35th Anniversary

Healthcare RISK MANAGEMENT

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Risk managers have moved from reactive to proactive over decades

No longer just taking care of slip & fall, risk managers now play prominent role

Seasoned healthcare risk managers know that the job has changed significantly over the years, going from a relatively low-level position in hospital administration to a more high-profile leadership role. No longer responsible for just slip-and-fall cases or the occasional malpractice case, risk managers now promote patient safety and protect the organization from significant liability and regulatory threats.

The evolution of the risk manager has been steady since *Healthcare Risk Management* first published in 1979. We asked our editorial board members and others with experience in risk management to reflect on the changes they have seen, and all agreed that the role has changed dramatically.

One of the biggest changes has been a move toward more prevention efforts, says **Grena Porto**, RN, MS, ARM, CPHRM, healthcare practice leader with ESIS Health, Safety and Environmental in Philadelphia and former president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. Rather than being primarily reactive by handling lawsuits filed against the healthcare provider, risk managers now are much more focused on ensuring safety and preventing injuries that can lead to liability, she says.

"Even when something does happen, we're focused more now on doing the right thing for the patient. I think that has been a pretty significant achievement by the industry," Porto says. "I don't know if everyone appreciates how big a change that is. When

Special report: 35 Years of *Healthcare Risk Management*

This month *Healthcare Risk Management* celebrates 35 years of bringing you the latest news, analysis, and advice on risk management in healthcare. We are pleased to celebrate this anniversary by bringing you a retrospective look at how the field of healthcare risk management has changed over the years and some of the more significant developments over that time. ✦

INSIDE

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Financial Disclosure: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study.

I started in this business 30 years ago, the attitude was we don't say anything to the patients, we don't tell them anything, and we don't admit anything. It was pretty much a circle-the-wagons approach, and that has radically changed for the better."

The field will continue to evolve as risk managers address new and developing risks, such as safety issues involving robotic surgery and telemedicine, Porto notes. The shift to an accountable care model also will change risk management in the near future, and it will force a switch from focusing on inpatient care to more outpatient care, Porto says.

HRM's 35 years corresponds almost exactly with the career of **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of ASHRM. When she looks back on her time in risk management, she realizes that one of the biggest changes is the availability of risk management education, guidance, and resources.

Executive Summary

The role of the risk manager has changed dramatically over the past 35 years. Originally responsible primarily for reacting to liabilities, risk managers now take a more proactive and extensive leadership position.

- Risk managers have access to far more resources than in previous years.
- Enterprise risk management will lead to further expansion of the risk manager's role.
- Professionals in this role still might struggle for adequate recognition.

"When I first started in risk management, we didn't have ASHRM, we didn't have any textbooks, and we didn't have any kind of media to rely on," Kicklighter says. "There was nobody to reach out to for help. If you were a risk manager, you felt like you were pretty much on your own, and nearly everybody learned on the job."

At that time the healthcare industry was lagging behind others in risk management, she says. The launch of *HRM* and ASHRM's first meeting in 1980 helped advance the field, she says.

With help from new information sources, the risk manager's role became more prominent in the organization, and key collaborations began to form. Unlike many in risk management at the time, Kicklighter did not have a background in insurance and found few resources to help her.

"I remember having to approve and sign an insurance policy before it could go to the board for approval, so I reached out to my broker, and they brushed me off. I had to go through the phone book until I found an agent that would take the time to help me understand it. At that time insurance brokers and risk managers were in different worlds," she says. "Now they're meeting together with the underwriters and combining their skill sets to get the best contracts for the healthcare provider."

That kind of role expansion helped risk management move from more of a

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trade to a profession, says **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of ASHRM. Early risk managers often were people who had come from the insurance industry, and then as other concerns took hold, the field attracted more nurses and attorneys.

"We wound up with a broader sea of people because the responsibilities had significantly increased," Trosty says. "We were still protecting assets, but now the assets included the people, the patients, the physical structure, the finances. Our charge became maximizing quality and safety while reducing liability."

That increased responsibility usually led to increased visibility in the organization, Trosty says. Risk managers began reporting to chief financial officers or chief operating officers, a positive move for the field. *(See the story below for more on how risk managers work with other departments. See the story on p. 4 for how risk managers are seen by others.)*

Government regulation also has increased significantly over the years, with risk managers now obligated to oversee the reporting of far more data to the government and clearinghouses, Kicklighter notes. Compliance quickly became a primary concern for risk managers, says **Jane McCaffrey**, DFASHRM, MHSA, director of compliance and risk management at The Blood Connection in Greenville, SC, and a past president of ASHRM. At the same time, risk managers were trying to determine exactly where they stood in their organizations.

"I remember when risk management and quality were duking it out, with quality questioning if we should even be involved in their concerns," McCaffrey says. "It was a battle back and forth for a while, and then we threw patient safety into the mix, which raised more questions about who was responsible for what."

That battle has ended now, for the most part, with the risk management and quality departments finding ways to work cooperatively in most institutions, she says. Though she says the evolution of risk management has been dramatic, McCaffrey still frets that risk managers do not get the recognition they deserve. Executive level risk managers at large organizations might be recognized, she says, but there are many others who are not.

"The day-to-day folks who actually do the investigations, the evaluations, work with people on policy, training, prevention, I don't think they get the attention that others get when they have the titles in patient safety and so forth," she says. "I think we're still a bit of the stepchild in the world of healthcare. Part of the problem still is how to prove your financial worth."

John C. Metcalfe, JD, FASHRM, vice president of risk management services with MemorialCare Health System in Fountain Valley, CA, has been in healthcare risk management since 1972 and says he has been gratified to see the distinct shift away from traditional risk management essentials to a focus on patient and workplace safety and patient, employee, and physician satisfaction.

"You see the shift come to life in the attachment when you review the operational issues," he says. "There is also an expansion of issues noteworthy under the technology, strategic and human capital list of issues. It is evident the healthcare risk manager is involved in a more diverse setting of risk issues than ever before."

SOURCES

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Risk managers now interact with all leadership levels

As risk managers took on more responsibility in healthcare organizations, they began interacting with a much broader group of hospital leaders, including clinical directors, notes **R. Stephen Trosty**, JD, MHA, CPHRM, president of Risk Management Consulting in Haslett, MI, and a past president of ASHRM.

The expansion of risk management into other areas of the hospital, along with more demands for risk management from The Joint Commission and from some state laws, made the profession more prominent. More responsibility also led to the expansion of risk management departments within healthcare, increasing the number of people in the profession, he notes.

The introduction of regulatory issues such as the Emergency Medical Treatment and Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA) greatly increased the need for compliance within healthcare organizations, which in turn created more value for the risk manager, Trosty notes.

"This was all reflected in the certification exams and the textbooks that were being developed, recognizing that there needed to be a consistent approach to some things in risk man-

agement," Trosty says. "The expansion of risk management meant that we were taking on more and more responsibilities, and people had to keep learning new skill sets."

The ASHRM past presidents all point to enterprise risk management as evidence of how much the field has evolved. This effort to be proactive in many areas of healthcare, and to contribute a positive effect on growth and quality rather than simply preventing negative effects, requires a risk manager with a wide range of skills, they say.

"You have to have skills in litigation, claims, finance, leadership, management, operations," says **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of ASHRM. "You have to have a whole lot of knowledge in a whole lot of things." ✦

Attorneys see risk managers gaining prominence

The reputation of healthcare risk managers is on the rise, according to attorneys consulted by *Healthcare Risk Management*.

For years, the department of risk management was looked upon with disfavor by physicians and given little thought by hospital administration or others, notes **George B. Breen**, JD, an attorney with the law firm of Epstein Becker Green in New York City. He is in the firm's health care and life sciences and litigation practice area and chair of the firm's National Health Care and Life Sciences Practice Steering Committee.

Frequently located in basement offices, risk managers were regarded by physicians as adversaries looking to attack when errors were found, he says. Administrators often used risk management as a place to send disgruntled patients or family members for service recovery and damage control. Reactionary risk assessment by a non-physician to an unanticipated clinical outcome drew the ire and distrust of the medical staff, he says.

As medical malpractice filings increased, physicians feared discipline and backlash and rebuffed interaction with a risk manager, adds **Mollie K. O'Brien**, JD, an attorney with Epstein Becker Green in Newark, NJ, in the firm's health care and life sciences practice.

Defense attorneys counseled physician clients not to work cooperatively with risk managers because anything they said could, and would, be discoverable and used against them in a liability suit, the attorneys explain

"Where physicians may have been willing, and programmed, to participate in a protected peer-to-peer discussion about outcomes and potential for improvement, cynicism abounded regarding the risk manager's willingness, or ability, to provide meaningful guidance or protection from reprimand or disclosure," Breen says. "As a result, data collection for medical misadventures was spotty, self-reporting of errors or near misses was nearly nil, and risk managers were at odds with their own medical community. A proactive risk approach was practically impossible."

That began to change in the 1990s when a national discussion evolved regarding patient safety, they say. That dialogue began a slow but steady alignment of the Department of Risk Management with the Department of Quality Improvement.

"News headlines proclaimed any number of preventable medical errors. Public outcry demanded transparency from clinicians. A necessary colloquy on proactive risk assessment came next," O'Brien says. "State laws requiring disclosure of medical errors by physicians and hospitals followed immediately. Those laws promised to protect physicians from liability for disclosure in the name of a safer practice environment and better patient outcomes but physicians remained understandably cynical."

Slowly, this change in the landscape shifted the perception of the risk manager's role within the hospital and illuminated the need for a partner who understood where risk lurked and how it could be mitigated, they say. Risk managers had to become educators on the law, delegates of the legal department to comply with reporting requirements, who had to induce physicians to discuss errors and potential for improvement, the attorneys recall. Risk managers evolved into a necessary and important part of the team.

"In 2013, the risk manager's role as an essential member of the hospital team is confirmed," Breen says. "The implementation of the Patient Protection and Affordable Care Act, and its mandate that quality of care and acceptable outcomes will determine reimbursement, has made investment in risk management and ERM [enterprise risk management] programs a priority. Government enforcers are increasingly examining quality and medical necessity under the False Claims Act rubric, connecting a hospital's financial survival to its risk management program."

SOURCES

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- Mollie K. O'Brien, JD, Epstein Becker Green, Newark, NJ. Telephone: (973) 642-1900. Email: mobrien@ebglaw.com. ✦

Hospital in hot water after complying with police

A hospital in New Mexico is facing a lawsuit that alleges clinicians there forcibly subjected a man to multiple manual searches of his rectum, along with three enemas, two X-rays, and a colonoscopy — all at the request of police who suspected he was hiding narcotics. After 12 hours in custody, the police finally relented when no drugs were found.

The lawsuit states that 54-year-old David Eckert was subjected to the invasive searches after police officers from Deming, NM, and Hidalgo County, NM, pulled him over for a traffic violation and suspected he was hiding narcotics in his body. Eckert was never charged, but according to the lawsuit, the hospital billed him for the cavity searches to which he did not consent. *(For more on the incident, see the story on p. 6.)*

Police obtained a search warrant and initially took the man to Mimbres Memorial Hospital in Deming, but doctors there said the requested search was unethical and refused the police request, according to the lawsuit. Officers then took Eckert to Gila Regional Medical Center in Silver City, NM, outside Hidalgo County. The lawsuit alleges that crossing the county line invalidated the search warrant.

The police and both hospitals declined to comment for this story, but attorneys familiar with the laws on forcible searches say Gila Regional might be in serious trouble for complying with the search request and taking it as far as the plaintiff claims. But they also acknowledge that hospital clinicians and administrators can find themselves in a difficult position when police request a blood draw or other invasive search on an unwilling subject.

Hospitals should always require a search warrant before even considering such a request, says **David Smith**, JD, a partner with the law firm of Garvey Schubert Barer in Seattle. He recently assisted the Washington State Medical Association in updating its guidance to Washington hospitals regarding disclosures to law enforcement, and he has researched the issue raised by a forced body cavity search. *(For more on why a search warrant is necessary, see the story on p. 6.)*

Even with a search warrant, the hospital still must tread carefully, Smith says. It can be reasonable for the hospital to decline the search, he says.

> *"Even if you have a warrant and the patient is harmed as a result of the search, you can still be sued."*

"Even if you have a warrant and the patient is harmed as a result of the search, you can still be sued. The warrant is not something that immunizes you from liability," Smith says. "Things like this are fraught with risk, and if a hospital called me with this situation, I would want to talk to the police officer and the judge who issued the warrant before allowing my client to proceed. The risk of being sued is very, very big."

Clinicians should be trained not to automatically comply with such police requests and to consult the risk manager and legal counsel. If you are sued, the insurance company might refuse to pay because the clinicians intentionally performed the search rather than the tort being the result of an accident or error, Smith says.

A body search at police request goes beyond a question of consent, Smith notes. Even if a person consents to the action by hospital personnel, the subject also must waive the constitutional right against unreasonable search and seizure. That is a legal issue that cannot be addressed solely by an emergency department physician, Smith says.

"The problem is that people often try to apply medical judgment to a problem that actually requires legal judgment," he says. "A hospital will be in trouble if it just complies with a request from law enforcement without really understanding that situations become very technical when you're talking about the Fourth Amendment."

In addition to a civil lawsuit, a public hospital is considered an agent of the state and can be sued under the federal Civil Rights Act, Smith notes.

The plaintiff in New Mexico also alleges that the repeated searches went beyond what was authorized by the

Executive Summary

A New Mexico hospital is being sued by a man who was subjected to repeated searches against his will because police thought he was hiding narcotics in his rectum. The case raises questions about when hospitals should comply with such a request and how far to go.

- ✦ One hospital refused the police request.
- ✦ Police had a search warrant, but the actions might have exceeded it.
- ✦ Risk managers should train clinicians to refer police requests to the risk manager and legal counselor for legal assessment and to avoid automatically complying with requests.

search warrant, and Smith agrees.

"The warrant probably authorized a search, but it did not authorize repeated procedures," he says. "Once you made the first search, you probably have done what the warrant authorizes. Anything done after that probably was done without legal justification."

Though emergency department clinicians usually try to cooperate with local police, risk managers should counsel clinicians against taking that relationship too far, says **Craig B. Garner**, JD, an attorney and adjunct professor at the Pepperdine University School of Law, Malibu, CA. He previously was chief executive officer at Coast Plaza Hospital in Norwalk, CA.

"It is reasonable to give the police a presumption that they are acting in good faith, to give them some benefit of the doubt," Garner says. "But you can't just follow them blindly."

SOURCES

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Man claims hospital repeatedly forced cavity search

David Eckert, 54, is suing Gila Regional Medical Center in Silver City, NM, accusing clinicians there of "subjecting him to multiple digital penetrations and three enemas," and other "shockingly invasive medical procedures," according to his lawsuit filed recently.

Eckert's attorney provided these highlights from his lawsuit:

• He was detained for a traffic offense, during which officers claim Eckert was acting nervous and clinching his buttocks. When a police dog indicated the presence illegal drugs, police sought to search Eckert's rectum.

• He spent more than 12 hours in custody in January 2013 at a police station and then at the hospital. However, he never was charged; nor did authorities find illicit substances on him.

• "Defendants acted completely outside the bounds of human decency by orchestrating wholly superfluous physical body cavity searches performed by an unethical medical professional," the lawsuit states.

• Police obtained a search warrant from a judge authorizing a search "to include but not limited to his anal cavity."

• Hospital personnel performed an X-ray, and two doctors performed two digital searches of his rectum. One doctor also searched his stool and found nothing.

• Later in the day, hospital personnel administered three enemas to Eckert, followed by a chest X-ray and finally a colonoscopy. No drugs were found.

• Many of the tests took place outside the 6 a.m. to 10 p.m. timeframe for which any such search warrant (unless otherwise authorized) is legally valid under New Mexico law, according to the lawsuit.

• The warrant also was invalid because the searches were performed outside the county in which it was issued, the lawsuit claims. ✦

Always require search warrant for forcible searches

Taking a person's blood or conducting any other invasive search is unconstitutional without a search warrant, explains **David Smith**, JD, a partner with the law firm of Garvey Schubert Barer in Seattle. Doing so opens up the hospital to serious liability.

In April 2013, the U.S. Supreme Court ruled in Missouri v. McNeely that warrantless blood draws were unconstitutional in most circumstances, Smith says. In so ruling, the Supreme Court overturned 46 years of precedent that had created a de facto exception to the warrant requirement for blood draws in arrests for driving under the influence of alcohol or drugs.

"Prior to McNeely, it was acceptable to justify warrantless searches under the exigent circumstances exception to the Fourth Amendment's requirements based on the government's argument that the natural elimination of alcohol from the bloodstream was sufficient justification for a warrantless search," Smith explains. "The Supreme Court rejected this argument in McNeely and required that warrants be obtained whenever possible."

Without a warrant it is likely that a common law battery claim could be established as a matter of law and that additional claims could be made for attorneys' fees and other relief under the federal civil rights statute, Smith says.

"The bottom line is that no hospital should agree to conduct a search of a patient's body for blood, drugs, or anything else without patient consent, a court order, or a warrant," he says. ✦

Court says insurer liable for data breach expenses

A recent court ruling that requires an insurance company to pay a healthcare provider's expenses related to a data breach should be heartening to risk managers who worry about the potentially huge costs of such an event. The ruling does not mean, however, that insurers will pay data breaches without a hassle.

The United States District Court for the Central District of California upheld coverage under a commercial general liability policy for a hospital data breach that compromised the records of nearly 20,000 patients in Hartford Casualty Insurance Company v. Corcino & Associates et al. *(See the story on p. 8 for more details on the case.)*

The costs in question were related to class action lawsuits alleging that Stanford Hospital and Clinics in Palo Alto, CA, and the insured medical consulting firm Corcino & Associates violated the privacy rights of patients by providing confidential personally identifiable medical information to an individual who posted the information on a public website.

The insured sought a defense and indemnity under its commercial general liability (CGL), but Hartford Casualty Insurance Co. said the policy did not apply to data breaches. The ruling should be encouraging to risk managers, says **Roberta D. Anderson**, JD, a partner with the law firm of K&L Gates in Pittsburgh. Providers have long hoped that a CGL would cover data expenses, but insurers had made it known they would resist paying.

"At least in California, this is a very significant decision," Anderson says. "The advertising and personal injury section of the policy contains a key definition that provides coverage for damages arising out of oral or written communication that violates a right of privacy. That absolutely can cover data breaches."

Even so, don't expect your insurer to happily pay the expenses of a data breach. Despite the court's ruling, this case illustrates that insurers will fight the claims even when a CGL policy has language that seems to explicitly include data breaches. "Insurers will tell you that they do not intend to cover data breaches, that they never did under the traditional policies," Anderson says. "Over the past 10 years, exclusions have made their way into the policies, and even if they don't have exclusions, insurers will take the position that it is not covered. You can still have to fight out in court and pay significant legal expenses."

Insurers are including more exclusions in CGL policies, and they are getting more specific in describing how data breaches are not covered, Anderson says. The Hartford policy in this case had an exclusion that the company argued voided the other clause that seemed to provide coverage for a data breach, so Anderson says the exclusions currently being added to policies might require court tests to establish their validity.

One reason insurers want to exclude data breach coverage, other than the obvious potential expense of coverage, is that they are simultaneously offering separate policies specifically designed for data breaches. Anderson says healthcare providers should consider such policies, because the notification costs alone for a breach can exceed $500,000. *(See the story on p. 8 for more on those policies.)*

The California ruling is reassuring in that it suggests the courts will interpret insurance coverage broadly and the exclusions narrowly, says **Betsy Baydala**, JD, an associate with the law firm of Kaufman Borgeest & Ryan in New York City. However, insurers are likely to respond. The court told Hartford that its exclusion was not sufficiently specific to deny coverage for the data breach, so Baydala says insurers might take that as a signal to be more explicit with the data exclusions in a CGL.

"If you are seeking coverage for data breaches, and you should, then the CGL is not the best solution," she says. "Previous general liability policies may have been worded in such a way that you can still obtain coverage for a breach, but that is not as likely in the future as the insurance industry responds to this concern."

The insurance industry is certain to continue fighting data coverage under CGLs, says **Richard D. Milone**, JD, a partner with the law firm of Kelley Drye & Warren in Washington, DC. Providers should be able to expect coverage for data breaches under a CGL, he says, but the huge costs of breaches is making insurers look for a way out, especially if they can turn around and sell you a separate cyber policy, he says.

"There is a growing number of lawsuits testing whether a general liability policy will provide coverage," Milone says. "This is a very good decision

Executive Summary

A federal court ruled recently that a commercial general liability policy must cover damages from a data breach. The insurer argued that the contract clause did not apply.

- ✦ The policy covered "personal and advertising injury."
- ✦ The insurer argued that another clause allowed them to deny data breach expenses.
- ✦ Risk managers should study the wording of such clauses and discuss them with insurers.

because it says the policyholder does get coverage under the standard policy. That is good for now, but we know that when insurers see themselves paying out a lot of money, they don't just accept it as the cost of doing business. They will continue to narrow the circumstances in which they pay as much as they can."

SOURCES

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Insurer tried to say CGL offered no breach coverage

A federal court ruled recently that a commercial general liability policy issued by Hartford Casualty Insurance Co. covers defense costs and damages that might arise from two lawsuits brought by patients who alleged a massive data breach exposed their personal medical information to public view for more than a year.

The U.S. District Court for the Central District of California rejected Hartford's argument that the policy's exclusion of statutory causes of action was triggered because the litigation was brought under the California Confidentiality of Medical Information Act (CMIA), court records show.[1] The exclusion did not apply because the state's common law has long recognized a right to medical privacy, the court reasoned.

Roberta D. Anderson, JD, a partner with the law firm of K&L Gates in Pittsburgh, offers this summary of the federal court decision: The ruling was prompted by litigation in which patients sued Stanford Hospital and Clinics and Corcino & Associates, and claimed that the protected health information (PHI) of almost 20,000 patients was posted on a public website for almost a year.

Leaders at Corcino thought they were covered. They sought defense and indemnification under a provision of their Hartford general liability policy that covers damages stemming from the "electronic publication of material that violates a person's right of privacy." The "personal and advertising injury" insuring clause of policy stated that Hartford Casualty Insurance Co. would "pay those sums that the insured becomes legally obligated to pay as damages because of … 'personal and advertising injury.'"

The term "personal and advertising injury" was defined in the policy as "including consequential 'bodily injury,' arising out of one or more of the following offenses: e. Oral, written or electronic publication of material that violates a person's right of privacy. As used in this definition, oral, written or electronic publication includes publication of material by someone not authorized to access or distribute the material."

But Hartford balked and said the policy specifically excluded coverage for injuries "arising out of the violation of a person's right to privacy" created by statute. It argued that the claim could be denied because it was excluded from coverage under the following exclusion pertaining to violations of statutorily created rights: "This insurance does not apply to: p. Personal and Advertising Injury, (11) Arising out of the violation of a person's right to privacy created by any state or federal act." Hartford took the issue to court and sought declaratory relief from having to defend and indemnify Corcino in the state court actions.

The federal district court dismissed Hartford's action and pointed to another clause in the policy that made the exclusion inapplicable where the insured could be liable for damages under the common law. The court explained that the exclusion only applied in instances in which a claim arising out of an invasion of privacy is created by statute.

California law recognizes a right to privacy and allows tort actions for violations of that right. "The statutes thus permit an injured individual to recover damages for breach of an established privacy right, and as such, fall squarely within the Policy's coverage," the court held.

In considering Stanford's motion to dismiss, the court noted that "insurance coverage is interpreted broadly so as to afford the greatest possible protection to the insured." The court said that "if any reasonable interpretation of the Policy would result in coverage, a court must find coverage even if other reasonable interpretations would preclude coverage."

Reference

1. Hartford Casualty Ins. Co. v. Corcino & Assocs., No. 2:13-cv-03728-GAF-JC (C.D. Cal. Oct. 7, 2013). ✦

Cyber policies a good deal, but choose carefully

Insurance policies that specifically cover the costs associated with a data breach are a good buy right now, but they are not all the same. Some provide excellent coverage while others are so general that you cannot be sure of what the insurer would pay for, says **Roberta D. Anderson**, JD, a partner with

the law firm of K&L Gates in Pittsburgh.

"The cyber policies can be extremely valuable, but they really vary so you want your broker and outside counsel to guide you in selecting the right policy," Anderson says. "Some are almost useless, and some are tremendously valuable, and there may be no difference in premium between the two."

A good cyber insurance policy will pay for your defense and indemnity for lawsuits arising from the breach, Anderson says, but it also will cover you on a first-dollar basis (or close to it) so there is no deductible for notification, legal advice on how to notify, credit monitoring, forensics to figure out what happened, and public relations work. A cyber policy currently costs about $15,000 per million of limits, a low cost because insurers are just now trying to promote the policies, she notes.

Insurers will be less likely to balk about paying for data breaches under a cyber policy, at least for now, she says.

"Right now insurers don't want to be the first to deny coverage under a cyber policy, so they will be more lenient in interpreting the contract language," Anderson says. "But five years from now when most providers have coverage, they won't be so timid about saying no if they can find a way. Some of the policies now do not reasonably respond to how hospitals handle data through vendors, cloud providers, and other outside sources." ✦

OIG targets sleep studies, and CMS promises crack down

Nearly $17 million of the $565 million spent on sleep studies in 2011 did not meet Medicare requirements, according to a recent report from the Office of the Inspector General (OIG). In response, the Centers for Medicare and Medicaid Services (CMS) said it would take a more critical approach to polysomnography.

OIG recommended that CMS tighten its claims processing for sleep studies and that the agency take action against providers and suppliers that might have received improper Medicare payments.

The report titled "Questionable Billing for Polysomnography Services" follows the OIG's 2013 work plan, which indicated its intent to review and identify questionable billing patterns for Medicare-covered sleep studies. That work plan was prompted by a marked increase in Medicare spending on sleep studies. The OIG noted that from 2005 to 2011, Medicare spending on sleep studies increased 39% from $407 million in 2005 to $565 million in 2011. *(The OIG report is available online at http://1.usa.gov/1gfI4su.)*

Even before the report, Florida-based American Sleep Medicine agreed in March 2013 to pay a $15 million settlement to resolve allegations that it submitted false claims to Medicare and other federal payers.

For the report the OIG reviewed provider and supplier billing for sleep study services. Medicare payments for sleep study services from 2011 were analyzed under 11 measures of questionable billing. There were three Medicare requirements for reimbursement. There were eight measures independently designed through collaboration between sleep medicine professionals and fraud investigators within and outside the OIG. The OIG found that $17 million of the payments made to providers in 2011 did not meet one or more of the three Medicare requirements and that 180 providers and suppliers exhibited patterns of questionable billing practices.

OIG recommended ... that the agency take action against providers and suppliers that might have received improper Medicare payments.

The OIG found that most of the facially inappropriate claims involved wrong diagnosis codes, duplicate services for the same beneficiaries, or invalid National Provider Identifier (NPI) numbers. Eighty-five percent of the invalid claims originated from hospital outpatient departments, a disproportionately high number considering that hospital outpatient department sleep study claims represented only 53% of all such claims in 2011.

The 180 providers and suppliers exhibiting questionable sleep study billing practices exhibited one or more of the following patterns:

- same-day or duplicate claims;
- double-billing for the professional component of sleep studies;
- repeated procedures;
- missing professional component;
- multiple sleep studies performed for the same beneficiaries;
- unbundled claims (services performed over two consecutive nights usually must be bundled together and billed on the same claim);
- missing visits from ordering provider.

The OIG made these recommen-

dations to CMS:

• Implement and improve claims processing edits and controls to prevent inappropriate payments.

• Recover payments for claims that were found not to meet Medicare requirements.

• Leverage measures of questionable billing practices identified in the study to identify providers and suppliers for further investigation.

• Take appropriate action regarding the 180 providers and suppliers that OIG found to exhibit questionable billing patterns. ✦

Hospital and physicians indicted in kickback case

The owner and three other executives of the now-closed Sacred Heart Hospital in Chicago and four physicians affiliated with the facility were indicted recently on federal charges alleging that they collectively paid and received hundreds of thousands of dollars in illegal kickbacks in exchange for the referral of hospital patients who were insured by Medicare and Medicaid.

Sacred Heart allegedly paid physicians bribes and kickbacks to induce patient referrals and increase the patient census, which, in turn, increased hospital revenue. Sacred Heart Hospital was a 119-bed acute care facility that closed in 2013. It filed for bankruptcy after Medicare payments were suspended in the aftermath of criminal charges that were first filed in April 2013. The recent indictment charges only conduct involved in the alleged kickback conspiracy while a broader investigation that was outlined in the earlier criminal complaint continues.

The eight defendants were charged in a 17-count indictment that was returned by a federal grand jury and announced by Zachary T. Fardon, JD, U.S. attorney for the Northern District of Illinois.

One of the defendants is Noemi Velgara, 64, of Chicago, who was Sacred Heart's vice president of geriatric services and was responsible for overseeing the Golden L.I.G.H.T. medical clinics, including managing employees responsible for marketing, and recruiting and transporting patients. All eight defendants will be ordered to appear for arraignment in U.S. District Court.

Four defendants were each charged with one count of conspiracy to violate the federal healthcare anti-kickback statute by offering and paying kickbacks and bribes, directly and indirectly, from Sacred Heart to physicians to induce them to refer patients to the hospital for services that would be reimbursed by Medicare and Medicaid.

Sacred Heart allegedly paid physicians bribes and kickbacks to induce patient referrals and increase the patient census ...

Two of the physicians were each charged with eight substantive counts of paying kickbacks for patients, while four were charged with two counts each of accepting kickbacks for patient referrals. The indictment also seeks forfeiture of illegal proceeds from the physicians, including the unspecified total amount of Medicare and Medicaid reimbursements made on claims submitted on behalf of hospital patients whose referral involved kickbacks, and the total amount of kickbacks paid to the four physicians.

According to the indictment, Sacred Heart's owner, executives, and administrators conspired between 2004 and April 2013 to pay physicians bribes concealed as consulting, employment, and personal services compensation, rent, and instructional stipends in return for referrals of Medicare and Medicaid patients. Although styled as payments for legitimate services, the payments actually contained disguised bribes paid to and for the benefit of physicians in exchange for patient referrals, according to the indictment.

The indictment alleges that the arrangement caused Sacred Heart to pay a physician hundreds of thousands of dollars in bribes disguised as rent and more than $150,000 in bribes to one physician, disguised as payments for purportedly teaching podiatric surgery residents. Some of the defendants allegedly agreed to have Sacred Heart offer to pay bribes to the hospital's transportation staff to recruit and refer patients to the hospital, and those three defendants also caused Sacred Heart to pay individuals employed as "marketers" to recruit patients.

Each count in the eight-defendant indictment carries a maximum penalty of five years in prison and a $250,000 fine. Restitution is mandatory. ✦

Report says hospital did not search for patient who was missing

Hospital leaders never ordered a full search for a missing San Francisco hospital patient until nine days after she disappeared, according to a recent report that alleges a series of errors by the hospital.

San Francisco Sheriff Ross Mirkarimi released a report on the investigation, prompted after the body of 57-year-old Lynne Spalding Ford was found in a stairway at San Francisco General Hospital. She had been missing for nine days.

Mirkarimi's report states that the Spalding Ford checked into the hospital Sept. 19, 2013, for a bladder infection. On the morning of Sept. 21, a hospital employee called the sheriff's department and reported that Spalding Ford has been missing for 40 minutes. (The sheriff's department oversees security at the hospital.).The caller also described the patient as African-American, but a sheriff's report later described her as Asian.

Authorities made a perimeter search of the hospital grounds, but deputies did not immediately classify the woman as a missing person, the report says. Evening shift deputies stationed at the hospital were not notified about Spalding Ford by the earlier deputies.

Four days after Spalding Ford's disappearance, the San Francisco Police Department asked the sheriff's department to pull surveillance video to see if there are any images of the patient leaving, but there were technical problems with viewing the tape.

Nine days after Spalding Ford was reported missing, the hospital asked sheriff's deputies to search its entire 24-acre campus. They did, but the search did not include all stairwells. On Oct. 1, a deputy realized the stairwells had not been searched and began searching them. But still only about half of them were searched. On Oct. 4, a hospital employee told the sheriff's department that someone reported a person lying on the third- or fourth-floor landing of Stairwell 8.

"The Communications Center staff responded, 'We'll take care of it,'" the sheriff said in a news conference announcing the report. "There is no indication that anyone was dispatched to that stairwell."

On Oct. 8, a hospital engineering employee who was conducting a routine check found Spalding Ford's body in an exterior stairwell. The hospital and sheriff's department said the stairwell is "a fire exit that is not routinely used by staff, patients, or the public." The stairwell door was alarmed, but it is not clear if it sounded.

Mirkarimi said his department will review policies and procedures regarding missing patients and campus searches. ✦

COMING IN FUTURE MONTHS

- ✦ Why your nicest patient may end up suing
- ✦ Who is covering for you on weekends?
- ✦ Employee health should be your risk concern
- ✦ Will ACA lead to doctor shortage?

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. **According to R. Stephen Trosty, JD, MHA, CPHRM, president of Risk Management Consulting and a past president of ASHRM, what was one effect of the introduction of regulatory issues such as the Emergency Medical Treatment and Labor Act (EMTALA) and the Health Insurance Portability and Accountability Act (HIPAA)?**
   A. They greatly increased the need for compliance within healthcare organizations, which in turn created more value for the risk manager.
   B. They had little or no effect on the role of the risk manager.
   C. They diminished the valued of the risk manager because other administrators more clearly understood the related risks.
   D. They created a hurdle for the advancement of risk managers because they required additional education.

2. **In the lawsuit filed by David Eckert regarding invasive searches at a hospital, which of the following is true?**
   A. Police had no search warrant.
   B. Police had a search warrant, but it specifically disallowed a cavity search.
   C. Police had a search warrant, and there is no dispute at its validity.
   D. Police had a search warrant, but the plaintiff argues that it was not valid in the county where the search took place.

3. **What does David Smith, JD, a partner with the law firm of Garvey Schubert Barer, advise regarding the need for a search warrant before complying with a police request to draw blood or take other invasive action?**
   A. It is never necessary to require a search warrant.
   B. It is always necessary to require a search warrant.
   C. A search warrant is needed only if the person must be restrained.
   D. A search warrant is needed unless the person is in police custody.

4. **In Hartford Casualty Ins. Co. v. Corcino & Assocs., what did the court decide regarding the insurer's obligation to pay for data breach expenses under the general liability policy?**
   A. Hartford must pay, even though there was an exclusion clause that the insurer said applied to the situation.
   B. Hartford must pay because there was no exclusion clause.
   C. Hartford does not have to pay because the exclusion clause nullified other sections that seemed to indicate coverage.
   D. Hartford does not have to pay because the policy was not a specific policy for cyber insurance.

Legal Review & Commentary

A Monthly Supplement to HEALTHCARE RISK MANAGEMENT

Botched removal of pacing wires leads to verdict of $5.5 million

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News: A woman surviving an extensive cardiac bypass surgery died after the removal of pacing wires in her chest caused fatal internal bleeding, directly leading to her death. After the successful placement of the pacemaker in the woman's chest, the pacing wires remained on her heart, as per the traditional protocol.Over several days, it was determined that the wires were no longer needed and were removed by a nurse. However, because the wires were improperly placed in the woman's chest, removal of the wires severed a vein graft, which caused uncontrollable internal bleeding. Despite attempts by the hospital staff and the on-call thoracic surgeon, the woman ultimately died as a result of the bleeding caused by improperly placed pacing wires. To make matters worse, a nurse was dispatched to inform the family of the tragedy instead of the surgeon doing so himself, which enraged the family. After the woman's death, the daughter brought suit, on her own behalf and on behalf of the estate of her late mother, against the surgeon responsible for placing the wires. Ultimately, the jury unanimously found that the cause of death was directly related to the misplaced wires and awarded the decedent's daughter $5.5 million dollars.

... the woman ultimately died as a result of the bleeding caused by improperly placed pacing wires.

Background: In February 2011, the adult woman underwent cardiac bypass surgery under the care of the surgeon at a hospital specializing in vein restoration. Heart bypass surgery has been performed on patients for about 40 years. Recent statistics indicate that about 500,000 bypass surgeries are conducted each year, which makes it one of the most common surgical procedures in the United States. While this surgery is common, extensive training of cardiovascular surgeons is essential not only for patient care during the surgery, but also patient care during the recovery stage.

For cardiac bypass surgery, the main goal is to create a literal bypass by grafting a section of a vein above and below an obstructed area of a patient's coronary artery. It is standard to place temporary pacing wires in the patient's chest, as well as tubes to drain excess fluids, to monitor and regulate a patient's heart rate after the surgery while the patient is recovering. The placement of these wires is vital because removal or placement of the wires might interfere with any vein grafts in the patient's chest. Generally, pacing wires are left in the patient's chest and trimmed from outside, or the wires are completely removed.After recovering from the surgery for approximately five days, the patient's nurse removed the pacing wires.

It should be noted that although removing pacing wires is a routine part of bypass surgeries, in this case, once the nurse was given approval to remove the wires, the woman began to

FINANCIAL DISCLOSURE: Author **Greg Freeman**, Executive Editor **Joy Daughtery Dickinson**, and Nurse Planner **Maureen Archambault** report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. **Damian Capozzola**, **Jamie Terrence** and **Angelina Gratiano**, co-authors, have no relationships to disclose.

bleed internally. Within a few minutes, the bleeding was uncontrollable, the woman became unconscious, and she ultimately died as a result of the extensive blood loss. Eventually the hospital staff realized that the vein graft had been severed as a result of removing the pacing wires; however, the hospital records did not indicate important information, such as who placed the wires. This kind of objectively pertinent medical information is always vital to be included in a patient's medical record, and indeed is required for submission to CMS and insurers.

Eventually the woman's daughter brought two causes of action individually and on behalf of her late mother's estate against the surgeon responsible for overseeing the placement of the wires: (1) negligent medical care and (2) wrongful death. Additionally, the daughter brought the same causes of action against the medical facility, claiming the doctor was the medical facility's agent. The daughter's lawsuit claimed that the doctor improperly placed the wires on her mother's heart. During the trial, the jury was allowed to note that the medical records failed to indicate not only who placed the pacing wires during the surgery, but also how many wires were placed in the patient's chest. Moreover, none of the surgical staff that testified at trial could recall this information.

The surgeon's defense at trial was that the plaintiff failed to meet the required evidentiary burden in the case. The surgeon asserted that since the plaintiff failed to provide evidence showing who placed the wires, the plaintiff failed to prove that the wires were, in fact, placed improperly. However, the plaintiff's attorney questioned the surgeon on the stand, asking repeatedly if information about who placed the wires in the patient was the kind of objective and relevant information that should be included in a patient's medical record. Eventually, the surgeon admitted that this is the kind of information that is objective and relevant to a patient's medical care.It remains to be seen whether this response swayed the jury, but the plaintiff's primary evidentiary focus was the fact that the surgeon filled out the death certificate indicating that the cause of death was a result of an injury caused by pulling the pacing wires from her chest.

Ultimately, members of the jury unanimously determined that the doctor and medical facility were responsible for the patient's death and awarded a $5.5 million dollar verdict, for which the doctor and the medical facility were jointly and severally liable.

What this means to you: Cardiac bypass surgeries are all too common in the United States. However, as with any kind of medical care, it is essential to diligently monitor and record patient care. Every effort should be taken to ensure that a patient's medical record includes all objective and relevant information. In this case, the failure of the surgeon and medical staff to properly memorialize common pertinent facts of a surgery presented an evidentiary problem at trial. By not including this information, the surgeon and the medical facility were not as prepared in developing their defense.

Unfortunately, staff members at hospitals and other medical facilities often leave critical information off the record. This issue can be especially problematic during surgical procedures. The primary surgeon seldom performs all aspects of a surgery. Most states and hospitals have regulations requiring surgeons to operate with an assistant surgeon in the room. Also, there are students, resident physicians, and often surgical equipment vendors participating in the procedure. Indeed, a common issue that defense attorneys see in the high-risk arena of labor and delivery is for the medical record to lack the name of the individual who actually delivered the infant. The Joint Commission and the Centers for Medicare and Medicaid Services have made great strides in ensuring that regulations require surgical teams to account for all instruments and sponges used during a surgical procedure. Your hospital or other medical facility needs to take this one step further to ensure that there is a complete accounting in the medical record of every individual in the surgical suite, even if they were only observing. Also note that the patient has the right to know who these people will be and approve of their participation before the surgery takes place.

Additionally, in situations in which a tragic mistake does happen, it is essential for the physicians to ensure that the lines of communication are open between themselves and the patients' families. Bedside manner matters. When something goes wrong, it might in some instances mean the difference between whether a lawsuit is filed or whether a doctor is named as an individual defendant. Unfortunately, in the case of this patient, the surgeon failed to personally inform the patient's family about the death and failed to speak with the family about the circumstances surrounding the complications. A nurse was designated to relay the tragic news to the family without explanation, which confused and angered the family, especially since prior to the surgery the surgeon had been generally available to the family.

That said, it is very unusual for hospital policy, which governs most aspects of nursing procedures, or medical staff rules and regulations, which govern the activities of the medical staff of the hospital, to permit notification of death or other serious adverse event, by anyone other than the physician caring for the patient. A nurse should never find himself or herself taking on this role and should refuse to do it.The reasons are many, but the primary issue is the ability of the nurse to answer the complex medical questions that might follow. The first thought that comes to the bewildered family members in these cases is that the physician is negating responsibility and is somehow implicated in the event and therefore unwilling or unable to face them. Trust is lost. While being open to confronting

a patient's family, specifically being the bearer of bad news, can be extremely difficult, it is the sole responsibility of the physician. Even if the doctor's actions are not the result of the patient's complications, speaking with the family can go a long way to ensuring that the family feels like they are "in the loop" and adequately understand what happened to their loved one. By avoiding the use of complex medical terms, which can leave patients and their families feeling confused or completely in the dark and explaining things at the level the patient and family understands, the physician builds trust and eliminates the uncertainty that often leads to them seeking plaintiff attorney counsel.

Hospitals also should take extra steps to remind patients that the physicians that practice in their hospitals are not hospital employees. Signs should be posted that state this fact. Patients should initial their understanding of this fact on consent forms. Physician badges should not bear the hospital name or logo. In some cases this approach might prevent the hospital from becoming a party to litigation if the negligence is clearly placed on the physician.

Lastly, in situations where the doctors have the option to settle with the patients or their families, the doctors might want to strongly consider the option of a confidential settlement agreement. Healthcare professionals might opt for this settlement when it makes sense to end litigation of the case quickly. Deciding to go to trial can create serious public relations problems for the doctor and the hospital and damage well-established and hard-earned reputations along the way.

Another important concern for healthcare professionals should be that an appearance of the likelihood for successful litigation might create further litigation. When a particular case is publicized in the press, the public (which includes potential plaintiffs) might perceive that other cases will be successful as well.With this in mind, a settlement agreement might help to avoid public disapproval of the doctor and/or hospital, as well as the potential inundation of lawsuits.

Obviously, settlement agreements might not be a good option when the doctor or the hospital has a good defense for claims of medical negligence or malpractice. However, if there is a strong likelihood that the plaintiff will be able to present evidence at trial that is likely to prove their case, a confidential settlement agreement might be the best option for the doctor and hospital.

Reference

No. CAL13-15952, Prince George County Circuit Court, Prince George County, MD.Sept. 6, 2013. ✦

Woman wins $9.3 million for overdose of incorrect drug

News: A tragic mistake at a hospital left a woman permanently disabled when she was admitted to the hospital to treat a urinary tract infection but incorrectly received an overdose of the drug Lovenox (exnoxaparin sodium), a blood thinner commonly used to treat deep vein thrombosis. The mistake in medication usage, as well as the overdose, left the elderly woman confined to a wheelchair, which she will need to rely on for the rest of her life. Additionally, the woman will continue to suffer serious ongoing medical issues throughout her life as a result of the overdose. After a two and one-half week trial, the jury awarded the woman $9.3 million in damages for the hospital's professional medical negligence in her treatment.

Background: Despite suffering from a urinary tract infection the 72-year-old patient was, by all accounts, a relatively active and healthy adult. In October 2007, the elderly woman was admitted to the hospital for treatment related to a urinary tract infection. While treatment for urinary infections can be fairly simple, these infections can create serious complications for the elderly, specifically kidney infections. Generally, treatment for a urinary tract infection involves the use of antibiotics to prevent the infection from spreading to the kidneys. In this case, a rigorous course of intravenous antibiotics was used via a tube inserted in her neck, to treat the infection and prevent it from spreading. However, a deep vein thrombosis (DVT) formed near the insertion point of the tube, and the patient was treated with Lovenox to dissolve the large blood clot. This medication is commonly used to treat and prevent DVT, which often can lead to pulmonary embolisms. It is often given to patients who are bedridden in hospitals. Unfortunately, there was a mistake in the proper dosage of Lovenox to administer to a female adult patient.

... the woman will continue to suffer serious ongoing medical issues throughout her life as a result of the overdose.

When the nursing staff came in to administer treatment, they failed to check with the patient's chart to ensure that the proper dosage for the medication was being given, given her age and weight. Instead of receiving the Lovenox intravenously with a proper

dosage, the female patient was given the dosage used for a 350-pound man.

To make matters worse, the nursing staff made the mistake of giving the patient more than should be administered to an adult patient based on their weight. The typical dosage of Lovenox for an adult varies depending on the underlying condition being treated. For example, for the treatment of DVT, the typical dosage is 1 mg/kg subcutaneously every 12 hours or 1.5 mg/kg subcutaneously once a day. If a mistake in dosing is caught early, it might be possible to treat this condition by holding off on additional doses to the patient and giving an antidote called protamine, transfusing the patient's blood, and administering blood clotting agents to control additional blood thinning or internal bleeding. Sadly, for this patient, the hospital staff overdosed her by overestimating her weight by 50%.

Moreover, despite the hospital's efforts, in this case the extent of the internal bleeding was severe enough to cause the patient go into cardiac arrest. Fortunately, the hospital staff was able to revive the patient. After revival, the patient needed multiple blood transfusions and required immediate surgical procedures to control the bleeding in her abdomen and to prevent additional damage to other internal organs. Additional medical complications arose, though, after she suffered a serious case of methicillin-resistant *Staphylococcus aureus* (MRSA), which left her in severe pain. As her condition continued to decline, a central line was inserted into her neck, which resulted in the formation of an orange-sized abscess. Eventually, after spending 75 days in the hospital, the patient was released. Ultimately, the overdose left the patient confined to a wheelchair for the rest of her life because she now suffers a permanent hernia as a result of the extensive swelling she suffered from the many blood transfusions needed to revive her. Additionally, she might require future medical treatments and surgeries.

After hearing the evidence presented at the eight-day trial on the hospital's failure to adopt and comply with standard procedures to ensure proper patient dosing, the jury deliberated for an hour and a half before finding the hospital negligent in the patient's medical care. The jury awarded the patient $9.3 million. This figure was based on the costs of her previous medical treatments, the anticipated ongoing medical treatments, as well as compensation for her loss of enjoyment of life and pain and suffering.

What this means to you: Mistakes can and do happen, despite the best efforts made by doctors and hospitals. It is likely that every registered nurse in the United States has made a medication error. There are almost four million nurses in practice at any given moment, so the number of errors can be staggering. Fortunately, most errors do not cause harm to patients and are noticed and reported quickly to prevent recurrence. While Lovenox is not considered a high-risk medication if given at the correct dose and by the correct route, any deviation from this puts the patient in harm's way. There are more than seven "rights" to giving medication to a patient that must be followed by the nurse. It must be the right medication given to the right patient at the right time by the right route at the right dose for the right reason after the right assessment and the right education for the patient. Then the nurse must document all of this information on the medical record.

These "rights' must be followed to minimize the harm associated with the any kind of medication routinely prescribed and administered in an inpatient setting. Even more care is taken if the medication is considered "high-risk." Most hospitals require an "independent double-check" by a second nurse before high-risk medications such as heparin, hydromorphone, and insulin can be administered. Creating a thorough protocol for recording and checking the patient's record is one way to help minimize these kinds of dosing mistakes. Many hospital use 12-hour and 24-hour chart reviews in this regard.

Additionally, comprehensive electronic medical record (EMR) systems have provided physicians and pharmacists greater access to relevant patient information, including their medication profile at the click of a button. Great care must be taken to ensure that there is a well-established system of checks and balances to ensure that the medication administration record is accurate and actually corresponds to the medication the patient is receiving. Had this patient's medication profile been reviewed by the pharmacist, the first medication error would have been noticed before the second one was committed.

Also, gone are the days of trying to track down the actual paper file to review the patient's medical record. Also, paper medical record systems are often inefficient in terms of storage costs, and there is also the problem of transferability. Problems often arise when a paper-based record is needed in multiple locations. For example, one copy of the patient's medical record might be needed at the hospital, one file at the internal medicine doctor's office, and one file at a specialist's office. With the EMR system, these files can be transferred and accessed with a much greater ease. Most importantly, when urgency is needed, these files can be accessed almost immediately.

In theory, all healthcare organizations are fully committed to providing the highest and safest quality of care to its patients. To remain true to this in practice, doctors and hospitals must routinely follow the established protocol for checking patient records forproper dosing.

Reference

No. FBT-CV-10-6007019-S, Bridgeport County Superior Court, Bridgeport County, CT. Oct. 25, 2013. ✦

Healthcare RISK MANAGEMENT

Changes in the healthcare industry could bode well for risk management field

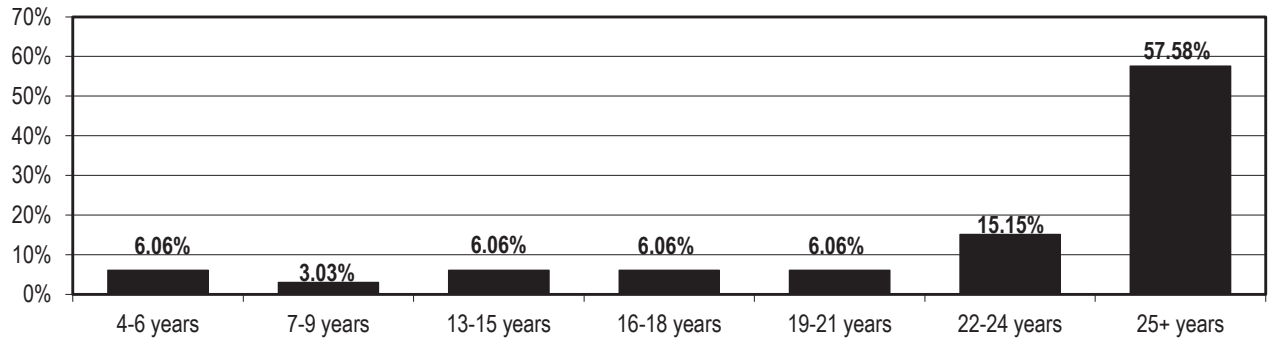
Uncertainty and new risk concerns mean leadership will be in demand

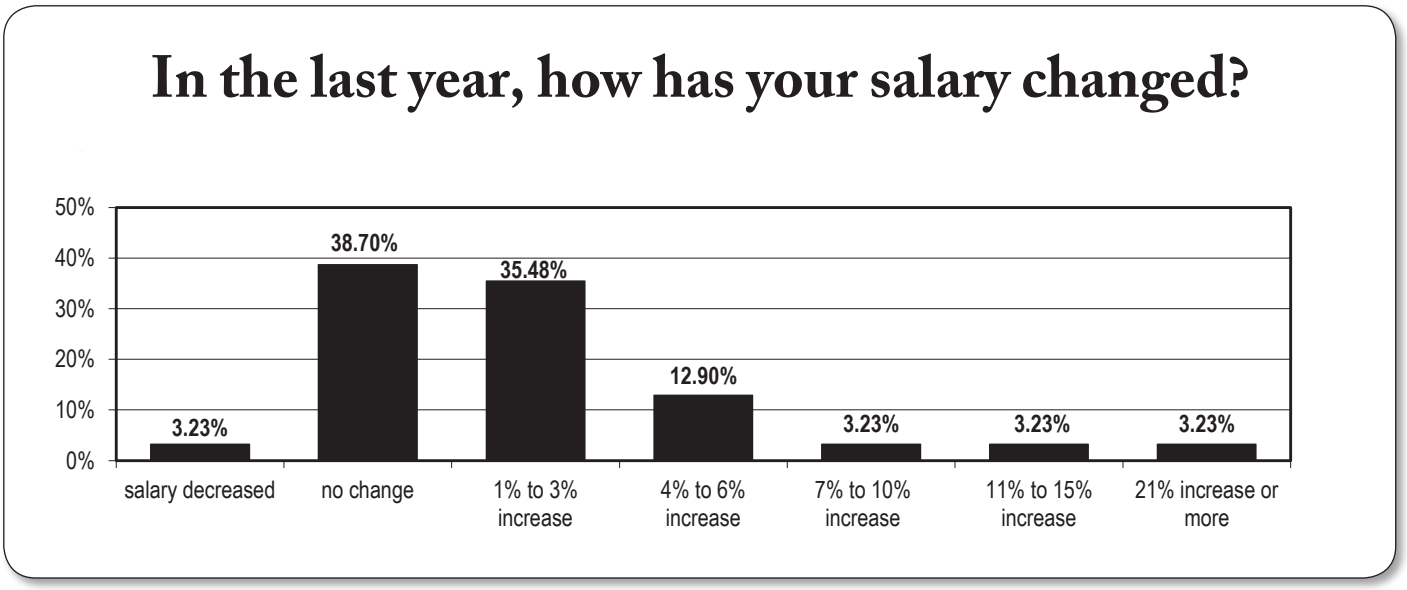
All the uncertainty about what the healthcare industry will look like in the future could be good for the career prospects of risk managers, some in the field say, because uncertainty brings risks and potential liability that must be addressed. Couple that with the expanding list of known exposures and safety issues, and you have a promising outlook for risk managers in hospitals and health systems.

The Affordable Care Act and the move toward an accountable care organization (ACO) model will drive many changes in healthcare and potentially make the risk manager's role more important in the near future, says **Grena Porto**, RN, MS, ARM, CPHRM, healthcare practice leader with ESIS Health, Safety and Environmental in Philadelphia and former president of the American Society for Healthcare Risk Management (ASHRM) in Chicago. In addition, she sees career growth opportunities in the continuing focus on cost-cutting in healthcare, which is leading to initiatives in areas such as employee health.

"There is a blurring of the lines between patient safety and worker safety, with the increasing under-

How long have you worked in healthcare?





standing that you can't have one without the other," Porto says. "We can't focus exclusively on patient safety without also focusing on the worker. So much of the sources of loss in both arenas are the same, like safe patient handling."

That issue is compounded by the fact that the ACO model is prompting hospitals and health systems to take on more physicians as employees, which makes the risk manager responsible for their health and safety, Porto notes.

"What does that do to your workers' comp exposure and the workers' comp loss prevention? And now that they are your employees, you have a vested interest in their productivity," she says. "You may want to do job hazard analysis to find out that if this intensivist has to wear a lead apron eight hours a day, what is that doing to his back? In the old days, maybe that wasn't our problem, but now it is."

Worker fatigue also is becoming a more prominent issue, Porto notes. Studies have established that sleep deprivation can produce effects similar to being intoxicated, but risk managers have not yet determined how to apply that knowledge to the workplace and protect workers and patients.

Healthcare reform also is changing physician practices in dramatic ways and exposing them to more risks, notes **Jane McCaffrey**, DFASHRM, MHSA, director of compliance and risk management at The Blood Connection in Greenville, SC, and a past president of ASHRM. That increasing risk could mean career opportunities for risk managers.

"I've always told people that you don't have to be a risk manager in a hospital, and now the opportunity is really opening up in physician practices," she says. "The compliance concerns for billing in a physician practice are bigger than they have ever been, and I only see that growing as an issue for them. Risk managers with a bent toward compliance can make a real contribution there."

Even if risk managers are taking on more responsibility, that increase might not translate into career advancement and income increases if the right people don't take notice. A continuing challenge for risk managers might be ensuring that all you do is known and valued by the organization's leaders, **Leilani Kicklighter**, RN, ARM, MBA, CPHRM, LHRM, a patient safety and risk management consultant with The Kicklighter Group in Tamarac, FL, and a past president of ASHRM.

"We are still struggling in many ways with showing our value to senior leaders and the board," Kicklighter says. "We still have to look at how they value risk managers and risk management as a whole, how they see the benefit in using them to enhance the value of the organization. But at the same time, we have to ask ourselves if we have all the capabilities necessary to address those risks from an enterprise risk management perspective."

SOURCES

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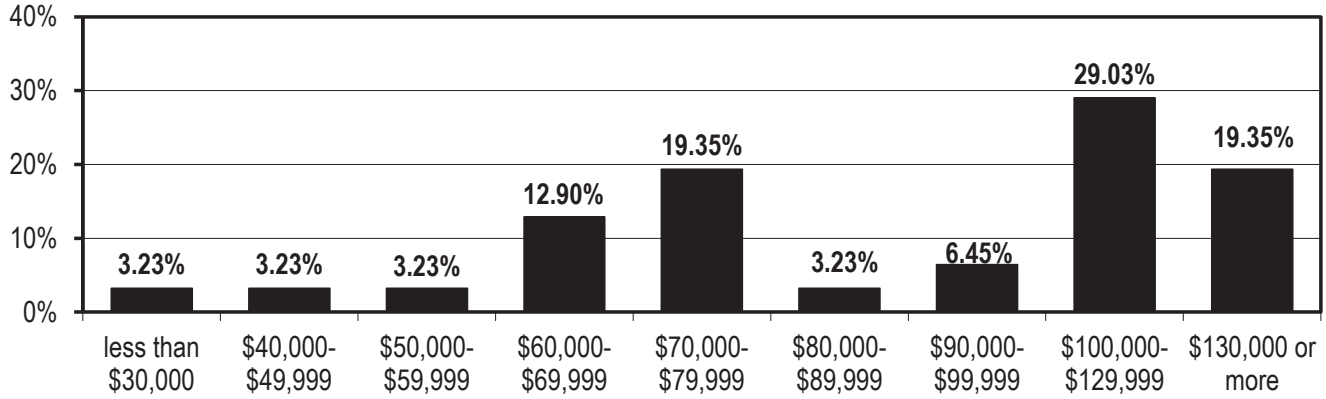
What is your annual gross income?



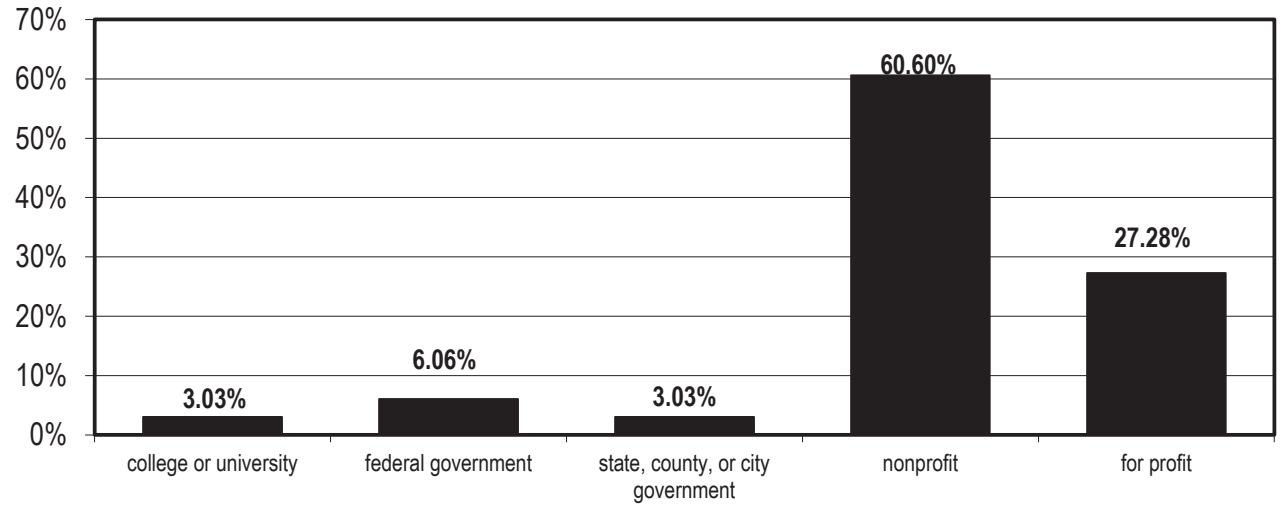
Risk managers see little improvement in income

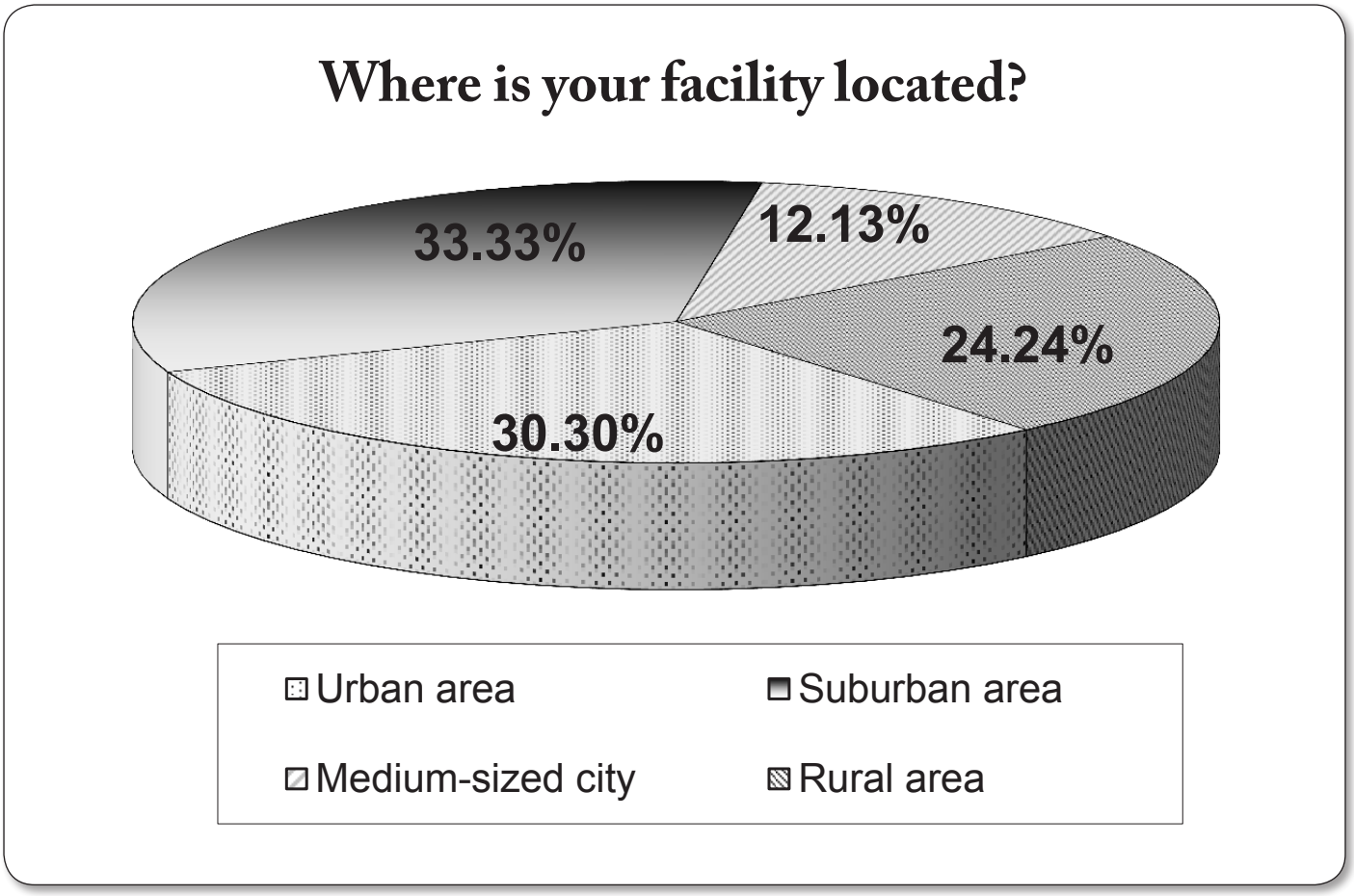
For the fifth year, income for risk managers has held steady

The exclusive 2013 *Healthcare Risk Management* Salary Survey was sent to 518 readers in the June 2013 issue. A total of 33 were returned, for a response rate of 6.3%. The results were tabulated and analyzed by AHC Media, LLC, publisher of *HRM*.

As for the past four years, the median income for healthcare risk managers in this year's survey is $90,000 to $99,999. *(See the chart, above.)* Just under 30% of respondents reported income in the $100,000 to $129,999 range, and 19% reported income of $130,000 or more, up slightly from last year's 18%. Six percent reported income in the $90,000 to

Which best describes the ownership or control of your employer?





$99,999 range.

The median salary increase over the past year was 1% to 3%, the same as the past few years. *(See the chart, p. 2.)* However, a higher percentage — 39% — reported no change in their income, versus 35% reporting the 1% to 3% increase. Last year, those reporting no increase totaled 26%.

Thirteen percent reported increases in the 4% to 6% range, and 3% report increases in the 7% to 10% range. Another 3% reported an increase of 11% to 15%.

Sixty-one percent of respondents work for non-profit healthcare organizations, down from last year's 72%. *(See the chart, p. 3.)* Twenty-seven percent work for for-profit providers, up from last year's 22%, with the remainder in educational or government settings. Fifty-eight percent of readers have worked in healthcare for more than 25 years, a figure down slightly from last year. (See the graphic, p. 1.) I added references to the two new charts, so you probably need to make each column one line longer to get in all the text.)✦

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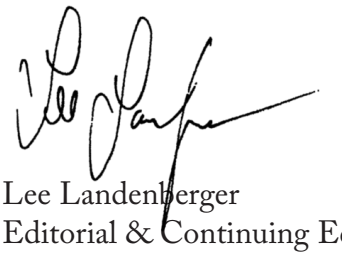

Lee Landenberger
Editorial & Continuing Education Director