anything less than 39 weeks, it automatically goes to me or the director maternal and fetal medicine," Spetalnick says. "They can't get it on the books unless it's appealed, and those appeals are conversations about medical indications, not social indications."

Vanderbilt puts the top OB leaders in the position of saying no, rather than leaving it to a scheduling nurse. That situation avoids giving the nurse the ability to make an exception, and it makes it pointless for physicians to pressure the nurse to do so. "If they ask because of some convenience issue like the patient living far from the hospital, usually when they're told it's going to be referred on to us they just say, 'Oh, never mind,'" Spetalnick says. "But if it gets to me or the vice chairman, then we're the bad guys, not the nurse."

In 2007, Vanderbilt used the ACOG guidelines to write its own in-house policy for scheduling deliveries before 39 weeks, and it spelled out the specific criteria that must be met for the procedure to be scheduled. *(See the story on p. 117 for a portion of the Vanderbilt policy.)*

"The policy was explained thoroughly to the caregivers when the policy was first implemented, and then there was new evidence in the clinical literature in 2009 that really showed the value of what we had already implemented here. That got a lot more people on board," Spetalnick says. "The education of our patients

Executive Summary

Vanderbilt University Medical Center in Nashville reports that it has practically eliminated early induction of delivery for non-clinical reasons. Strict requirements must be met before hospital leaders will approve an early induction.

- ✦ Clinical literature consistently indicates that early elective induction threatens patient safety.
- ✦ The American Congress of Obstetricians and Gynecologists, the American Academy of Family Physicians, and The Joint Commission all discourage elective deliveries before 39 weeks.
- ✦ Any request for an early induction must be approved by the lead OB physicians.

has come through our providers, who understand and can explain the reasons behind the policy."

References

1. ACOG Practice Bulletin Number 10 – Induction of Labor. *Ob Gyn* 1999; 94(5).
2. American Academy of Family Physicians position on elective deliveries: Cacciatore M, Hill DA. Rationale for a 39-week elective delivery policy. *Am Fam Physician* 2011: 15;84(12):1,335-1,356.

SOURCE/RESOURCES

- **Bennett Spetalnick**, MD, Director of Labor and Delivery, Vanderbilt University Medical Center, Nashville, TN. Telephone: (615) 322-3894.
- Summary of The Joint Commission's measure concerning elective deliveries is titled **"Perinatal care: percentage of patients with elective vaginal deliveries or elective cesarean sections at greater than or equal to 37 and less than 39 weeks of gestation completed."** Web: http://tinyurl.com/JCAHOinduction.
- **The Joint Commission's Set Measure PC-01 concerning elective deliveries.** Web: http://tinyurl.com/JCAHOmeasure.
- **The March of Dimes toolkit to aid in discouraging elective deliveries before 39 weeks.** Web: http://www.cmqcc.org/_39_week_toolkit.
- **"The Medical Center's Labor and Delivery Policy."** Web: http://tinyurl.com/VUMCl-dpolicy.
- **Vanderbilt University Medical Center's policy on induction of labor and Cesarean section scheduling.** Web: http://tinyurl.com/VUMCinductionpolicy. ✦

Elective policy aims to cut pre-39 week deliveries

This is a portion of the Elective Delivery Policy use at Vanderbilt University Medical Center in Nashville to minimize unnecessary deliveries before 39 weeks gestation:

Planned deliveries will be in one of the following categories:

1. Indications not requiring EGA [estimated gestational age] of >= 39 weeks gestation. Indicated deliveries based on provider decisions do not require confirmation of fetal lung maturity. Fetal lung maturity testing may be helpful in decision making for borderline indications. The provider should consider maternal and fetal conditions, gestational age, cervical status and other factors. The following list of indications for delivery is not to be considered either exhaustive or absolute. Indications for delivery may include:

a. Abruptio placentae
b. Chorioamnionitis
c. Fetal demise
d. Pregnancy Induced Hypertension (PIH), preeclampsia and eclampsia
e. Premature Rupture of Membranes (PROM)
f. Post term pregnancy
g Prior cesarean sections with vertical incision
h. Prior classical cesarean section
i. Maternal medical conditions, including but not limited to:

- Diabetes mellitus
- Maternal HIV disease
- Renal disease
- Chronic pulmonary disease
- Chronic hypertension
- Maternal heart disease
- Fetal compromise including but not limited to:
  - Intrauterine growth restriction
  - Oligohydramnios
  - Fetal anomalies requiring early delivery
  - Non-reassuring fetal surveillance

2. Indications for delivery that require an EGA of >=39 weeks gestation or confirmation of fetal lung maturation includes the following:

a. Logistical reasons
b. Risk of rapid labor
c. Distance from the hospital
d. Psychosocial indications

Fetal lung maturation MUST be confirmed before elective delivery at <39 weeks gestation (38 6/7 weeks or less) unless fetal lung maturation can be inferred from any of the following criteria listed below:

- Fetal heart tones have been documented for 20 weeks by nonelectric fetoscope or for 30 weeks by Doppler stethoscope.
- It has been 36 weeks since a serum or urine human chorionic.
- Gonadotropin was found to be positive by a reliable laboratory.
- Ultrasound measurement of the crown-rump length at 6-11 weeks of gestation supports a gestational age equal to or greater than 39 weeks.
- Ultrasound measurement at 12-20 weeks supports a clinically determined gestational age of 39 weeks or greater.

If any of these criteria confirms an EGA of >= 39 weeks in a patient with normal menstrual cycles (no oral contraceptive pill use immediately prior to conception), it is appropriate to schedule delivery at >= 39 weeks of gestation in accordance with menstrual dates. Ultrasonography may be considered confirmatory of menstrual dates if there is a gestational age agreement within one week by crown-rump measurements obtained at 6-11 weeks of gestation or within 10 days by an average of multiple measurements obtained between 12-20 weeks of gestation.

EGA based only on a third trimester ultrasound is not acceptable under ANY circumstance.

V. Procedure(s):

When an elective delivery is planned the following steps will be followed:

A. The provider will notify the charge nurse in Labor and Delivery (L&D). Scheduling of the case will be dependent upon unit census and staffing.

B. The charge nurse will document the following in the schedule case book:

1. Patient's name, medical record number and phone number

2. Date and time of procedure and time patient is to come in to L&D
3. Name of the patient's provider or provider group
4. EDC and gestational age
5. Indication for the procedure
6. The date the procedure was scheduled
7. Name of the attending provider who approved the scheduling
8. The signature of the person scheduling the procedure
9. FLM or documentation of fetal lung maturity when indicated. ✦

Study finds $2.6 trillion savings with new liability system

Replacing the American medical liability system with a no-fault patients' compensation system would create at least $2.6 trillion in savings over 10 years, according to a new study by the German economics firm BioScience Valuation in Grainau.

The actuarial study, commissioned for Patients for Fair Compensation, a patient advocacy group based in Alpharetta, GA, found that doctors would scale back the practice of defensive medicine if the medical tort system were replaced with one that is legally patterned after workers' compensation.

BioScience Valuation, a company that specializes in healthcare economics and financing, estimates that defensive medicine costs in the United States run about $270 to $650 billion annually. BioScience estimates doctors would reduce the practice of defensive medicine by 30% to 70% under a patients' compensation system as proposed by Patients for Fair Compensation.

Every state should embrace this model to reduce the costs associated with medical malpractice, says **Richard L. Jackson**, chairman of Patients for Fair Compensation. "There is no single effort that could reduce the cost of healthcare as quickly as eliminating the practice of defensive medicine," he says.

Under a patients' compensation system, similar to one found in Sweden, a patient who was medically harmed could file a claim for review by a panel of experts, Jackson explains. If that panel deemed the injury was "avoidable," the claim would be forwarded to a compensation board to award compensation. This system would create a predictable model where patients are assured their cases would be heard, he says. Injured patients would have access to justice and, unlike the current tort system, low-value claims would be heard, Jackson explains.

The system also would provide more injured patients compensation, they would receive predictable settlements in much faster time, and doctors would know they wouldn't be hauled into court for frivolous reasons, Jackson says.

These are more highlights of the BioScience Valuation report:

• The patients' compensation system would bring a savings to taxpayers of about 12% percent of the Medicare budget or about $7 billion in the first year and an estimated $80 billion annually after the first five years. Savings for Medicare over 10 years would be an estimated $700 billion.

• All healthcare payers would see a savings of $156 billion to $363 billion annually from 2015 and beyond.

• Medicaid would save an estimated $48 billion to $113 billion annually beginning in 2015. The projected 10-year savings total would be similar to Medicare.

• Under the system proposed by the group, 34,000 patients a year would be compensated for their injuries, which is 77% more than currently receive compensation.

• The average payment could increase 100% to $640,000 per patient harmed by a physician, without increasing malpractice costs currently incurred by doctors and hospitals.

"A change in our medical liability system of this magnitude would not only create a significant savings in healthcare but would be helpful to those truly harmed," Jackson says. "It really is the path toward bringing fiscal sanity to spiraling healthcare costs in America while promoting a system that provides real access to justice and improves patient safety."

SOURCE

• Richard L. Jackson, Chairman, Patients for Fair Compensation, Alpharetta, GA. Telephone: (877) 248-1689. Email: info@patientsforfaircompensation.org. ✦

Court rules against malicious prosecution claim by docs

Two doctors cannot pursue a malicious prosecution claim against a patient who sued them for malpractice and then dropped the lawsuit, the Tennessee Supreme Court ruled recently.

The physicians were responding to a lawsuit by patient Tracy Allain, who was told by a physician at Vanderbilt University Medical Center in Nashville in 2005 that a previous medical procedure had left a guide wire in a vein leading to her heart. In response to that information, Allain sued Williamson Medical Center in Franklin, TN, Elliot Himmelfarb, MD, and Douglas York, MD.

A few weeks later, Vanderbilt took responsibility for the wire, and Allain dropped her lawsuit. The physicians sued her, alleging malicious prosecution and abuse of process, but a unanimous decision by the state Supreme Court stopped the lawsuit. The opinion said a

high standard for malicious prosecution is needed because such suits can deter people from using the courts to settle disputes.

The opinion is available online at http://tinyurl.com/d2uq4vf. ✦

Pacific Health, related entities agree to $16.5 million for kickbacks

The United States has entered into a settlement agreement with Pacific Health Corp. (PHC) and related entities in which they agreed to pay the government and the state of California $16.5 million for allegedly engaging in an illegal kickback scheme in Los Angeles, the Justice Department announced recently.

The civil settlement resolves a U.S. and state investigation of three PHC-affiliated hospitals for engaging in a scheme in which the hospitals paid recruiters to deliver homeless Medicare or Medi-Cal beneficiaries by ambulance from the "Skid Row" area in Los Angeles to the hospitals for treatment that often was medically unnecessary, according to information from the Justice Department.

The hospitals are Los Angeles Metropolitan Medical Center (LA Metro); Newport Specialty Hospital, formerly known as Tustin Hospital and Medical Center; and Anaheim General Hospital. They allegedly billed Medicare and Medi-Cal for these services to the homeless, violating rules that permit payment only for necessary treatment, said Stuart Delery, the acting assistant attorney general in charge of the Justice Department's Civil Division, in announcing the settlement.

The government contended that these services were induced by illegal remuneration in violation of the anti-kickback statute and the resulting billings to Medicare and Medi-Cal violated the False Claims Act.

Also as part of the resolution of the same matter, a subsidiary of PHC, Los Angeles Doctors Hospital, has agreed to plead guilty to a federal conspiracy charge arising out of the illegal kickback scheme. In addition, the three hospitals, a fourth related hospital (Bellflower Medical Center), and their related entities have entered into a corporate integrity agreement with the Office of Inspector General for the Department of Health and Human Services intended to deter future misconduct. PHC's parent corporation, Health Investment Corp., also is a party to the civil settlement and the corporate integrity agreement.

This settlement arises out of the same investigation which in 2010 resulted in consent judgments against Intercare Health Systems, formerly doing business as City of Angels Medical Center, and its former owners Robert Bourseau and Rudra Sabaratnam for a similar illegal kickback scheme in Los Angeles. Several individuals have pleaded guilty in connection with the scheme, including two who were sentenced to three years and one month, and two years in prison, respectively, for their part in the scheme. ✦

COMING IN future MONths

- ✦ Evidence of EMTALA misuse
- ✦ Pathologists at greater risk of medical malpractice
- ✦ Moving the risk manager to the board table
- ✦ Reducing retained items in OB

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. In the recent infant abduction at from Magee-Women's Hospital, how was the baby removed from the unit without setting off the proximity alarm?
A. The infant was never fitted with a sensor.
B. An investigation determined that the sensor was defective.
C. The alarm system was down temporarily for maintenance.
D. The sensor had been removed already as part of the discharge process.

2. How does R. Stephen Trosty, JD, MHA, CPHRM, president of Risk Management Consulting, characterize the choice of a hospital to go without medical malpractice insurance coverage?
A. It is a reasonable and relatively risk-free financial strategy.
B. It is a reasonable but risky financial strategy.
C. It is a strategy that should be employed only as a last resort.
D. It is illegal in almost all states.

3. According to Gary Patterson, MBA, CPA, CEO of FiscalDoctor, what is the potential risk to board members when a hospital goes bare?
A. Board members are protected and cannot be held personally liable for a malpractice award.
B. Board members can be held personally liable for an award that the hospital cannot pay.
C. Board members can opt out of personal liability for awards at the time the hospital goes bare.
D. Board members will be held personally liable only for malpractice awards in which they had some direct involvement.

4. Which is true of the policy on elective deliveries prior to 39 weeks at Vanderbilt University Medical Center?
A. They are prohibited unless they meet specific clinical criteria.
B. They are prohibited unless they meet clinical criteria or a specific set of social criteria.
C. They are prohibited under any conditions.
D. They are allowed unless there are indications that the early delivery could threaten patient safety in that particular case.