Healthcare RISK MANAGEMENT

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Hospital prevails in nurse's lawsuit claiming pay for meal breaks

Court rules hospital had good intent — Nurse didn't pursue compensation

A Tennessee hospital has come out on top in a lawsuit filed by a nurse regarding pay for time worked during meal breaks. However, hospitals might see more cases in which employees argue that they should be paid for time in which they were officially "off the clock," yet their duties as a healthcare provider required them to engage with patients and co-workers.

The 6th Circuit Court of Appeals court affirmed the judgment of the trial court in dismissing a lawsuit under the Fair Labor Standards Act (FLSA) against Baptist Memorial Health Care in Memphis, TN, which was represented by **Paul E. Prather**, JD, a shareholder with the law firm of Littler Mendelson, also in Memphis.

The court found that the hospital was diligent in its effort to ensure that a reasonable procedure was in place for employees to report and be paid for any missed or interrupted meal breaks; however, the plaintiff, Margaret White, failed to utilize the established procedures to receive pay in lieu of meal breaks. *(The full court opinion is available online at http://tinyurl.com/flsaopinion.)*

... an employer should not be liable for work performed when the employee fails to report that time ...

This decision has implications for other hospitals as it demonstrates that an employer should not be liable for work performed when the employee fails to report that time and there is no other basis for the employer to know that the employee worked and was not paid, Prather says.

"This has become a hot topic, and we've seen a big uptick in this type of litigation in the healthcare industry in the past five or six years," Prather says. "We call this 'off the clock litigation,' as opposed to more typical FSLA litigation in which someone claims they worked overtime and didn't get paid, or they're not being paid the correct rate. In this

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type of claim, they're saying they were forced to work when they were officially off the clock."

White was the original plaintiff in the case. However, the court certified a class action, and about 200 people joined her in suing Baptist Memorial. The White case is the second of two such lawsuits recently brought against Baptist Memorial. In an earlier lawsuit, plaintiffs made a similar claim against Baptist Memorial and two other hospitals about not being paid for meal times, and they were certified by the court for class action litigation. About 450 plaintiffs joined that lawsuit.

In both cases, however, the court eventually dismissed the class action certification and then ruled against the individual plaintiffs.

"In the White case, the court dismissed her claims because it said the hospital had a procedure to notify them that she worked through a meal break, she had used that procedure, she voluntarily chose to quit using that procedure, and the hospital had no way to know that she was both working and not getting paid," Prather says. "The certification question was appealed, the summary judgment was appealed also, but the appeals court said it was her responsibility to use the procedure set up by the hospital. And because she could not prevail, she could not represent the class action participants."

One lesson from the case is that class action lawsuits are not well-suited to this type of claim, Prather says. Risk managers should not assume too quickly that class action is the right method for resolving this type of FSLA claim, he says. *(See p. 3 for more lessons from the White case.)*

Such claims against hospitals are not uncommon, and many hospitals settle them quickly to avoid what can be high litigation costs and the fear of a high payout, Prather says. "In this case, the hospital said, 'we think we've done this right and until somebody tells us otherwise, we're not going to just roll over and pay millions of dollars to plaintiffs' lawyers,'" Prather explains. "It's become a little bit of an industry, where you have plaintiffs' lawyers going out and soliciting people to file these claims in the healthcare industry. It's partly because so many people in healthcare do use automatic deductions for meal breaks as a payroll

Executive Summary

A nurse's lawsuit claiming a hospital failed to pay her for meal breaks was dismissed. The court determined that the hospital was diligent in trying to assure employees were paid for meal breaks but that the nurse did not follow the procedure for claiming her wages.

- ✦ The trial initially dismissed the lawsuit and the nurse appealed.
- ✦ Hospitals must pay nurses for time spent on meal breaks, the courts affirmed.
- ✦ Employees have the responsibility to report time spent on meal breaks; hospitals do not have to seek the information.

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Editorial Questions

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function."

Risk managers should be cautious not to read too much into the ruling, says **Elisa J. Lintemuth**, JD, an associate with the law firm of Dykema in Grand Rapids, MI.

"While the 6th Circuit's decision does not shelter employers who turn a blind eye to the hours its employees work, it does provide protection to employers that, as a result of employees' actions or inactions, are not made aware of uncompensated work time," Lintemuth says. "In light of White, employers should review their policies and consider clarifying the employee's duty to report missed meal breaks and overtime."

SOURCES

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- **Paul E. Prather**, JD, Shareholder, Littler Mendelson, Memphis, TN. Telephone: (901) 322-1225. Email: pprather@littler.com. ✦

Establish procedures, audit your payment processes

The recent dismissal of a lawsuit under the Fair Labor Standards Act (FSLA) against Baptist Memorial Health Care in Memphis, TN, holds several lessons for risk managers, says the health system's attorney, **Paul E. Prather**, JD, a shareholder with the law firm of Littler Mendelson in Memphis.

Prather offers these suggestions:

- Ensure that your hospital has procedures in place for employees to report missed meal breaks and other work performed off the clock. These procedures must be in writing and effectively communicated to employees.
- Frequently reaffirm that employees will be paid for missed meal breaks and similar periods and that such requests will not result in retaliation or other negative action against the employee.
- Create a track record of actually paying for that time so you will have a good defense in showing that the hospital pays for the time when notified.
- Use internal audits to find potential problems with compensating for off-the-clock time. Remember that typical audits in this area focus on overtime pay and minimum wage issues, so meal times and similar concerns could be overlooked. ✦

Does your crisis communications plan need updating?

The healthcare industry is made up of people who handle crises on a daily basis. They are great under pressure and can make quick decisions when it comes to dealing with life and death aspects of human nature. But while they are focused on the immediate care of patients, they and their administrators can sometimes overlook a crisis that might be developing concurrently: a public relations (PR) crisis.

When it comes to handling a PR crisis, organizations need to make sure they prepare ahead of time, says **Adele Cehrs**, president of Epic PR Group, a public relations firm in Alexandria, VA, that assists corporations with crisis communications. Good preparation will save headaches, panic, and money down the road.

Most providers have at least a rudimentary crisis communications plan, Cehrs notes, even if it as simple as referring inquiries to the CEO and telling everyone else to keep quiet. Whether your plan is that basic or much more sophisticated, chances are good that it needs updating, Cehrs says. The largest reason is the explosion of social media such as Facebook and Twitter.

"With the widespread adoption of social media, your organization's image or reputation can be called into question around the world instantaneously."

"With the widespread adoption of social media, your organization's image or reputation can be called into question around the world instantaneously," Cehrs says. "That changes everything. You can't rely on an old plan in which you just didn't comment and hoped the local reporters gave up. And even a good crisis communications plan from several years ago probably didn't factor in social media enough."

With more than 3.5 billion pieces of content shared each week on Facebook, 234 million websites, and 126 million bloggers, tracking online conversations is a challenge, Cehrs says. Crises in the healthcare industry require quick, strategic responses to minimize damage and avoid fueling the fire, she says. The process begins with fact finding, identifying whether the issue is in fact a

crisis, and assembling the appropriate stakeholders to discuss how to respond or not respond. *(See the story below for other advice.)*

How you respond to a crisis will determine how the public will perceive your organization not only immediately, but in the future. Your response could be the difference in viewing what happened as an isolated incident or a fundamental problem with your organization/company, Cehrs says. It might determine whether someone decides to use your services or take their business elsewhere.

Before responding, remember that a consumer's reactions and evaluations during a crisis will be determined by your response. Crisis responses that emphasize emotions and concern for people (as opposed to messages focusing on the law, justice, and punishment) greatly improve the public's perceptions of the organization, Cehrs says.

Executive Summary

Crisis communications is a key component of any risk management program, but don't rely on plans that were formed years ago. Communication plans must be revised periodically to reflect changes in media, your own organization, and cultural expectations.

- ✦ Social media have dramatically changed what is necessary in crisis communication plans.
- ✦ Prepare for the worst-case scenario in terms of how the public will respond.
- ✦ Aim for maximum transparency during a crisis.

Cehrs cites research from the University of Missouri, where a study focused on the reactions of readers when exposed to a news story about an organization's crisis. One group read an "anger-frame" story that blamed the organization for the crisis. Another group read a "sadness-frame" story that focused on the victims and how they were hurt by the crisis. Those who read the "anger-frame" story read the news less closely and held more negative attitudes toward the company than those exposed to the "sadness-frame" version.

Before you make a big announcement or decision, it is essential that you prepare for and consider the worst-case scenario. If you're concerned that a decision or a policy will be unpopular with consumers, do the necessary research and preparation before making a public statement, Cehrs suggests. If you're anticipating negative feedback, consider investing in focus groups or surveys to gauge consumer reactions ahead of time. ✦

Be transparent when talking about a crisis

Consider the following points when responding to a crisis, according to **Adele Cehrs**, president of Epic PR Group, a public relations firm in Alexandria, VA, that assists corporations with crisis communication:

• **Create a command central.** Just as a surgical team will gather together to quickly respond to patient's case, so must your communications team. Gather the appropriate parties, and decide on a response strategy. During the crisis, create a place on your company's website or blog where you can address issues as quickly as possible via a Q&A document. Provide appropriate information via the company's Facebook page, Twitter account, and other social media.

• **Be as transparent as you can.** Be honest about not being able to answer at the time of the crisis, and ensure your key stakeholders that you will provide more information at a later time. Say something. Don't let your social media audience rule the conversation. Crisis communications is a time when leadership and a straightforward approach are paramount.

• **Determine what conversations warrant a response.** Not only must you have a place where consumers can ask questions about their concerns, but your PR team should determine which questions will get answered. Look at the negative conversations to see what people are really thinking, then respond accordingly. Develop an online Q&A at a central location on your website to answer consumer as well as media questions related to the crisis that your company is comfortable answering.

• **Use both traditional and social media.** Don't forget that traditional media will tune into your social media presence as soon as a crisis breaks to get a sense of what others are feeling at the moment. They will repeat that information and build a story around it. Remember that social media isn't just another tool. It is an extension of your brand's story. Be sure you are the one telling it.

• **Get ahead of potential issues.** Consider developing a website beforehand that can address potential crisis situations with a strategic Q&A, messaging and issue-resolution strategies. When the crisis hits, turn the site on, and you are ready to address the issues at hand, quickly and effectively.

SOURCE

• Adele Cehrs, President, Epic PR Group, Alexandria, VA 22314. Telephone: (703) 299-3404. Email: info@epicprgroup.com. ✦

Johns Hopkins reports that it has reduced bedside alarms up to 74% in some units

A group of Johns Hopkins nurses, physicians, and engineers have significantly reduced the number of distracting, non-critical bedside alarms in some of the hospital's noisiest areas — up to 74% in some cases — in an improvement that has been linked to patient safety.

ECRI Institute, an independent, nonprofit institute that conducts research about and assesses best practices in patient safety and quality, has called clinical alarms the number one health technology hazard of the year. For its efforts in reducing bedside alarms, the group recently awarded The Johns Hopkins Hospital its Health Devices Achievement Award for 2012.

The effort is an example for how a methodical and carefully analyzed research process can be applied to alarm management and result in a significant improvement in patient care, says **Maria Cvach**, MSN, RN, CCRN, assistant director of nursing clinical standards at Johns Hopkins and leader of the hospital's alarm improvement efforts since 2006.

"This project came about because, like a lot of healthcare organizations, we were concerned about how to improve safety with clinical alarms," she says. "One of the top reasons for missing an alarm is alarm fatigue. There are too many alarms, and people are just desensitized to the amount of noise. They either hear it and ignore it, or they don't hear it and don't take action."

> *"There are too many alarms, and people are just desensitized to the amount of noise."*

Ironically, improvements in monitoring have led to the need to reduce the number of alarms, Cvach explains. "In healthcare we have created the perfect storm with all of these monitoring devices," Cvach says. "Monitor alarm systems are set to be very sensitive and unlikely to miss a true event but result in too many false positives."

Baseline measures revealed the scope of the challenge for Johns Hopkins' Alarms Management Committee: One 12-day alarm system analysis registered 58,764 alarms, an average of 350 per patient per day. That rate was doubled on the noisiest unit, and analysis revealed a 90% false-positive rate among alarms in the pediatric intensive care unit set on monitors for apnea, a breathing lapse. *(See p. 6 for more on collecting baseline data and other tips.)*

In addition to noise reduction, the quality-improvement project sought to prevent "alarm fatigue," potentially hazardous conditions that arise when nurses and other caregivers become so desensitized by frequent, unnecessary crisis alarms that they become less likely to respond. "Frequent alarming can cause a 'cry-wolf' effect," Cvach explains.

By collecting baseline measurements, defining and validating appropriate alarm settings, and working with each unit to develop an alarms improvement plan, the multidisciplinary team safely reduced the cacophony from monitors, infusion pumps, ventilators, bed exit systems, and other bedside devices hospitalwide. Reductions ranged from 24% to 74% across six units. *(See p. 6 for more on analyzing the data.)*

In another pilot study, the researchers cut in half the total number of alarms by asking nurses to change patients' monitor electrodes daily, explains **Andrew Currie**, MS, CBET, Hopkins' director of clinical engineering. He co-chairs the alarms committee with Cvach and **Adam Sapirstein**, MD, associate professor in the Department of Anesthesiology/Critical Care Medicine in The Johns Hopkins School of Medicine and also a faculty member in the Johns Hopkins Armstrong Institute for Patient Safety and Quality.

"Patients and staff need a quiet environment," Currie says. "We are trying to reserve noisy alarms for the most important, actionable events. In some cases, units switched some lower-priority alarms to visual rather than auditory

Executive Summary

An ongoing program at Johns Hopkins Hospital in Baltimore, MD, has reduced the number of bedside alarms by 24% to 74% across different units. Reducing bedside alarms is considered an important patient safety issue because nurses and others can be overwhelmed and start ignoring critical alarms.

- ✦ The hospital's efforts won an award from ECRI, an independent, nonprofit institute that conducts research about and assesses best practices in patient safety and quality.
- ✦ Collecting baseline data was a key part of the effort.
- ✦ Changing patient electrodes daily was helpful in reducing alarms.

notifications."

Cvach and Sapirstein say that partnering with leaders on each unit was essential to their success, because improvements needed to be tailored to individual settings. "A one-size-fits-all approach would not have received the kind of support we needed to address this problem," Currie says.

Before setting out to alter alarm settings, the committee analyzed and rated each alarm based on importance and risk to ensure back-up notification systems were in place for the most critical alarms. Cvach says, "For high-priority alarm conditions, redundancy is important. Our units need multiple ways to ensure audibility of alarm signals and patient safety."

The group's other efforts include testing new equipment, assessing alarm management alternatives, developing new policies, creating and assessing training efforts, and considering new alarm technologies. *(See p. 7 for more lessons learned from the Johns Hopkins experience.)*

A current pilot study is testing a system that sends messages about priority alarms to cell phones and pagers carried by nurses, who, with the press of a button, can call for back-up if they're unable to respond. Another initiative that Sapirstein is leading will look into "smart alarm" systems that integrate data from multiple machines and predict problems before they occur.

SOURCES:

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Baseline assessment was key to reducing alarms

In 2006, **Maria Cvach**, MSN, RN, CCRN, assistant director of nursing clinical standards at The Johns Hopkins Hospital and Andrew Currie, MS, CBET, the director of clinical engineering, were asked to head a team to reduce clinical alarms. But first they had to define the problem. Just how many alarms were going off, and what kind?

They put together a small task force that began analyzing alarm systems on one unit using a quality improvement rapid cycle change approach.

"Our first challenge was learning how to analyze alarm system data," Cvach says. "It took us two years to figure out how to extract the right data. It's hard to believe it took that long, but that's how difficult it was."

Currie was able to create a real-time surveillance system to integrate data feeds at the bedside from multiple medical devices. "We were suddenly seeing unfiltered data from our GE monitors, and we saw an unbelievable number of alarms," Currie says.

By observing the alarm condition patterns, they identified that many of the conditions were clearly false. For example, apnea alarms were coming from patients on ventilators. Experience with this system drew their attention to the high volume and the inaccuracy of alarm conditions coming from their monitors.

Adam Sapirstein, MD, associate professor in the Department of Anesthesiology/Critical Care Medicine in The Johns Hopkins School of Medicine and also a faculty member in the Johns Hopkins Armstrong Institute for Patient Safety and Quality, was involved in the pilot project. "It could have been one full-time person's sole job to just silence all of those alarms," he says. To him, the patient safety implications of so many false alarm conditions were clear.

At the same time, Cvach and the task force were focusing on the number of alarm conditions the nurses were encountering in their unit, which she says were "astronomical." She worked with Currie to access the data, and a valuable partnership was formed. "You need quantitative data to evaluate the applications of alarm management in hospitals," says Currie. "Our initial efforts to generate data were very basic."

The GE monitors they used had a pager system that ran off of a local area network, he says, and a server listened to messages from the monitors and kept a log when it sent messages to pagers.

"I began looking at that log and tracking the changes that our alarm group instituted to measure the success of our efforts," Currie says. ✦

Analyzing alarm data was no easy task

Simply gathering the data about clinical alarms wasn't enough to help The Johns Hopkins Hospital improve patient safety. Those numbers have to be broken down into meaningful parts.

When **Maria Cvach,** MSN, RN, CCRN, assistant director of nursing clinical standards, receives an alarm data download from the clinical engineering group, she cuts the data down from 29 fields to six, including such key data as the bed number, why the alarm sounded, and how long it sounded.

"Every physiological monitor on every patient generates lots of data,"

Cvach says. "For example, we had to fine-tune 315 separate parameters for the monitor default parameters. Once we saw a download, we began to understand how many alarm conditions were occurring on the units."

Members of the alarms task force decided to use the average number of patient alarm conditions per bed per day as the key metric that would guide their efforts. That metric has proved useful and is still used today to evaluate improvement efforts. Whenever alarms changes are implemented, they first record baseline alarm condition data and then measure changes to that key metric as the improvement efforts moved forward.

Using that monitor data, Cvach was able to identify that a huge portion of the alarms were low priority, inactionable "nuisance" alarms. "And even many of the true alarms were not clinically significant," she says.

Members of the task force decided to tackle the alarms problem on several fronts. Their goal was to eliminate as many nuisance alarm conditions as possible and quiet the cacophony of sounds coming from monitors, infusion pumps, ventilators, bed exit systems, and the multiple other devices that beep or buzz and combine to make hospitals anything but the quiet, healing environments they were intended to be. ✦

Lessons learned from Johns Hopkins' alarm reductions

The task force that reduced clinical alarms at The Johns Hopkins Hospital learned many valuable lessons along the way, says **Maria Cvach**, MSN, RN, CCRN, assistant director of nursing clinical standards.

Cvach offers these tips to risk managers who want to duplicate the success of Johns Hopkins:

• Understand the problem and state the goal. For example, the goal can be "to eliminate 30% of alarm conditions throughout the hospital."

• Share your goals with key hospital staff, including clinicians, administration, clinical engineers, and biomed technicians.

• Recognize the problem as institution-wide

• Recognize the resolution of the problem as long-term and ongoing.

• Obtain the support of your administration to achieve your goals.

• Engage a multi-disciplinary team to study and address the problems. Include nursing staff, clinical engineers, biomed technicians, device vendors, and others as appropriate.

• Analyze the problem. Access the right data, and know how to extract it. Identify key data such as (but not limited to) bed number, purpose, and timeframe/length or alarm condition.

• Conduct a fault tree analysis to understand the failures to respond to critical physiologic alarm conditions in a timely manner.

• Identify a key metric, such as the average number of alarm conditions per bed per day.

• Implement safety checks on alarm settings.

• Revise alarm default parameters in each unit to actionable levels. Recognize that settings might vary from one unit to another.

• Implement revisions or changes incrementally.

• Prioritize and differentiate between actionable alarm signals in each unit, such as visual vs. audible. Recognize that settings might not be the same from one unit to another.

• Define alarm types as false, true, nuisance, actionable, or other categories, and ensure that definitions are understood by unit staff.

• Gather quantitative baseline data to evaluate alarm conditions.

• Examine logs from the network that track alarm messages from devices in order to capture the quantitative data.

• Compare pre- and post-data to measure changes.

• Ask the right questions and gather the right data:

o Where the alarms are coming from? What is the bed number?

o Who is the patient?

o What is the cause?

o How long are alarms sounding?

o How many alarms are occurring in units?

o When an alarm signal goes off, what do you do?

o When an alarm goes off, how do you hear it?

o What is the average number of patient alarms per bed, per day?

o What is the workflow of a clinical unit e.g. backup notification, nurses per unit, assignments, etc.?

o What is the clinical significance of an alarm? What are the high/low priority alarms along with high/low risk alarms? ✦

Health system to pay $9.3 million for alleged False Claims Act, Stark violations

Freeman Health System, a healthcare provider and hospital system located in Joplin, MO, has agreed to pay $9.3 million to resolve allegations that it violated the Stark Law and the False Claims Act by knowingly providing incentive pay to physicians in a manner that violated federal law, the Department of Justice (DOJ)

announced recently.

The Stark Law forbids a hospital from billing Medicare for certain services referred by physicians that have a financial relationship with the hospital. A prohibited financial relationship includes an agreement between a hospital and a physician to compensate a physician based on the volume of the physician's referrals or the revenue realized through those referrals.

Freeman disclosed to the U.S. Attorney for the Western District of Missouri that a number of its physicians were eligible for incentive compensation that might have taken into account the value and volume of their referrals. Based on its investigation of Freeman's disclosures, the United States alleged that Freeman knowingly compensated some of its physicians in a manner that violated the Stark Law. Specifically, the United States alleged that Freeman provided incentive pay to 70 physicians employed at clinics operated by the health system based on the revenue generated by the physicians' referrals for certain diagnostic testing and other services performed at the clinic. The United States alleged that this financial arrangement created an incentive to refer patients for such procedures.

Paula Baker, MS, president of Freeman Health System, issued a statement saying the 2009 internal review revealed that Freeman had inadvertently made errors in the way it structured its physician-compensation agreements. Administrators at the health system realized that those agreements did not meet what she described as "very complex" federal guidelines.

Freeman engaged outside experts to analyze and provide recommendations for improvements to the system. Their review confirmed that the health system's physician contracts did not comply with the law, but it also found that no patient or governmental entity was billed for any service that was not provided, according to Baker's statement.

The health system … immediately changed its compensation formula …

The health system voluntarily disclosed that it was in noncompliance with the law and immediately changed its compensation formula to ensure full compliance.

The health system probably avoided a worse outcome by voluntarily disclosing the possible violations, suggests **Lindzi Timberlake**, JD, an attorney with the law firm of McGuire Woods in Richmond, VA, and Scott Becker, JD, a partner with the same firm in Chicago.

They offer these lessons from the Freeman case:

1. Hospitals should proactively review physician contracts to ensure compliance with federal regulations. By conducting an audit of its contracts, Freeman caught its potential noncompliance with federal law prior to any investigation by federal authorities. Freeman's proactive steps enabled it to quickly implement improvements in its contracting practices and likely helped Freeman avoid a more costly and invasive investigation.

2. It is wise to engage outside, expert assistance in the review process. The external review demonstrated a good-faith effort on Freeman's part to correct its mistakes and bring its practices into compliance with federal law. In addition, the external audit revealed that all services billed to patients or government entities actually were provided. This was a discovery that likely strengthened Freeman's ability to negotiate a better agreement with the DOJ, given the circumstances, when it ultimately disclosed the information.

3. Hospitals should be especially careful in drafting contracts for physicians employed in clinic settings and seek outside counsel when necessary. In this case, Freeman allegedly provided incentive pay to physicians employed at clinics operated by the health system for referrals for certain diagnostic testing and other services performed at the clinic. By avoiding physician contracts structured on the revenue generated by a physician, hospitals can ensure that physicians make decisions based on a patient's best interests and that the hospital does not jeopardize its own compliance with federal law.

Executive Summary

A Missouri health system will pay $9.3 million to resolve charges that it violated the Stark Law and the False Claims Act with incentive pay to physicians. The health system disclosed the possible violations to federal authorities.

✦ The system's self-disclosure probably helped it escape more severe penalties.
✦ Hospitals should proactively review physician contracts to ensure compliance.
✦ Contracts with physicians in a clinic setting might pose a higher risk.

SOURCES

• Scott Becker, JD, Partner, McGuire Woods, Chicago. Telephone: (312) 750-6016. Email: sbecker@mcguirewoods.com.

• Lindzi M. Timberlake, JD, Associate, McGuire Woods, Richmond, VA. Telephone: (804) 775-7819. Email: ltimberlake@mcguirewoods.com. ✦

Study finds rising med mal payments

An analysis of surgical malpractice claims shows rising payment amounts, with patient outcomes as the strongest predictor of payment size. Considerable variation in payment size between states suggests a profound impact from local legal environments.

The researchers at the University of California San Diego conducted a retrospective analysis of surgery-related malpractice payments using the National Practitioner Data Bank from 1990 to 2006.[1] Payments were adjusted to 2006 dollars. They evaluated predictors of payment size and large payments (defined as those larger than $1 million). Statutory law in the states demonstrating significant predictive values also was analyzed.

In total, 58,518 surgical malpractice payments met the inclusion criteria. Patients were predominantly female (62%) and inpatient (63%), with a mean age of 42 years. The number of payments decreased and payment sums increased during the study period. The median payment was $132,915.

Claims most frequently cited improper performance (42%). Patient outcomes were the strongest predictor of payment size and likelihood of a large payment. Children younger than 10 years old were 70% more likely to receive a large payment, and patients older than 70 years were 80% less likely.

Large variations across states were seen for payment size and likelihood of large payment. Patient outcomes were the strongest predictor of payment size and likelihood of a large payment. Children younger than 10 years old were 70% more likely to receive a large payment, and patients older than 70 years were 80% less likely. The likelihood of reaching out-of-court settlement did not appear to be correlated with known factors.

Reference

1. Orosco RK, Talamini J, Chang DC, et al. Surgical Malpractice in the United States, 1990–2006. *J Amer College of Surgeons* 2012; 215:480-488. ✦

Doctors don't disclose conflicts of interest on social media

As the use of Twitter and other social media by physicians and patients rises, some professionals worry that physicians increasingly seem to forget to do what many consider crucial for building doctor-patient trust: disclose potential conflicts of interest. However, physicians are not entirely at fault, according to a researcher at The Johns Hopkins University School of Medicine in Baltimore, MD.

Prominent medical societies have failed to lay out comprehensive guidelines for physicians on when and how to disclose a conflict of interest when using social media, says **Matthew DeCamp**, MD, PhD, a researcher in the Division of General Internal Medicine at Johns Hopkins. He also holds a fellowship at the Johns Hopkins Berman Institute of Bioethics.

In a commentary published online in the Journal of General Internal Medicine, DeCamp argues that some physicians use social media to give advice to patients and the public without revealing drug industry ties or other information that might bias their opinions.[1] Without serious efforts to divulge such information, which is standard practice when publishing in medical journals and recommended in one-on-one contacts with patients, DeCamp says consumers are left in the dark. "As physicians and patients increasingly interact online, the standards of appropriate behavior become really unclear," DeCamp says. "In light of norms of disclosure accepted throughout medicine, it's surprising that major medical guidelines fail to adequately address this issue."

Among the national organizations that have issued social media guidelines are the American Medical Association and the Federation of State Medical Boards. *(See resources at end of article.)* DeCamp acknowledges that use of social media has the potential to improve patient care and trust by increasing patient access to information, but he says vigorous online boundaries are needed to not only ensure privacy and confidentiality, but also to protect patients from misinformation and biased advice.

In an office setting, for example, when doctors prescribe a blood pressure medication, professional guidelines say they are ethically bound to tell patients if they have any financial relationship, such as receipt of consulting fees, with the company that manufactures the drug. Guidelines also call for disclosure when they publish studies about blood pressure medication, and medical journals require them to fill out a detailed disclosure form. But online, it's "an unacceptably gray area," DeCamp says.

One reason might be difficulty in determining just how to disclose within the constraints of the online world, DeCamp notes. The popular social media tool Twitter, for example, allows each entry to be just 140 characters long. But a generic disclosure — "The author has no conflict of interest to report related to this tweet" — has 70, leaving little room to discuss the research itself.

DeCamp says one solution is the use of electronic tags that disclose conflicts of interest and follow the information tweeted and re-tweeted by a physi-

cian. At the very least, he says, doctors should post potential conflicts in their online profiles, and consumers should be wary of posts and advice from anyone claiming to be a doctor.

"The history of conflict of interest in medicine is such that you don't want to be late to the table," DeCamp says. "You need to be proactive so that your undisclosed conflict doesn't end up on the front page of The New York Times. Conflicts need to be disclosed, and it's surprising that we have so far to go regarding disclosure and management on social media."

Reference

1. Decamp M. Physicians, social media, and conflict of interest. *J Gen Intern Med* 2012; Nov. 6. [Epub ahead of print.]

SOURCE/RESOURCES

• Matthew DeCamp, MD, PhD, Division of General Internal Medicine, The Johns Hopkins Hospital, Lutherville, MD. Telephone: (410) 583-2926.

• American Medical Association. AMA Policy: Professionalism in the Use of Social Media. Web: http://tinyurl.com/2bykytd.

• Federation of State Medical Boards. Model Policy Guidelines for the Appropriate Use of Social Media and Social Networking in Medical Practice Policy on Social Media. Web: http://www.fsmb.org/pdf/pub-social-media-guidelines.pdf. ✦

'Wait for Labor' campaign discourages induction

To increase awareness about the health risks of elective inductions of labor and the importance of full-term pregnancies, the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) has launched the "Wait for Labor to Start on Its Own" online pledge. The campaign encourages pregnant women who are healthy and well to wait for labor to start on its own rather than seeking an elective induction.

Elective induction of labor can lead to cesarean surgical birth, hemorrhage, and infection, AWHONN reports. Babies born even in those last few weeks of pregnancy are at greater risk for breathing problems, feeding issues, jaundice, low blood sugar, and problems maintaining their own body temperature.

"It's best to let baby pick her birthday," says said AWHONN's CEO **Karen Peddicord**, PhD, RN. "A baby may be due by the traditional definition of term at 40 weeks after the first day of a woman's last period. However, women aren't always certain when they got pregnant, and research shows estimates can be off by a week or more."

Pregnant women, their healthcare providers, families, and friends are encouraged to sign and share the pledge. Mothers who sign the pledge promise to talk with their healthcare provider about their desire to wait for spontaneous labor and learn the reasons why it is important for women to go the full 40 weeks of pregnancy if mother and baby are healthy and well. Participants also commit to sharing the pledge with others to build a strong community of supporters who can encourage women to wait for labor to start on its own and avoid non-medically indicated labor inductions or cesareans.

"The 'Wait for Labor to Start on its Own' pledge encourages the best and healthiest outcomes for pregnant women and their babies," Peddicord says. "Labor should only be induced for medical reasons, not for convenience or scheduling concerns. It is critical that women's health nurses work with their patients to help them understand the risks of elective induction of labor and motivate them to carry their babies to term."

The pledge and additional information can be found online at http://tinyurl.com/waitforlabor. AWHONN launched the pledge in conjunction with its Go the Full 40 campaign, which can be found online at http://tinyurl.com/full40. The campaign helps expectant mothers and women everywhere understand why babies need at least a full 40 weeks of pregnancy to grow and develop.

SOURCE

• Karen Peddicord, PhD, RN, CEO, Association of Women's Health, Obstetric and Neonatal Nurses, Washington, DC. Telephone: (201) 261-2400. ✦

Pennsylvania hospitals implement wrong-site best practices

More than 30% of Pennsylvania healthcare facilities have successfully implemented 21 potential recommendations for preventing wrong-site surgery, according to the Pennsylvania Patient Safety Authority (PPSA).

The PPSA recently sent 417 Pennsylvania facilities with operating rooms its 21 potential recommendations to prevent wrong-site surgery and asked the facilities to describe barriers for implementing the recommendations that would prevent them from meeting the standard or standards for the goal.

The PPSA survey divided the 21 potential recommendations into five groups, with a total of six goals and eight proposed measurement standards for the groups. For each of the six goals, the PPSA asked facilities

to describe barriers for successful implementation. Seventy facilities responded to the survey. Two-thirds of the responses were from hospitals, and one-third were from ambulatory surgical facilities, says **John Clarke**, MD, clinical director of the PPSA.

"Overall, the surveyed Pennsylvania healthcare facilities felt they could successfully implement the potential recommendations for preventing wrong-site surgery," Clarke says. "Less than 20% of surveyed healthcare facilities identified some barriers to implementation, but all of the barriers could be modified or overcome through education, policy changes, or culture changes."

Pennsylvania healthcare facilities responding to the survey gave their reasons for successful implementation of the 21 potential recommendations to prevent wrong-site surgery. "Education, audits, leadership, and empowerment of nurses to 'stop the line' were some of the strategies facilities cited they have used to successfully implement wrong-site surgery best practices," Clarke says. "Elaboration of these strategies includes leadership buy-in from surgery departments and respectful interactions with staff."

Clarke added that 27 facilities commented about the feasibility and potential cost impact of implementing the potential recommendations associated with each of the eight standards. "Most respondents — 20 out of 27 — had no concerns, indicating that the potential recommendations were in place or that they thought implementation was feasible at minimal cost," Clarke said. "Seven expressed primarily cost concerns."

Concerns about potential cost impact include: personnel time to verify and reconcile information, resources to monitor compliance, personnel time for redundant checking of information, resources needed to implement the evidence-based best practices, resources and time for education, resources to upgrade electronic and paper documents, possible increased staffing, OR delays and loss of business, and physician availability on-site or remotely for a second verification of intraoperative images.

Clarke adds that physician behavior and accessing accurate information before the patient's arrival in the preoperative holding area were cited by surveyed Pennsylvania healthcare facilities as common barriers.

The PPSA's program to prevent wrong-site surgery began in December 2007 after research revealed that Pennsylvania healthcare facilities were submitting about two and one-half wrong-site surgery reports per week. Since the prevention program began, wrong-site surgeries in Pennsylvania have decreased by 37% from an average of 19 reports per quarter to an average of 12 reports per quarter.

In April 2012, the PPSA began another wrong-site surgery initiative with 28 Pennsylvania healthcare facilities that have made the commitment to reduce and eliminate wrong-site surgeries.

SOURCE

• **John Clarke**, MD, Clinical Director, Pennsylvania Patient Safety Authority, Harrisburg. Telephone: (717) 346-0469. ✦

COMING IN FUTURE MONTHS

- ✦ How to use HIPAA de-identification guidelines
- ✦ Avoiding bad hires — What you can and can't do
- ✦ Providers still not reporting adverse events well
- ✦ Patient safety scores questioned by hospitals

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.

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CNE QUESTIONS

1. In the recent 6th Circuit Court of Appeals ruling concerning a hospital nurse who was not paid for time spent on meal breaks, what did the court conclude regarding the hospital's practices?
A. The hospital was diligent in its effort to ensure that a reasonable procedure was in place for employees to report and be paid for any missed or interrupted meal breaks.
B. The hospital intended to pay employees for meal breaks but did not have a specific plan in place to provide compensation.
C. There was no intention or effort to provide compensation for meal breaks, but the hospital was under obligation to do so.

2. In crisis communications, what does Adele Cehrs, president of Epic PR Group say is one impact of social media?
A. Traditional media will pick up on comments in social media and repeat them.
B. Social media will stick to the storyline provided by traditional media.
C. Social media can be counted on ignore healthcare issues.
D. Traditional media usually will not pay attention to comments in social media.

3. What does Maria Cvach, MSN, RN, CCRN, assistant director of nursing clinical standards at The Johns Hopkins Hospital, cite as a main reason people fail to respond to a clinical alarm?
A. The alarms are not loud enough.
B. Alarm fatigue makes the person ignore the alarm.
C. The person is too busy to respond.
D. The alarm is sounding in an area that is someone else's responsibility.

4. In the $9.3 million settlement involving Freeman Health System and allegations that it violated the Stark Law and the False Claims Act, what is probably one reason that the system did not fare even worse?
A. The alleged violations were minor.
B. The health system self-disclosed the potential violations.
C. The alleged violations had occurred more than 10 years earlier.

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Lee Landenberger
Continuing Education Director
AHC Media

Legal Review & Commentary

A Monthly Supplement to HEALTHCARE RISK MANAGEMENT

Widow awarded more than $6.7 million due to hospital's failure to prevent fatal heart attack

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News: In 2005, a 43-year-old man was crushed by an all-terrain vehicle when it crashed and flipped over while he was riding it. He was promptly airlifted to the nearest hospital. Tests revealed indications of internal bleeding, but they were ignored by the hospital. The patient died 36 hours later when pressure from internal bleeding caused one of his lungs to collapse and resulted in a massive, fatal heart attack. The jury awarded plaintiff $6.7 million.

Background: The injury occurred on May 6, 2005. A 43-year-old man was riding in an all-terrain vehicle that crashed and rolled over on top of him. He was crushed by the all-terrain vehicle and suffered several broken ribs, among other injuries. The patient was airlifted to the closest hospital equipped to handle his numerous injuries. A CT scan taken in the emergency department revealed indications of internal bleeding. The patient died 36 hours after arriving at the hospital when the pressure from internal bleeding caused one of his lungs to collapse. This lack of oxygen led to a massive, fatal heart attack. His untimely death occurred on his 44th birthday, which also was Mother's Day. Tragically, his wife, children, and parents witnessed his death as they were visiting the patient at the hospital to celebrate both occasions.

The patient died 36 hours after arriving at the hospital when the pressure from internal bleeding caused one of his lungs to collapse.

Plaintiff argued that the treating physicians failed to follow up on the initial CT scan taken in the emergency department and they should have ordered further CT scans in order to monitor the initial indications of internal bleeding. Plaintiff also argued that the patient's death could have been avoided if doctors would have used a chest tube to drain the fluid that gradually was accumulating in his chest.

The defense representatives for the hospital maintained that the doctors and nurses provided the patient with excellent care. They argued that the medical evidence proved the patient died of an unexpected and unpredictable rupture of an intercostal artery. The hospital representatives did not think that any battery of tests would have predicted or prevented the

Financial Disclosure: 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. **Elizabeth Janovic**, **Carol Gulinello,** and **Jonathan D. Rubin**, co-authors, have no relevant relationships to disclose.

unfortunate outcome.

The trial only lasted for six days. Despite the findings of a pre-litigation screening panel that unanimously held the actions alleged by plaintiff did not cause the patient's death, the jury ultimately held in favor of plaintiff. Plaintiff was awarded $11,000 for funeral and burial expenses, $1 million for the patient's conscious suffering before his death, $1.2 million for loss of economic support, and $4.5 million for loss of companionship and emotional distress, for a total of more than $6.7 million. The award is the largest medical malpractice award ever handed down by a jury in the state of Maine.

According to the verdict survey form, eight of the nine jurors agreed with the verdict. Plaintiff's attorney said the award most likely will be reduced to a figure closer to $6 million. Damages for conscious suffering and loss of companionship and emotional distress have been capped by the state legislature in Maine.

What this means to you: Based on the summary, the patient had evidence of several broken ribs and other nonspecific injuries. Therefore, based on this fact pattern, several assumptions must be made.

This male, who sustained a crush injury to his chest, was airlifted to a hospital that was equipped to handle such injuries, such as a Level I Trauma Center. Once there, a full physical assessment should have been done to include any evidence of visible trauma, level of consciousness, vital signs, neurological assessment, type and screening for blood type, and an arterial blood gas with placement of a pulse oximetry device to measure the level of oxygen circulating in the bloodstream. Additionally, all routine diagnostic imaging tests for such an injury, such as a CT with contrast of the chest, abdomen, and pelvis and a full body X-ray, should have been done. Assuming that the initial CT scan revealed a minimal amount of bleeding into the chest cavity, a repeat study to monitor any slow bleeding is a prudent plan.

The award is the largest medical malpractice award ever handed down by a jury in the state of Maine.

Because there was evidence of internal bleeding noted on the initial CT scan, with enough pressure to cause one of the patient's lungs to collapse, we are assuming that the bleeding was noted in the chest cavity. According to the Committee on Trauma of the American College of Surgeons, the standard of care for hemo/pneumo thorax is chest tube insertion. This procedure provides a release of pressure within the lung cavity and allows the patient's lung to properly re-expand. It allows for accurate monitoring of any drainage of fluid from the lung to relieve pressure. Failure to drain the fluid from the chest will result in increased pressure within the cavity, causing a shift in the mediastinum. Once a chest tube is in place, the patient's chest pressure is released, his condition can be better evaluated, drainage from the lung cavity can be properly measured, and his blood oxygen levels can be effectively monitored.

According to the hospital, the patient died of an unexpected and unpredictable rupture of the intercostal artery. However, if this rupture was the case, placement of the chest tube for drainage would have significantly helped manage that situation. The bloody drainage from the chest cavity into the drainage system would have significantly increased. This increase would have triggered an alert to the practitioners of an emergent situation. This rupture of the intercostal artery might have been unpredictable, but had a chest tube been placed, the effects of the rupture would not have been unpreventable.

Corrective actions for this case could include the formulation of critical pathways when managing patients who have sustained traumatic crush injuries to the chest. These critical pathways could include routine placement of a pulse oximetry device on the patient's finger to continuously monitor the blood oxygen levels and serial CT scans to capture any changes of blood accumulation and enable the practitioner to react to even subtle changes in condition. However, chest tube insertion, in patients with any evidence of hemo/pneumo thorax or internal bleeding into the chest is the standard of care and should be followed.

Reference

CV-2008-115, Superior Court of Penobscot County, Maine (2011). ✦

Over $4.6 million award for failure to maintain adequate blood supply resulting in death of mother

News: This case involves the death of a 36-year-old woman following the caesarean section delivery of her first child. The infant was healthy, but the patient developed a postpartum hemorrhage shortly after delivery, and the hospital claimed it did not have an adequate blood supply. Without this blood supply, doctors were unable to properly manage the patient's condition and did not think they could successfully operate on the patient in order to alleviate her hemorrhage. This inability to manage the bleeding or replace her lost blood resulted in the patient's eventual death. A jury awarded just more than $4.6 million to plaintiff.

Background: On Jan. 17, 2008, a woman arrived at the hospital for the delivery of her first child. The patient was given a labor-inducing medication on Jan. 18, 2008, and after several hours of unsuccessful labor, her obstetrician decided to perform a caesarean section. A healthy infant boy was delivered by caesarean section at 6:50 p.m. The patient was stable, but her uterus was suggestive of atony, which was addressed with medication and a uterine massage.

A few hours later, the patient was noted to be bleeding heavily, and an on-call obstetrician was contacted. The on-call obstetrician responded to the page as she drove to the hospital, and she instructed the hospital staff to type and cross the patient's blood. The on-call obstetrician then requested two units of blood for the patient. The patient's blood type came back as Type A-. About 9 p.m., the on-call obstetrician instructed the staff to immediately begin transfusing the blood, but at 9:18 p.m. the blood transfusion still had not begun. The hospital staff informed the on-call obstetrician that Type A- blood was not in supply, and the on-call obstetrician immediately ordered two units of Type O- blood, four units of red blood cells, four units of fresh frozen plasma, and two additional units of fresh frozen plasma to be placed on hold for transfusion.

The patient continued to bleed and was treated again for atony. It was at this time that the on-call obstetrician began planning surgical procedures to treat the bleeding. She discussed a hysterectomy procedure with the patient. At 9:41 p.m., the staff provided two units of O- blood and began transfusing. The patient's obstetrician arrived at the hospital at 10 p.m. and requested all available blood be given to the patient. The hospital staff informed the obstetrician that no more blood was available. The on-call obstetrician contacted another hospital to inquire about transferring the patient there for additional blood and a radiation procedure that could be performed only there. The patient was airlifted to the second hospital. Her condition significantly deteriorated during the transfer, and she suffered a fatal cardiac arrest shortly after her arrival to the second hospital.

Plaintiff revealed during trial that the hospital did have blood available for transfusion, but failed to use it.

Plaintiff revealed during trial that the hospital did have blood available for transfusion, but failed to use it. Plaintiff reached a settlement agreement with defendant doctors, but the hospital was unwilling to negotiate. Plaintiff took the position of defending the doctors, undermining the hospital's cause of death opinion, proving the hospital's violation of the standard of care, and establishing damages. Plaintiff retained experts in blood management, perinatology, and cardiovascular pathology to support its case against the hospital.

The hospital argued that the patient's doctors were negligent as they should have performed surgery to stop the patient's bleeding. They also argued that defendant doctors did not need additional blood to perform surgery. An expert pathologist testified for the hospital that the patient did not die from blood loss, but instead died from peripartum cardiomyopathy.

The jury found that the settling physicians were not at fault and placed 100% of the negligence on the hospital. The jury awarded just over $220,000 in past economic loss, $750,000 in past non-economic loss, $1.4 million in future economic loss, and $2.25 million in future non-economic loss, for a total of just over $4.6 million. Defendant hospital filed post-trial motions for a new trial and a new trial on damages. The district court denied the motions, so the hospital appealed the decision. The appellate court affirmed the district court's decision. In 2012, the

hospital decided to suspend obstetrics services.

What this means to you:
Maternal hemorrhage is a probably the most common cause of maternal mortality. Since this condition is highly preventable, the goal of the healthcare providers is early recognition and treatment of this precarious condition. As such, many healthcare institutions have formulated guidelines to handle these emergencies.

The facts in this case reveal that this 36-year-old female, pregnant with her first child, was admitted to the hospital at 41 weeks gestation. The gestational age of the fetus is considered postdated, because the optimal gestational age is 39-40 weeks gestation. The age of this patient, along with it being her first pregnancy, put her in a high-risk category. What is not mentioned in the summary is whether she was treated as high risk during her prenatal course and why she was not delivered before 41 weeks. These two factors put her at greater risk for heavier than normal postpartum bleeding.

Upon admission it is noted that the patient received a labor-inducing drug and after several hours required a caesarean section to deliver her infant. The documentation in the admission history and physical should have included the calculation of a Bishop score, a numeric score from 0-10 which measure certain pre-natal criteria and would indicate the success of the induction efforts. A higher Bishop score equates to a better chance at a vaginal delivery. This score provides the obstetrician with very useful information regarding the management of the labor. However, the patient was allowed to labor and eventually did require a caesarean section.

Herein lays the crux of the case. According to the summary, it appears as if, despite the notation of suggestive postpartum uterine atony, which is a precursor of hemorrhage, the attending obstetrician left the hospital instead of closely monitoring the patient's condition. Had the physician been present during this critical time, early recognition and treatment of this condition could have occurred, and this life-changing event possibly could have been prevented. Instead, the on-call attending obstetrician was notified by the nursing staff, and by the time the on-call obstetrician came into the hospital and decided on the treatment plan, her efforts were fruitless.

The attending obstetrician failed to stay with the patient despite evidence of post-partum uterine atony, which delayed any lifesaving intervention.

Furthermore, the issue regarding the lack of adequate prenatal diagnostic workup such as a routine type and screening for possible transfusion, accurate communication to the on-call obstetrician by the nurses regarding critical components of the patient assessment, lack of communication of the gravity of the situation to the blood bank, and a lack of an organized approach to responding to hemorrhage were evident and further delayed a crucial treatment plan.

This case presents several opportunities for improvement. The attending obstetrician failed to stay with the patient despite evidence of post-partum uterine atony, which delayed any lifesaving intervention. Although the hospital had a massive transfusion policy, it is clear that the nursing staff failed to follow the policy. They were clearly not familiar with the indications and process for its activation. Additionally, they relayed incorrect information to the obstetricians regarding the availability of blood products and failed to articulate to the blood bank the gravity of the patient's condition. This incorrect information directly affected the physician's treatment plan for this patient.

Corrective actions for this case could include the following: Simulation training in managing postpartum hemorrhage for all obstetrical staff with subsequent mock scenarios and drills that would be an important educational component to the staff. Also helpful would be the formulation of a post-partum hemorrhage algorithm with assigned roles for the obstetrician, charge nurse, and primary nurse allowing for smooth handling of the emergency while giving guidance to all practitioners as to the appropriate treatment plan for each decision matrix.

An educational initiative for reinforcing the indications and use of the massive transfusion protocol is warranted. A revision to the obstetrical history and physical form should be made to include the documentation of Bishop scores for all obstetrical patients admitted for induction of labor. A subsequent medical record review or audit should be undertaken to ensure compliance with the documentation standard. Additionally, training in effective communication techniques such as SBAR (situation, background, assessment, and recommendation) would be helpful in assisting clinicians in relaying critical information in a concise and organized fashion, especially in an emergency situation.

Reference

A11-1212 Minnesota Court of Appeals (2012), 86-CV-09-5000 Wright County District Court (2010). ✦

Healthcare RISK MANAGEMENT

The uncertainty in healthcare brings more demand for risk managers

Advanced nursing degree, not business, may open doors

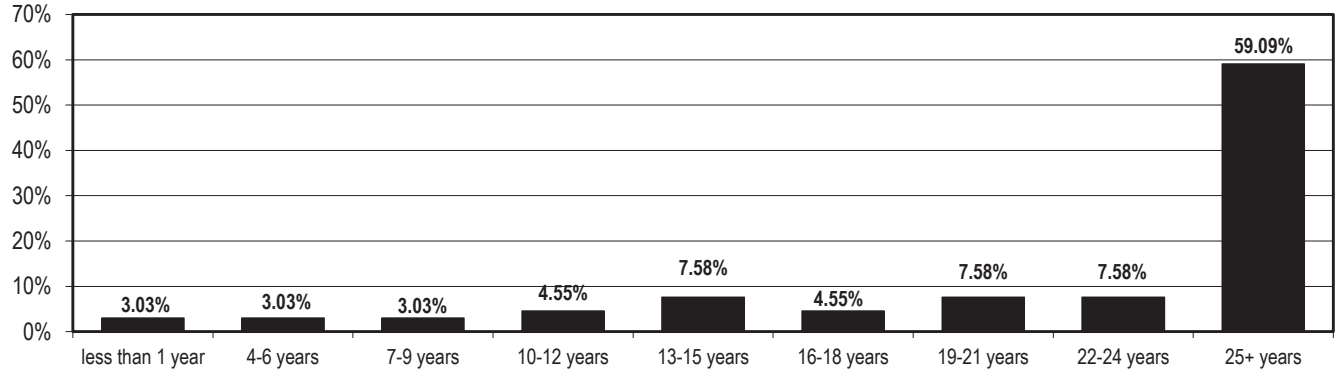
Risk manager, your time has come. With all the turmoil in the healthcare industry from changes associated with the Patient Protection and Affordable Care Act (PPACA), moves toward electronic records, and an increased focus on fraud from government regulators, you might be in more demand than ever before.

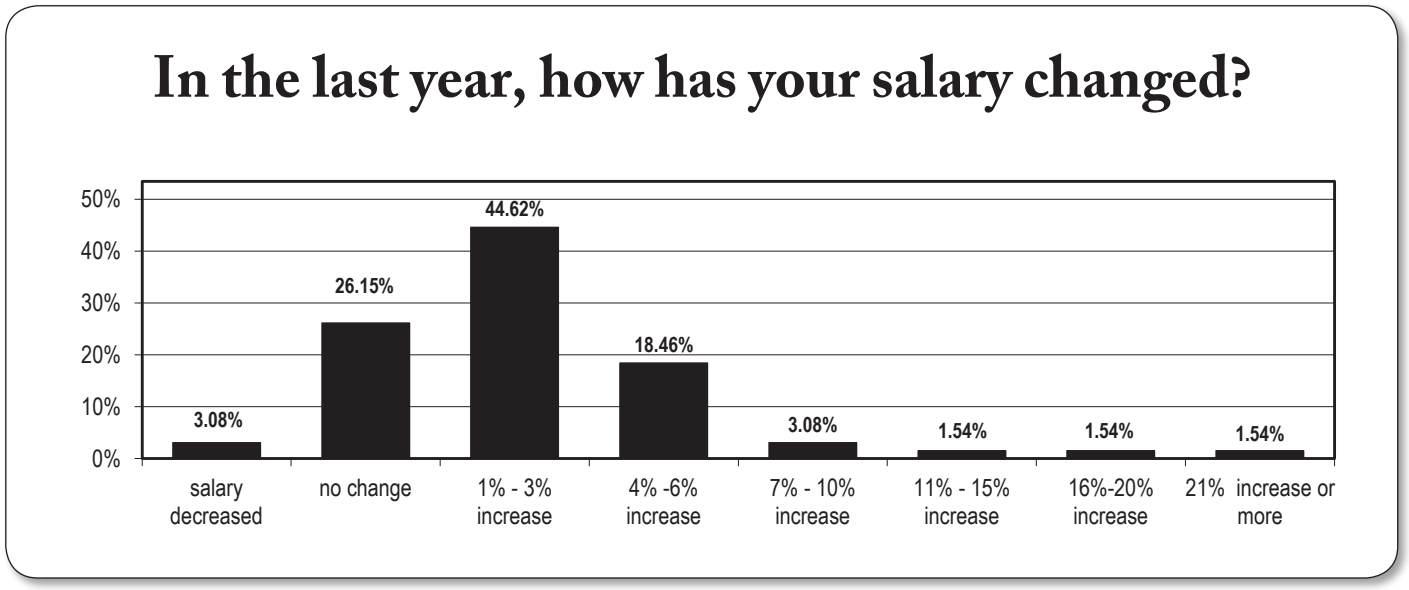
That's the assessment of **John Fulcher**, CSAM, director of the healthcare division of Bauer Consulting Group, an executive recruiting company based in El Paso, TX. Fulcher is filling several executive-level risk management positions for healthcare clients, and he expects the field to be hot for the near future.

"I haven't done much risk management placement in recent years, but just in the past few months I've been hit with multiple requests for risk management and quality positions," Fulcher says. "A lot of it is tied to the initiatives kicking in with Obamacare. As more of the requirements kick in and bring with them all sorts of questions and risks, there's going to be an uptick in interest for risk management, quality, infection control, all of these areas. Definitely an area of growth."

The increase is consistent across the country, Fulcher says. The greatest interest in risk management expertise is at the corporate level, rather than individual hospitals,

How long have you worked in healthcare?





he says. Many health care corporations are creating or expanding roles for risk managers in which they oversee facilities at a regional level, he says. *(See the results of the* 2012 Healthcare Risk Management Salary Survey *on p. 3.)*

"I'm seeing layers being created, new positions rather than just filling a slot left open by someone's departure," Fulcher says. "I usually explain to people I'm recruiting why the position is open, but lately I'm telling them that it's a newly created position, and I don't get to say that much. In healthcare there are not usually a lot of newly created positions."

The best way to position yourself for these new positions, or to advance otherwise in risk management, is to further your education, Fulcher says. Many risk managers have a bachelor's level education, which often is sufficient, he says. But to take advantage of growing opportunities, Fulcher advises risk managers to seek a master's in nursing.

"Managers tend to think they should get MBAs, but a lot of times the hospitals and health systems want their risk managers to have MSNs," he says. "They'll look at MBAs, but if you have to go head to head with another applicant, all other qualifications being the same but you have different degrees, they're going to lean toward the master's in nursing side. I saw a candidate get rejected yesterday because they wanted a master's in nursing and she had a master's in health administration, and she was already doing the job they wanted."

Another important qualification is longevity in a risk management position. Particularly for younger risk managers or those who have migrated to the field from other healthcare positions, staying in one risk management role for a few years will add gravitas to your qualifications aside from your education, Fulcher says. *(See p. 1 for survey results on longevity in the field.)*

"Longevity is huge right now. We know that younger generations are more likely to move around, and that's just a factor of their generation and the recent economy. But if you're looking to position yourself for forward growth, you definitely need to try to stay stable," Fulcher says. "Don't move around because you had a bad day at work. The longer you are unemployed, the more your stock goes down."

That advice holds true particularly if you find yourself in a good position even though your credentials are not top notch, Fulcher says. He occasionally encounters health professionals who are looking for a better position, but then he finds that he would have difficulty placing them in the same level of their current work.

"I tell those people to stay where you are because you're not going to do any better. Hold on to this position because you're not going to do any better without seriously improving your credentials," Fulcher says. "That can happen sometimes when a person is good at what they do, and maybe the employer hired from within or didn't use the highest standards. If that's the case, don't be lured away just because there are new positions opening up."

Fulcher urges risk managers to constantly be on the lookout for ways to improve their value to employers through education, credentialing, work with professional associations, and anything else that promotes you as an exceptional, highly involved risk manager.

"Get your name out there any way you can," he says. "Be the master of your profession, and put yourself in that top 1 or 2%. Those are the people we go after, and those are the people that get hired first."

SOURCE

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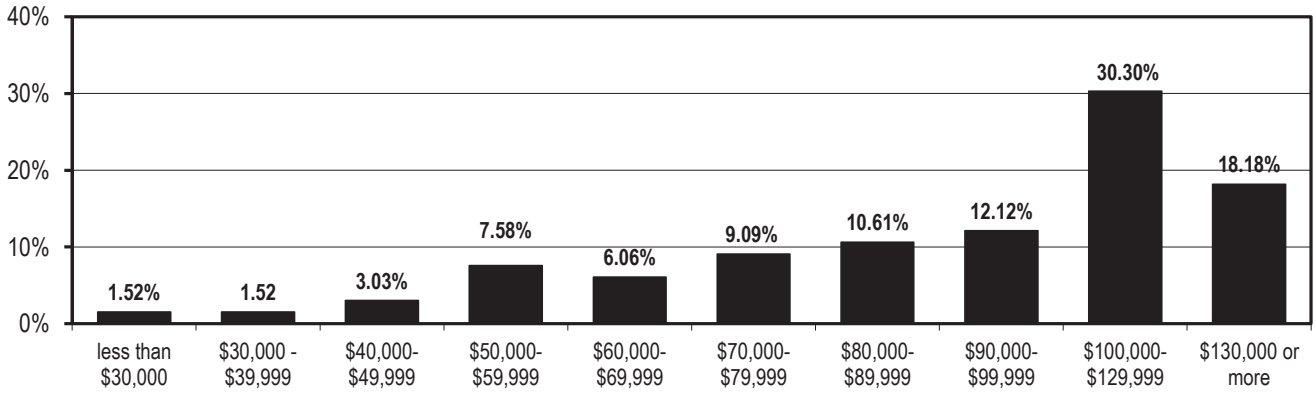
What is your annual gross income?



Risk managers see little improvement in income

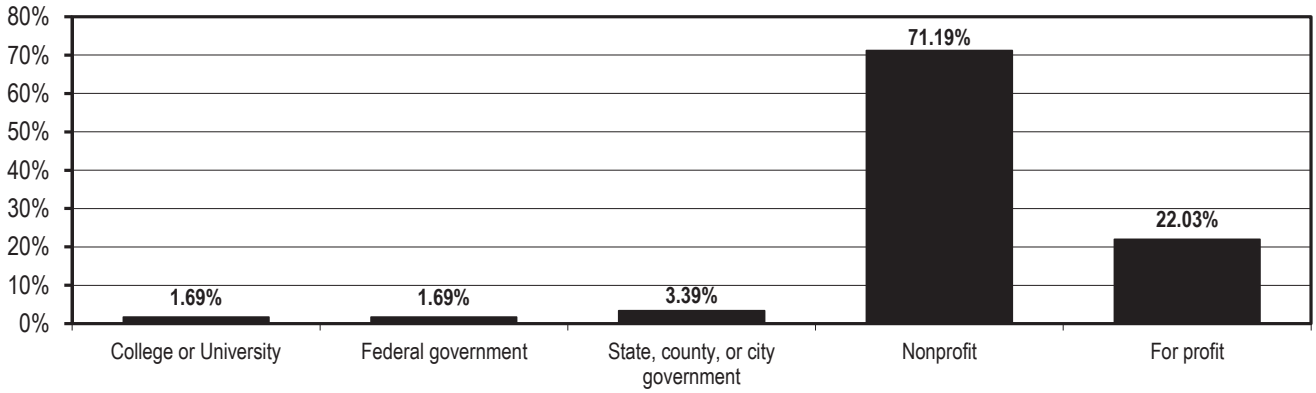
For the fourth straight year, income for risk managers has remained steady with no appreciable increase. In most years that would not be great news, but considering how the poor economy has affected other employees across the country, holding steady might be a blessing.

The exclusive *2012 Healthcare Risk Management Salary Survey* was sent to 1,155 readers in the June 2012 issue. A total of 66 were returned, for a response rate of 5.7%. The results were tabulated and analyzed by AHC Media, publisher of HRM.

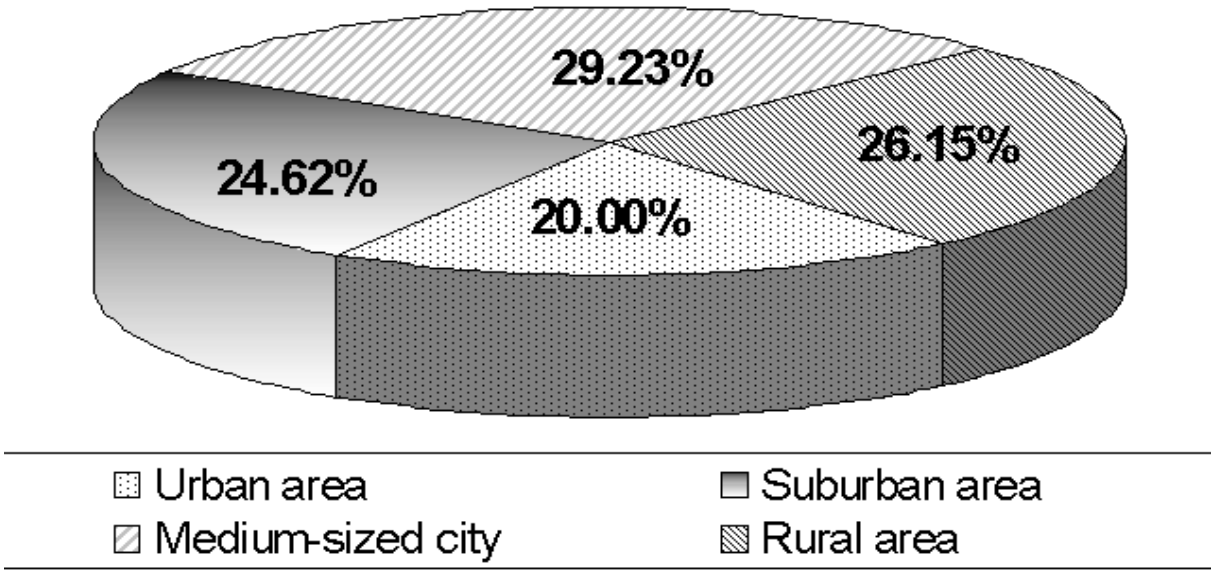
The median income for healthcare risk managers in this year's survey is $125,000, the same as the past three years. *(See the chart, above.)* Income levels had been rising in previous years. About 30% of respondents reported income in the $100,000 to $129,999 range, and 18% reported income of $130,000 or more. Another 12% reported income in the $90,000 to $99,999 range.

The median salary increase over the past year was

Which best describes the ownership or control of your employer?



Where is your facility located?



1% to 3%, the same as the past few years. (*See the chart, p. 2.)* About 45% of respondents report salary increases in the 1% to 3% range, up slightly from last year's 41% and closer to the previous year's figure of 47%. Eighteen percent report increases in the 4% to 6% range, and 3% reported increases in the 7% to 10% range. One fortunate reader reported an increase of 21% or more.

Twenty-six percent report that their salaries had not changed this year, and two readers (3%) report a salary decrease.

Seventy-two percent of respondents work for non-profit healthcare organizations, and 22% work for for-profit providers, with the remainder in educational or government settings. Sixty percent of readers have worked in healthcare for more than 25 years. ✦