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INSIDE

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Workplace violence a growing threat — Recent attack highlights the risks

The video is chilling to anyone, but especially to nurses who can imagine being in exactly the same vulnerable position. A man's brutal attack on unit nurses at St. John's Hospital in Maplewood, MN, is putting the spotlight on violence in healthcare facilities and the potential harm facing the victims and the hospital.

The Minnesota incident was a graphic reminder of the risk faced by healthcare employees. A hospitalized patient suddenly went on a rampage. He rushed to the nurses' station on his unit and attacked four nurses with a metal pole. Four nurses were injured. Security cameras recorded the attack. Police caught the assailant three blocks away, and he died soon after being handcuffed. *(See the story on p. 4 for more details on the attack.)*

Not long after that attack, a patient attacked staff members at a hospital in Oklahoma City. He cut a security guard, bit a nurse, and injured another. (*See the story on p. 4 for more on that incident.)*

> "IF YOU WANT TO PREVENT WORKPLACE VIOLENCE AND RETAIN YOUR NURSES, YOU HAVE TO LOOK AT THE VERBAL ABUSE AS PART OF THE PROBLEM..."

Workplace violence is a recognized hazard in the healthcare industry. The International Healthcare Security and Safety foundation reports that 60% of workplace assaults occur in healthcare facilities. The United States Department of Labor defines workplace violence as any act or threat of physical violence, harassment, intimidation, or other threatening

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disruptive behavior that occurs at the work site. It can range from threats and verbal abuse to physical assaults and even homicide.

In 2010, the Bureau of Labor Statistics (BLS) data reported healthcare and social assistance workers were the victims of approximately 11,370 assaults by persons, which was a greater than 13% increase over the number of such assaults reported in 2009. Almost 19% of these assaults occurred in nursing and residential care facilities alone. The Department of Labor believes many more incidents probably go unreported. *(For more statistics and guidance on addressing workplace violence, see the Department of Labor web site at http://tinyurl.com/oht557f.)*

Team responds

Addressing the risk starts with knowing what forms workplace violence can take, what violence is occurring across all industries, and what violence already has occurred at your own facility, says **Maureen McGovern**, RN, CPHRM, director of risk management and patient safety officer at South Nassau Communities Hospital (SNCH) in Oceanside, NY. She and her colleagues at SNCH watch the media for trends in workplace violence and track all incidents at their facility.

SNCH also uses a specially trained team that responds to reports of a patient or other person exhibiting signs of potentially violent behavior. When healthcare workers recognize signs of agitation and a buildup toward violence, they call a "Code Grey" on the hospital intercom system. Employees with special training in de-escalating behavior and containment of violent subjects respond. "All employees are trained in recognizing potential workplace violence and the availability of the Code Grey team," McGovern says. "They team is called out most often for situations that do not result in violence, but we're OK with that. There is no penalty for calling the Code Grey team."

Also, the presence of the Code Grey team often defuses a person who otherwise might have become violent, McGovern explains. A nurse may call the team for a disruptive patient who refuses to take medications, for example, and seeing the team there and ready to intervene might make the patient think twice about lashing out.

All nurse managers are trained for the Code Grey team, along with nursing supervisors, and many are certified in crisis intervention through the Crisis Prevention Institute in Milwaukee, WI. *(See the resource at the end of this article for more information on the certification.)* Some members of the hospital's security department also are certified in crisis intervention.

EXECUTIVE SUMMARY

Recent attacks on nurses and other employees are bringing attention to the threat of violence against healthcare workers. The industry is among those most at risk of workplace violence.

- Sixty percent of workplace assaults occur in healthcare facilities.
- The incidence of violence in healthcare settings is on the rise.
- Healthcare employers face significant liability risk from violence against patients or employees.

"They have been trained on what might trigger the situation to become violent and what techniques to utilize to calm the patient and avoid violence," McGovern says. "For instance, they are trained to always speak in a calm, clear voice, always be polite, be aware of their own body language, listen to the person, and show confidence and compassion. They learn what the patient's complaint is and restate it to ensure they understand, apologize if appropriate, and give the person options for how to resolve the situation."

The team members also calmly but firmly outline the limits of what can be done to address the person's concerns. At SNCH the Grey Team is usually called out between 20 and 30 times per month.

What prompts violence?

Understanding what typically prompts a patient to threaten violence or act violently is important, McGovern says. In healthcare, the motivation might be pain, alcohol or drug withdrawal; a reaction to a medication; disregard of the person's personal space; slow response to the patient's needs; delirium and dementia; or a number of other causes.

Every Code Grey call is debriefed to determine how the process worked in defusing or containing the violence, and any injuries are studied closely to see if improvements in the process would reduce them. Very few Code Grey calls result in injuries, McGovern says.

SNCH also has developed an "active shooter" protocol on the off chance that a gunman would attack in the hospital. That protocol was tested in a full-scale drill with the local police department more than a year ago, but tabletop drills are done more frequently because they are less disruptive.

Some pose more risk

The risk of violence can be affected by the type of patients being treated, notes **Nan Jordan**, RN, senior clinical consultant at Compliagent, a compliance consulting firm in Los Angeles. She is writing a guidance statement for a large national long-term care provider chain on the specific issue of preventing violence by long-term care facility residents against the medical staff. The violence guidance is part of a larger engagement about dealing with sex offenders who are facility residents.

"We have a population that is aging, and aging criminal offenders are being released after long prison sentences. So we're seeing some of these people with past offenses who are now requiring long-term care," Jordan says. "This is difficult to handle when you are dealing with a clientele that is primarily old, fragile, and vulnerable."

Some healthcare providers, such as long-term care facilities, can screen patients for the potential to reoffend or act violently, Jordan says. A criminal history or violent past does not necessarily mean the patient will repeat those actions, so Jordan says it more appropriate to screen for the potential to reoffend. To that end, she advises her long-term care clients to look for antisocial personality traits, lack of bonding, and persons who blame others and refuse to accept responsibility for their actions.

Mental strain a problem

Violence at healthcare facilities, or the threat of it, can significantly affect patients and nurses psychologically. **Christine Tenley**, JD, an attorney at the Atlanta law firm of Taylor English Duma, has worked closely on the issue with a company managing healthcare facilities, and she says employers must be aware of the potential for liability from violence and threats.

"The healthcare environment is often a hectic one, and once something is done everyone moves on, with no more thought to the verbal abuse that took place," Tenley says. "If you want to prevent workplace violence and retain your nurses, you have to look at the verbal abuse as part of the problem and not just accept that as part of the job."

Another wrinkle in healthcare settings is physicians and other superiors who scream, threaten, throw things, and otherwise terrorize their coworkers, Tenley notes. *(See the story on p. 5 for more on this issue.)* "Nurses are getting it from all sides: patients, families, doctors. The day-to-day abuse from people that doesn't rise to the level of actually hitting someone still can be enough to cause damage to the nurse that might be compensable," Tenley says. "Policies and training could be significantly improved at most hospitals, and a zero tolerance policy is the way to start."

Hospitals should have a standalone workplace violence policy that defines violence and has a clear reporting mechanism, Tenley says. Training is imperative, she says, and administration often resists the expense.

Insurance coverage is available to mitigate the damages from workplace violence, notes **Rich Kosinski**, president of Specialty Insurance Advisors (SIA) in North Andover, MA. SIA offers Needle Stick and Workplace Violence coverage. In the event of unexpected medical fees and a potential sudden inability to work, Essential Professionals Insurance Coverage (EPIC) pays up to a

$200,000 lump sum if an employee suffers an injury at the workplace as a result of an assault or accidental infection. "For employers, this provides the additional indemnity coverage if there is an assault at work or even off premises if they are doing the normal course of work for the employer," Kosinski says. "There also is the benefit of psychological and trauma counseling, which can help the healthcare employer comply with the federal guidelines that require post-incident response treatment and therapy."

Additional coverage such as EPIC provides a better safety net from employees than simply relying on workers' compensation, Kosinski says. Victims such as the nurses attacked in Minnesota can use the funds to cope with sometimes debilitating injuries from assaults. *(See the story on p. 5 for more details on EPIC coverage.)*

"Workers' comp helps the employee, but there is nothing there for the employee who can't continue to work and still needs to pay the mortgage and get the kids through college," Kosinski says. "The nature of a workplace assault, unfortunately, is that people can be left with severe disabilities, and adequate coverage helps a hospital do its best to look after its employees."

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RESOURCE

- Certification in crisis intervention is available through the **Crisis Prevention Institute** in Milwaukee, WI. Options include a one-day introductory seminar, a two-day comprehensive workshop, and four-day instructor certification. Costs are determined by the type of training and the number of attendees. For more information, go to www.crisisprevention.com or call (888) 426-2184. ■

Video shows brutal attack on nurses

The violent attack on nurses at St. John's Hospital in Maplewood, MN, was caught on surveillance video that soon was released to the public. The images are disturbing, particularly because the staff members are so defenseless against their attacker.

The videotape shows Charles Emmett Logan, 68, of St. Paul, MN, appear suddenly at the nurses' station at 2 a.m. He was swinging a metal pole that he took from his hospital bed. Logan had been hospitalized with episodes of confusion and paranoia.

Staffers immediately try to escape from Logan's wild swings of the metal pole. They scramble to get away from him and through the doors leading off the unit. As they flee, several staffers try to secure the door behind them and isolate the attacker, but Logan bursts through and makes forceful overhead swings at two nurses who had fallen to the floor.

Four nurses were injured before Logan ran outside the hospital. Ramsey County Sheriff's deputies chased Logan and caught up with him three blocks away. Deputies first electrically stunned Logan and then tackled him. When Logan became unresponsive after being handcuffed, deputies took him back to St. John's, where he was pronounced dead.

The four nurses injured by the attacker ranged in age from 22 to 40. They suffered a range of injuries including a collapsed lung, a fractured wrist, and multiple cuts and bruises.

A report on the attack by CNN, which includes the security camera video, is available online at http://tinyurl.com/ksy4y4c. ■

Security guard knifed, nurses injured in attack

A recent attack on staff at a hospital in Oklahoma City left a security guard with a knife wound and two nurses injured by a patient.

Police were called to Deaconess Hospital shortly before midnight on Dec. 8, 2014, after 58-year-old patient Keith Bain attacked staff, according to information released by the Oklahoma City Police Department. Bain had come to the emergency department seeking medical treatment and became belligerent after being taken to an examination room. The man threatened staff, and when a security guard responded, Bain cut him with a knife, according to the police.

Nurses tried to help the security guard, but then Bain assaulted them as well, the police report. One nurse

was bitten on the lip and another was injured, but the type of injury was not reported by the police.

Bain then barricaded himself inside the room and pulled a sink out of the wall. The resultant flooding caused more than $2,500 of damage before officers were able to arrest him, the police report. Bain was charged with assault and battery with a deadly weapon and malicious injury and destruction of property. ■

Violence insurance helps with HCAHPS score

Providing insurance to employees for damages stemming from workplace violence can increase your facility's MediCare Value-Based Purchasing Program Scores, says **Rich Kosinski**, president of Specialty Insurance Advisors (SIA) in North Andover, MA, which provides such coverage. Even a bonus is possible.

Under the Affordable Care Act, Medicare and MediCaid implemented "value-based purchasing" (VBP), which equates to pay for performance, Kosinski explains. The better a healthcare facility's performance assessment is on an annual basis, the higher a bonus payment that facility can earn.

These performance assessments are implemented via the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). In December 2012, one California hospital purchased Essential Professionals Insurance Coverage (EPIC) for a group of its nurses as a new benefit. Beginning in January 2013 the HCAHPS survey for this hospital was 74% dependent on nursing performance. The 2013 survey contained 25 questions, 19 of which were related to the performance and dedication of the nursing staff and how well they interacted with and responded to patients. In the first full year of coverage, the facility's HCAHPS scores improved significantly, which resulted in a 0.24% bonus.

The hospital administration and management believe there was a correlation between adding the EPIC benefit and the nurses' reported job satisfaction being reflected in their performance and therefore the survey results, Kosinski says.

When applied to the hospital's $600 million Medicare reimbursement for 2013, the bonus amounted to $1.44 million. That was 20 times more than the hospital spent on the insurance coverage. That result prompted the hospital to purchase EPIC for every hospital employee.

An average EPIC Group Policy from SIA costs $200 per employee per year for $200,000 of coverage. This amount is equivalent to $1 per $1,000 of coverage per employee per year, Kosinski notes. ■

Raging physicians, coworkers also pose a threat

Patients attacking employees is not the only type of workplace violence that should trouble risk managers, says **Steve Paskoff**, the founder and CEO of the workplace learning company ELI in Atlanta.

Abusive coworkers should be considered part of the workplace violence problem and addressed in prevention efforts, Paskoff says. Abuse, in this sense, includes not only physical violence, but also includes verbal abuse and intimidation, he says.

The power imbalance between physicians and nurses or other hospital employees can lead to abuse of this type, Paskoff notes. Nurses commonly complain about doctors who swear at them and throw things, he says. "This problem is preventable, so why do we have it? We have it because we have tolerated it, looked the other way, and we haven't given it primacy," Paskoff says. "The healthcare industry is realizing now that workplace abuse can hinder effective communication of services. Culturally, we have to change it."

That change means that in addition to policies prohibiting abuse and procedures for reporting it, the healthcare organization must demonstrate at the top levels that it will not be tolerated. Executives at the top level must frequently and publicly acknowledge the problem and declare a commitment to ending workplace abuse.

Paskoff suggests making this type of workplace abuse a common discussion point in meetings and educational sessions at all levels. He cautions that writing policies and procedures is not enough.

"I'm sure everyone can compose a policy that spells out what is not acceptable in the workplace, but that is not going to prevent workplace abuse," Paskoff says. "If you have a good policy and you still have workplace violence, it's because you have a problem in leadership and accountability."

When abuse is reported, the organization must follow up with a thorough investigation and appropriate intervention, Paskoff says.

"This will happen in a high-energy, stressful environment with

the public coming in and often in an emotional state," Paskoff says. "The response has to be a cultural change, not handling each incident as a routine problem for human resources."

SOURCE

- **Steve Paskoff**, CEO, ELI, Atlanta. Telephone: (770) 319-7999. ■

System settles false claim charges for $37 million

The healthcare system involved in a false claims investigation prompted by a former employee blowing the whistle has settled the case. Dignity Health hospital system, based in San Francisco, has agreed to pay $37 million to settle the charges.

The whistleblower in the case, former director of medical management Kathleen Hawkins, will receive about $6.25 million of the settlement total, the Department of Justice announced recently.

Hawkins had charged that 13 of Dignity Health's hospitals in California, Nevada, and Arizona knowingly submitted false claims to Medicare and Tricare by admitting patients who could have been treated on a less costly outpatient basis. Dignity Health said in a statement there is "widespread confusion" about federal standards for approving coverage of patient admissions.

The United States alleged that from 2006 through 2010, 13 Dignity hospitals billed Medicare and TRICARE for inpatient care for certain patients who underwent elective cardiovascular procedures (stents, pacemakers) in scheduled surgeries when the claims should have been billed as outpatient surgeries. In addition, the government alleged that from 2000 through 2008, four of the hospitals billed Medicare for beneficiaries undergoing elective kyphoplasty procedures, which are minimally-invasive and performed to treat certain spinal compression fractures that should have been billed as less costly outpatient procedures.

Lastly, the government alleged that from 2006 through 2010, 13 hospitals admitted patients for certain common diagnoses where admission as an inpatient was medically unnecessary and appropriate care could have been provided in a less costly outpatient or observation setting. *(For information on the risk manager's role as whistleblower, see* Healthcare Risk Management*, June 2014, pp. 49-53.)* ■

Malpractice caused Joan Rivers' death, critics say

What at first seemed the tragic but otherwise unremarkable death of an elderly woman, comedian Joan Rivers, has turned out to be entirely preventable and the result of serious malpractice, according to a federal report and malpractice attorneys.

The Manhattan clinic that treated the 81-year-old celebrity made several serious errors, including failing to identify deteriorating vital signs and providing timely intervention, according to a report by the Centers for Medicare & Medicaid Services (CMS). Rivers died Sept. 4, 2014, a week after an appointment at Manhattan's Yorkville Endoscopy clinic.

CMS noted these errors that could have contributed to Rivers' death:

- failing to identify deteriorating vital signs and provide timely intervention;
- failing to record Rivers' weight prior to the administration of medication for sedation;
- failing to consistently document the dose of Propofol, a sedative, administered;
- failing to get Rivers' informed consent for each procedure performed;
- failing to ensure that she was cared for only by physicians granted privilege in accordance with the clinic's bylaws;
- failing to abide by its own cell phone policy by allowing a photograph to be taken of a surgeon and Rivers while she was under sedation.

The string of deficiencies does not surprise **Jamie Koufman**, MD, an

EXECUTIVE SUMMARY

The clinic and surgeons caring for comedian Joan Rivers at the time of her death made several errors that could have contributed to her death, according to a federal report.

- Fallout from Rivers' death could lead to changes in the standards for some types of outpatient surgery.
- A report by the Centers for Medicare & Medicaid Services (CMS) found multiple deficiencies at the clinic.
- The clinic has issued a plan of correction.

acid reflux specialist and director of the Voice Institute of New York in New York City. She is an expert in the type of surgery that Rivers was undergoing, and she says standards of care are insufficient. The standard of care clearly was not met in the Rivers case, Koufman says, but she says patients are at risk even when the standard is met. Performing complex surgery in an outpatient setting has long drawn criticism, and Koufman says too many physicians offer these profitable procedures without the proper training, equipment, or precautions.

"The standard of care for this surgery is like the standard of care for bloodletting," Koufman says. "Not every patient died of bloodletting either, but that doesn't mean the standard of care made things safe for the patient."

The Rivers case shows that the longstanding and troubling problem of inadequate pre-surgical examinations of patients continues, says **Harry Nelson**, JD, partner at Nelson Hardiman in Los Angeles. "I think it results from many surgeons being quick to cut without making sure all of the 'i's' are dotted and 't's' are crossed. Many surgeons don't want to have to go through the time-consuming and not-well-reimbursed work of getting all patient vitals and screening thoroughly for risk issues," Nelson says. "It's much less of an issue in hospitals, which have adopted many safeguards in pre-surgical review in recent years, so the issue is bigger in the outpatient surgery centers."

Nelson's firm has represented plaintiffs in several cases of patient deaths and injuries that were probably preventable with better compliance for pre-surgical review. There have been proposals for legislative solutions to the issue, Nelson notes, but the most effective approach might be getting patients to understand the importance of, and to insist upon, thorough pre-op reviews, including anesthesiologists' review.

> "BASED ON REPORTS IN THE MEDIA, IT APPEARS THAT THE CLINIC HAD ONGOING AND SYSTEMIC PROBLEMS THAT WERE NOT CORRECTED."

"Many doctors are only concerned with ensuring the patient is hemodynamically stable, and in some cases not even that, but patients should expect more," Nelson says. "Also, surgery center owners must insist on more compliance policies and procedures to cover the need for better pre-ops."

But the insufficient pre-op review was not the only problem, notes **Kenneth D. Powell Jr.**, JD, a partner in the Medical Malpractice Group at the law firm of Weber Gallagher in Philadelphia. It appears that one or more of the physicians was not properly credentialed, and the institution is always responsible for proper credentialing, he says.

Also, "there are inconsistencies in the documentation concerning the use of Propofol, and the importance of accurate documentation can never be emphasized enough," Powell says. "Failing to accurately record a patient's weight exposes all healthcare providers involved, particularly when the weight is needed to calculate an appropriate dose of medication."

Citing reports that the physician performed a procedure other than what the patient consented to, Powell says that in most jurisdictions this is a technical battery and the physician is liable even if the patient is not harmed. In Pennsylvania, the institution is not responsible for the battery, but that law might not be the same in other jurisdictions, he says.

"Based on reports in the media, it appears that the clinic had ongoing and systemic problems that were not corrected. Because they were not corrected, this adds to the exposure in the Rivers case," Powell says. "The publicity tends to bring other potential claimants to the forefront who will be able to use these system failures to their advantage."

Yorkville Endoscopy issued a statement in response to the CMS report and noted that it already has "submitted and implemented a plan of correction that addressed all issues raised. The regulatory agencies are currently reviewing the corrective plan of action and have been in regular contact with Yorkville. In addition, the physicians involved in the direct care and treatment referenced in the report no longer practice or provide services at Yorkville."

SOURCES

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Hospital reduces alarms by 80% with changes

At a facility in Ohio, changes in how cardiac monitors are used on pediatric patients resulted in an 80% reduction in alarms, which reduced the likelihood of the alarm fatigue known to threaten patient safety.

Clinicians at Cincinnati (OH) Children's Hospital Medical Center (CCHMC) were concerned that excessive cardiac monitor alarms were leading to desensitization and alarm fatigue, says **Christopher E. Dandoy**, MD, MSc, instructor of pediatrics in the bone marrow transplant (BMT) unit. In response, they created a standardized Cardiac Monitor Care Process (CMCP) on a 24-bed pediatric BMT unit. CCHMC is a large, urban pediatric medical center, and the BMT team performs 100 to 110 transplants per year.

The BMT unit has 24 beds. About 70% of patients on the floor are on cardiac monitors, which include pulse oxygen saturation (SpO_2) monitoring as well as cardiopulmonary monitoring, Dandoy explains. Patients admitted to the BMT unit often are hospitalized for up to 40 days, and they can be on monitors for 60% of their hospitalization.

Dandoy and his colleagues developed a standardized CMCP that included family/patient engagement in the CMCP; creation of a monitor care log to address parameters, daily lead changes, and discontinuation; development of a pain-free process for electrode removal; and customized monitor delay and customized threshold parameters. *(See the story on p. 9 for more information about the changes.)*

Much of the effort involved using the cardiac monitors appropriately for children, rather than adults, Dandoy explains. The parameters for triggering an alarm are different, for example, but many hospitals neglect the need to adjust the settings. Even with pediatrics, not all settings are the same.

> ... THEY CREATED A STANDARDIZED CARDIAC MONITOR CARE PROCESS (CMCP) ON A 24-BED PEDIATRIC BMT UNIT.

"We would have infants come in and placed on a monitor, with default settings. That might mean we have an infant using monitor parameters for a 12-year-old," Dandoy says. "The infant's heart rate will be 130 or 140, whereas the 12-year-old's heart rate is about 90. The alarm is going off all the time. That bring us to the risk of alarm fatigue, and it could threaten the patient's care if the monitor isn't alerting nurses at the right time."

Members of the CCHMC team determined appropriate settings based on clinical evidence so that they could be trusted to signal when appropriate, he says. Determining the correct parameters is better than simply choosing "better- safe-than-sorry" alarm triggers that are too sensitive, Dandoy says.

"That's when you get into alarm fatigue," he explains. "Your nurses and everyone needs to know that the alarms are set properly so they can trust that when the alarm sounds, the patient really does need attention. If they understand that you set the parameters too loosely, you can have exactly the opposite effect with alarm fatigue."

From January to November 2013, compliance with the CMCP increased from a median of 38% to 95%. During this time, the median number of alarms per patient day decreased from 180 to 40. Dandoy and his colleagues concluded that the standardized CMCP resulted in a significant decrease in cardiac monitor alarms per patient day.

The CCHMC team published their results in the journal *Pediatrics*. An abstract of the study and links to the full report are available online at http://tinyurl.com/pxymlje.

SOURCE

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EXECUTIVE SUMMARY

A pediatric hospital reduced unnecessary alarms by 80% by implementing changes at the bedside. Alarm fatigue has been cited as a significant threat to patient safety.

- Pediatric patients typically are on monitors longer than adult patients.
- Family members were involved in the effort.
- More frequent lead changes was effective in reducing false alarms.

7 steps led to reduction in alarms

The risk of alarm fatigue prompted clinicians at Cincinnati (OH) Children's Hospital Medical Center (CCHMC) to institute processes that reduced cardiac monitoring alarms by 80%. These are the processes implemented at the hospital:

• **Family engagement:** Family members were recruited to help identify barriers to implementation of the Cardiac Monitor Care Process (CMCP) and were made part of the multidisciplinary team. The lead change protocol was discussed with family members on initiation of cardiac monitoring. Family members and patients communicated problems with alarms to the nursing staff, and these issues were addressed directly and documented in the monitor log. Family perception of timely attention to monitors by staff was measured in a satisfaction questionnaire.

• **Standardized age-appropriate ordering of monitor parameters:** To address that pediatric patients need different monitor settings than adults, the team created an age-appropriate order set with baseline parameters in the electronic medical record. Initial monitor parameters were documented on the cardiac monitor log.

• **Daily lead changes:** Prolonged electrode use can result in signal impedance and increased signal noise due to decreased conductivity, which leads to increased false alarms. To avoid that problem, daily lead changes were instituted. To reduce the pain associated with removing the leads, it is done during daily baths.

• **Daily assessment of monitor parameters:** The cardiac monitor log was completed daily by the nursing staff and reviewed daily by the medical team. Excessive false alarms were investigated and corrected by the nursing staff with a monitor troubleshooting algorithm.

• **Clearly defined roles and responsibilities:** Staff were educated through a mandatory computer module and by the CMCP team.

• **Standardized reliable process for monitor discontinuation:** The hospital created intentional redundancy in the assessment of the discontinuation of the monitors. Providers and nurses assessed the need for the cardiac monitors, and this information was documented in the cardiac monitor log.

• **Customized monitor delay and increased threshold settings:** CCHMC increased the oxygen saturation alarm delay from five to 10 seconds because most oxygen saturation alarms self-correct within the delay period set. ■

GUEST COLUMN

Understanding large deductible policies and captives

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(Editor's note: The first part of this two-part column explores some fundamentals of captives and large deductible insurance policies. In next month's issue of Healthcare Risk Management*, part two of this special report will further explore captives and large deductibles, and it also will explore how to reach a risk financing decision that suits your healthcare organization.)*

Risk financing is critical to enterprise risk management, but many healthcare administrators, including risk managers, can get lost in the financial details and decisions to be made. With the right background, a risk manager can assess all the options and make the right choice for the organization.

Let's start with the basics about the two most popular options for risk financing.

Risk financing begins with first-dollar risk transfer, also known as buying insurance, and ends with transferring risk to the capital markets. Along the risk financing continuum are large deductible insurance plans and captive insurance companies. These are two very common and efficacious methods with which healthcare providers, small and large, for-profit and not-for-profit, employ to fund exposures to loss such as workers' compensation, automobile, general, and professional liability.

A large deductible plan is just as it sounds. A large deductible plan can be characterized as self-insurance without giving up the benefits of commercial insurance. The insured organization buys an insurance policy that allows it to retain loss up to certain dollar amount on a per-occurrence or per-loss basis, with an annual aggregate cap on losses retained. The insurance company provides claims management and loss consulting services. The insured is able to retain that portion of the loss that is predictable, usually high

frequency and low to moderate severity based upon its risk appetite.

Large deductibles are most commonly associated with workers' compensation but also can be used for automobile, general, and even professional liability.

The key benefits of a large deductible program for the insured include the ability to employ self-insurance without regulatory approval in order to seek more control over losses, with the goal of reducing cost of risk while retaining traditional commercial company services. Moreover, the insured usually remains compliant with any state regulation, contract, or bond covenant requiring it to show evidence of commercial insurance. In addition, the large deductible insurance carrier provides a financial hedge against a catastrophic loss.

There are, however, some important disadvantages to a large deductible plan. First, the insured might have to collateralize open loss reserves. The commercial insurance company remains ultimately responsible for all loss covered under the policy's terms and conditions. It then bills the insured for losses within the deductible, which can include indemnity and allocated loss adjustment expenses. This liability is collateralized to protect the insurer from its credit exposure: the event for which the insured cannot reimburse it for the deductible losses.

If the insured is seeking to take more control over claims management as it takes more risk, then it might be frustrated because the large deductible carrier will retain control and even resist material input from the insured into how its deductible claims are managed, reserved, and settled. I would also assert that because the large deductible carrier manages the claims within the deductible, it is responsible for Medicare Secondary Payer Reporting Requirements, unless claims management is unbundled.

The other commonly used option is a captive insurance company (captive), a wholly owned insurance subsidiary incorporated for the purpose of insuring the risks of the parent(s). Most healthcare provider-owned captives are single-parent pure captives. In other words, they insure the "related" exposure to loss of the parent. The captive requires greater administrative commitment and expense than a large deductible plan.

Before you commit

There are three critical characteristics that must be understood before committing to a captive.

First, it requires a commitment of capital that is dependent upon the captive's domicile and the nature of the risk retained. Second, the captive operates outside of the commercial market place. It is not regulated as a commercial carrier requiring the parent to establish best practices for its governance. Third and most importantly, it must fulfill a risk financing goal, or why bother?!

A captive requires the parent as shareholder to elect a board usually from its senior management. The parent also must construct an infrastructure to manage the program that includes hiring a captive manager to maintain financial records and keep the captive compliant with the domicile regulations. The insurance/reinsurance broker and consultant are needed to provide technical support and Excess of Loss/Aggregate Stop Loss coverage. Other professionals to support or serve the captive include:

- an actuary to certify loss reserves and promulgate premiums;
- an auditor because captive financial statements must be audited prior to filing with the domicile regulator;
- an insurance company lawyer to address regulatory, compliance, and coverage issues;
- an investment manager to implement the approved investment policy when investing surplus and reserves.

A captive comes with no traditional commercial insurance services because it has no employees. The following services also must be replaced by the parent or by employing a third-party administrator or vendor to perform:

- underwrite to set premium by exposure unit or allocate premium funding;
- provide any loss prevention and mitigation consulting previously provided by an insurer;
- manage asserted and un-asserted claims. (The captive usually indemnifies the insured with no duty or obligation to defend the claim.)

A captive insurance company provides several key benefits for the parent/insured, including control over how claims are managed and the provision of coverage terms and conditions, i.e., manuscripting policy

COMING IN FUTURE MONTHS

- Fighting a cyber attack
- Liability in patient complaints
- Sentinel events expand
- Emergency medicine doctrine in med mal?

coverage language to meet the needs of the insured.

Other benefits include control over how the risks are underwritten (premium development or cost allocation) and access to reinsurance to cap catastrophic losses on a specific excess of loss basis and possibly in the aggregate as well.

Depending on the risk, aggregated stop loss coverage might be very expensive, thus offering an unreasonable attachment value and providing dubious benefit. Finally, a captive enables the insured to smooth its cost of risk for high frequency and low- to moderate-severity losses over time.

The captive insurance company provides a flexible vehicle to finance exposures to loss including unrelated (third-party risk), which allows the parent to attain a strategic goal such as addressing a key stakeholders' need for affordable insurance coverage, such as professional liability coverage to affiliates or voluntary medical staff.

This basic understanding of the two options still leaves much to be said about the pros and cons. ■

Healthcare system liable for $1.6M for overdose

A jury in Utah returned a verdict for $1.6 million in a wrongful death and medical malpractice action against Intermountain Healthcare, based in Salt Lake City, for fatally overdosing a patient with a cocktail of medications.

The original complaint alleged Intermountain, which has 22 hospitals and more than 185 clinics in Utah, negligently and carelessly acted below the standard of care by prescribing a combination of medications to Randy Krambule, who had been seeking treatment for chronic back pain. Krambule's treatment included sedatives, painkillers, and sleep aids that reached to more than 30 pills per day, according to the *Standard Examiner*.

As a result, the cocktail of medications "metabolized and accumulated" in Krambule's body, which led to drug toxicity and ultimately his death on April 3, 2008. His wife filed suit in 2010.

In Utah, a wrongful death suit may be brought by the surviving spouse or the victim's heirs against the person responsible for the conduct or, as in this case, the employer who is responsible for the employee's misconduct. ■

Hospital gave wrong med to patient, admits error

An Oregon hospital acknowledges that a patient died because she was administered the wrong medication.

Loretta Macpherson, 65, died two days after she was given a paralyzing agent typically used during surgeries instead of an anti-seizure medication, according to statements issued by St. Charles Health System. The error occurred in the emergency department at the St. Charles Hospital in Bend. Having recently undergone brain surgery, she had gone to the hospital for assistance with dosing the anti-seizure medication.

Macpherson stopped breathing and suffered cardiac arrest and brain damage after the paralyzing agent, rocuronium, was administered. The drug is commonly used in the operating room while the patient is attached to a ventilator. She was supposed to receive fosphenytoin.

After an investigation, hospital officials reported that the drug prescribed by the physician, fosphenytoin, was correctly entered into the electronic medical records system and the hospital's pharmacy received the correct medication order. The IV bag also was correctly labeled.

Somehow a pharmacy worker inadvertently filled the bag with the wrong drug. A second worker then reviewed the vials of medication and the IV bag without catching the error.

The hospital's fire alarm sounded soon after the medication was administered, which prompted a staff member to lock the door of Macpherson's room "to protect her from potential fire hazards," the hospital reported. Macpherson suffered cardiac arrest during the 20 minutes she was alone before a nurse returned to check on her. Three employees involved in the error have been placed on paid administrative leave. ■

CNE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. describe the legal, clinical, financial, and managerial issues pertinent to risk management;
2. explain the impact of risk management issues on patients, physicians, nurses, legal counsel, and management;
3. identify solutions to risk management problems in healthcare for hospital personnel to use in overcoming the challenges they encounter in daily practice.

HEALTHCARE RISK MANAGEMENT™

CNE INSTRUCTIONS

To earn credit for this activity, please follow these instructions:
1. Read and study the activity, using the provided references for further research.

2. Scan the QR code to the right or log on to www.cmecity.com to take a post-test; tests are taken after each issue. 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 test, 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 Maureen McGovern, RN, CPHRM, director of risk management and patient safety officer at South Nassau Communities Hospital (SNCH) in Oceanside, NY, when is its Code Grey team most often called out?

A. For instances that do not result in violence.
B. For instances that result in only minor injuries.
C. When police have been called but have not arrived yet.
D. When hospital security officers are not available.

2. According to a report by the Centers for Medicare & Medicaid Services, what was a deficiency that might have contributed to the death of Joan Rivers?

A. Employment of a nurse whose license had been revoked.
B. Failing to record Rivers' weight, prior to the administration of medication for sedation.
C. Insufficient infection control procedures in the ambulatory surgery center.
D. Failure to have procedures for responding to cardiac arrest.

3. When Cincinnati Children's Hospital Medical Center sought to reduce cardiac alarms by instituting daily lead changes, what was one problem encountered?

A. The cost of the leads
B. The time required to change the leads
C. Inaccurate readings after lead changes
D. The pain associated with removing the lead

4. Which of these is not a critical characteristic that must be understood before committing to a captive?

A. It requires a commitment of capital that is dependent upon the captive's domicile and the nature of the risk retained.
B. The captive operates outside of the commercial market place; it is not regulated as a commercial carrier requiring the parent to establish best practices for its governance
C. It must fulfill a risk-financing goal.
D. It will save the hospital money, when compared to a large deductible policy.

LEGAL REVIEW & COMMENTARY
EXPERT ANALYSIS OF RECENT LAWSUITS AND THEIR IMPACT ON HEALTHCARE RISK MANAGEMENT

$7.9 million verdict for man paralyzed during pain management procedure

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News: The patient, a 63-year-old man, suffered from severe neck pain and opted to undergo a high risk pain management procedure in November 2010. The treatment involved bilateral deep and dangerous injections in the C1 and C2 cervical vertebrae, the two vertebrae located closest to the skull. The procedure is rarely performed in the United States. Two pain management anesthesiologists at a hospital were involved with the procedure. Nine days after the procedure, the patient began to feel numbness in his extremities, and he was admitted to a hospital where a serious spinal cord abnormality was detected. The patient spent 13 months hospitalized and developed quadriplegia as a result of the injuries suffered during the pain management procedure. The patient and his wife brought suit against the two anesthesiologists and the hospital, and they alleged that that their actions caused his condition. The defendants denied any wrongdoing. The jury found the primary anesthesiologist and the hospital liable, and the secondary anesthesiologist was found not liable. The jury awarded the patient and his wife a total of $7.9 million in damages.

> ... THE PATIENT ARGUED THAT THE PRIMARY ANESTHESIOLOGIST DID NOT FULLY INFORM HIM OF THE POTENTIAL DANGERS AND CONSEQUENCES OF THE PROCEDURES...

Background: In this matter, the patient was a 63-year-old man who suffered from severe neck pain and chose to undergo a high risk pain management procedure in November 2010. Two pain management anesthesiologists at a hospital were performed the procedure, which involved bilateral deep and dangerous injections in the C1 and C2 cervical vertebrae. Due to the inherent danger associated with procedures at that level of the spinal cord, this procedure is rarely performed in the United States. At trial, the patient argued that the primary anesthesiologist did not fully inform him of the potential dangers and consequences of the procedure, and he stated that he would not have proceeded with the procedure had he been so informed.

Nine days after the procedure, the patient began to lose sensation in one hand, followed by loss of control in both hands and his right leg. He was subsequently admitted to a hospital where a serious spinal cord abnormality was detected, along with a buildup of fluid at the injection site. As a result of injuries suffered during the procedure, the patient spent 13 months in the hospital, and he became a quadriplegic. He now requires a regular caregiver, suffers continually from painful sensations throughout his entire body, and lives on a liquid diet that he receives through a feeding tube placed

Financial Disclosure: 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 Tim Laquer, co-authors, have no relevant relationships to disclose.

in his stomach.

The patient and his wife brought suit against the two anesthesiologists and the hospital. They claimed that the anesthesiologists acted negligently and that the hospital was responsible for their actions as their employer. The patient alleged that the primary anesthesiologist, the director of pain management at the hospital, was negligent by failing to inform the patient of the serious dangers and consequences of the procedure.

For the secondary anesthesiologist, it was alleged that she allowed the procedure to continue with the iodine contrast iohexol, known as Omnipaque, even though the patient had a documented allergy to the substance. However, this claim lacked sufficient evidence to prove that the patient received Omnipaque or that his condition could be contributed to an allergy or trauma. The patient claimed that the hospital was liable as the employer of the anesthesiologists. The defendant, the primary anesthesiologist, attempted to argue that the condition was caused as the result of an "evolving stroke" that coincidentally occurred during the procedure. The defendant hospital denied any liability and instead stated that the primary anesthesiologist, despite being the director of pain management, was an independent contractor and thus the hospital was not responsible for his negligence. After more than a day and a half of deliberation, the jury found that the primary anesthesiologist was 60% liable and the hospital was 40% liable, while exonerating the secondary anesthesiologist of any liability. The jury awarded the patient $6.97 million and awarded $1 million to his wife for loss of consortium.

What this means to you: Enough cannot be said about the importance of informed consent. Dangerous procedures, which often include neck and spine procedures, raise several potential concerns for physicians and hospitals in regard to lawsuits and liability. Hospitals and their nurses, technicians, and ancillary personnel are not responsible for informing patients about the risks, benefits, alternatives,and other elements of informed consent. Informed consent is solely the surgeon's or other physician's responsibility. Before a procedure takes place, hospital employees do have a responsibility to ensure that the patient is asked if the physician has informed him or her about the procedure and that this information has been documented in the patient's medical record. If not, except in an emergency situation, the procedure must be delayed until these tasks are completed. A failure to disclose important information to a patient can create liability for a medical care provider.

The level of disclosure varies based on the nature of procedure. More complicated or dangerous procedures might require a more involved discussion, while a simple procedure with fewer risks might not need such. In this case, the procedure was extremely dangerous, with the opportunity for serious, life-threatening consequences, and unconventional. Court documents revealed that the procedure is not taught in any medical school in the United States and is not part of any training of pain management specialists. For a procedure of this level, complete disclosure of all elements, risks, consequences, and alternatives is extremely important in order for medical care providers to protect themselves from liability. It is easy for patients to look back after the fact and claim that they would not have undergone the procedure having known about these risks, so the only way to prevent this step is by actually informing the patient of the risks prior to the operation and receiving their fully informed consent (ideally in writing so as to eliminate the possibility of denial).

Also, the governing board of the hospital generally is responsible for credentialing physicians. This process is especially important if they are performing unusual procedures. The board usually assigns this task to the medical staff of the hospital. The medical staff, as a peer review body, must ensure that proctoring by other physicians experienced in the procedure in question has been demonstrated. They also must ensure that the procedure is not experimental in nature. A frequent cause for hospital liability is based on the fact that physicians often are considered employees (in states where hospitals are allowed to hire physicians. Theefore, the hospital is liable under the legal doctrine of "respondeat superior," which allows an injured party to recover damages from an employer based on the actions of the employee. It is often difficult to categorize a physician working for a hospital as an employee or an independent contractor (which prevents liability for a hospital).

Ostensible agency also applies in this case. Hospitals often put signage in public places and on procedural consents reminding patients that the physicians are independent contractors and are accountable to the medical boards in their states. The determination is court-made and depends upon a number of factors that vary based on the particular circumstances of the relationship between the physician and hospital. Influential in this case was the fact that the primary anesthesiologist was the director of pain management. An

individual's title, or any contractual agreement, is not dispositive for determining whether that individual is an employee or independent contractor, but being the head of a major division in a hospital can tend to favor a finding of employee, as evidenced here.

REFERENCE:

Superior Court of Los Angeles, CA. Case No. BC476993. May 5, 2014. ■

Patient awarded $3.35 million after bowel perforation and barium misuse

News: The patient, a 22-year-old college soccer star, was diagnosed with athletic pubalgia by a general surgeon and underwent surgery in 2009. The surgery was performed and the patient was discharged the same day, without the physician realizing that a bowel perforation had occurred during the surgery. The patient experienced severe abdominal pain and was prescribed multiple pain medications, which were not effective. The following day, the patient went to a hospital emergency department where a CT scan was performed. Due to a lack of communication, the scan was performed with a barium contrast that is contraindicated in any patient with a known or suspected bowel perforation. The scan revealed the perforation along with spillage of bowel contents and barium throughout the patient's body. The original surgeon repaired the bowel, but the patient required an extended stay and additional surgery. He continues to have barium in his system and pain from deep scar tissues. The patient brought suit against the surgeon and hospital. Both defendants denied liability. The jury found both were negligent, but only the hospital was found liable for the barium injury. The jury awarded the patient $3.35 million in damages.

Background: The patient was a prominent college soccer star who had obtained a contract to play professionally in Colombia. He was diagnosed with athletic pubalgia, commonly known as a sports hernia. In 2009, he underwent surgery to repair the injury. It was performed by a general surgeon who frequently had professional athlete patients. After the surgery, the patient was discharged the same day; however, a bowel perforation that had occurred during the surgery was not diagnosed.

The patient experienced severe abdominal pain within an hour of discharge. He was prescribed multiple pain medications that proved ineffective. Because of continued and worsening pain, the patient went to an emergency department the next day. It was determined that his white blood cell count was high. The original surgeon was concerned that a possible bowel perforation had occurred, and that surgeon instructed a resident about this concern. During a shift change, the resident turned over the case to a second resident and instructed the second resident to order a CT scan. However, the first resident did not inform the second resident that a bowel perforation was a concern. Due to this failure, the second resident ordered a CT scan with a barium contrast. A radiology expert opined during trial that barium is never administered to a patient at risk for perforation or who has recently undergone an abdominal surgery. With these patients, if there is a perforation that the physician isn't aware of, the contrast would be absorbed into the body and wreak havoc. It could cause serious problems such as extreme inflammation and infection.

The scan revealed the bowel perforation, as well as spillage of bowel contents and barium throughout the patient's body. The original surgeon was brought back for another surgery to repair the bowel. The patient remained in the hospital for 18 days. He required more surgery to remove abscesses in his abdomen and had two drains placed in his back for infected fluid that had accumulated around his organs. Despite extensive physical therapy, the patient was unable to regain his core strength, which led him to abandon pursuing a professional soccer career. He continued to suffer pain from deep scar tissues caused by barium, which can remain in a person's body indefinitely.

The patient brought suit against the original surgeon and the hospital, and he alleged that each was negligent in different ways. For the surgeon, the patient claimed that the perforation was negligent and set in motion the events leading to the barium mishap.

The hospital's liability rested solely on the barium being used in the CT scan. The suit claimed it breached the standard of care by administering the barium contrast to a patient who was at high risk for a bowel perforation. A unanimous jury found that the surgeon and hospital's conduct fell below the standard of care and thus they breached their duty to provide the patient with appropriate care. However, the jury found that only the actions of the hospital were the

cause of injuries to the patient. As a result, the hospital was 100% liable for any injuries, and the surgeon was not liable. The jury awarded $3.35 million in damages.

What this means to you: This case reveals critical elements of a medical malpractice action that must be established before a physician or hospital can be found liable. Medical malpractice is a specific type of negligence action that generally requires a duty to an individual, a breach of that duty, causation, and damages. Thus, if a patient fails to establish any single element of these four, then there cannot be liability, despite the fact that an injury occurred. In this case, the jury found that the physician's conduct fell below the applicable standard of care; thus, he breached his duty to the patient. However, the physician ultimately was found not liable because the third element, causation, was not met.

Causation in this sense consists of distinct elements: factual cause and proximate cause. Factual cause was easily satisfied here. "But for" the physician's perforation of the bowel, the patient would not have required the CT scan and suffered injuries from the barium. The physician's perforation set into motion the series of events that resulted in the patient's injuries, so without his actions, none of these events would have occurred.

However, "proximate cause" is a more difficult concept. It essentially is legal fiction, in which a physician or hospital might escape liability based on the acts of a third-party or the un-foreseeability of the injury. This concept can be a great method for defending against a medical malpractice case, as a lack of proximate cause eliminates liability despite the physician or hospital failing to meet appropriate standards of care. In this case, the jury determined that the actions of the hospital by administering the CT scan with barium essentially superceded the actions of the physician, thus breaking his link to any injuries incurred, despite his actual responsibility for creating the events in the first instance. When an injury occurs, physicians and hospitals should carefully investigate the events that led to the injury. Some events might be able to be used as a defense to limit liability, especially when there are actions of a third-party such as other medical professionals or even patients themselves.

Hospitals and physicians alike often lose sight of the fact that residents are students. Residents always should be functioning under the supervision of an attending physician, and it is the medical staff and the hospital's residency program's responsibility to ensure that this supervision is happening. Bowel perforations during any type of abdominal surgery are not uncommon and are known risks. An experienced attending physician would know this fact and most likely would ask the right questions to ensure that the use of barium contrast was appropriate. A newly licensed resident physician might not.

In this case, the necessary hand-off communication that occurred during shift change took place between two students, and critical information was omitted. The second resident had a responsibility to contact the patient's attending physician, as the first resident had done, and inform him of his or her plan to order the barium. Additionally, the patient's medical record, had it been reviewed by the resident, nurse, or technician administering the barium contrast, would have listed the previous bowel surgery the day before, which is a known contraindication for the use of barium. Communicating with the attending and reviewing the medical record were two barriers that could have blocked the errors from happening had they been used by providers of this patient's care.

Communication among medical professionals and hospital staff is always of critical importance, and a lack of communication can severely injure patients and create liability for physicians and hospitals. This communication might be difficult for hospital staff members, especially where there can be numerous individuals with different responsibilities all relating to a single patient's treatment. Having the proper procedures and standards in place for facilitating communication among all these individuals is important to prevent injury and defend against liability.

Rotations or shift changes are a necessity and reality in the hospital setting, but they can create extra difficulties regarding communication, as evidenced in this case in which the information was lost during a shift change of two residents. Detailed written details of the shift's events can help alleviate this potential for information slipping through the cracks, although there is no way to ensure with perfect certainty that information always will be conveyed. Having appropriate and reasonable, perhaps even overly cautious, procedures in place can go a long way toward preventing such occurrences in the first case and provide some defense during trial to allegations of improper or insufficient communication standards.

REFERENCE

Court of Common Pleas, PA. Case No. 111201343. June 30, 2014. ■

HEALTHCARE RISK MANAGEMENT™

High demand for nonclinical healthcare roles at hospitals and health systems across U.S.

Risk managers are in demand at hospitals and healthcare systems across the country, but the need for experience could be a hurdle to some, 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 the American Society for Healthcare Risk Management (ASHRM).

Healthcare employers are looking for risk managers, Kicklighter says, but their demands for experience are shutting out some applicants. And even for risk managers who get the job, the salary might be disappointing.

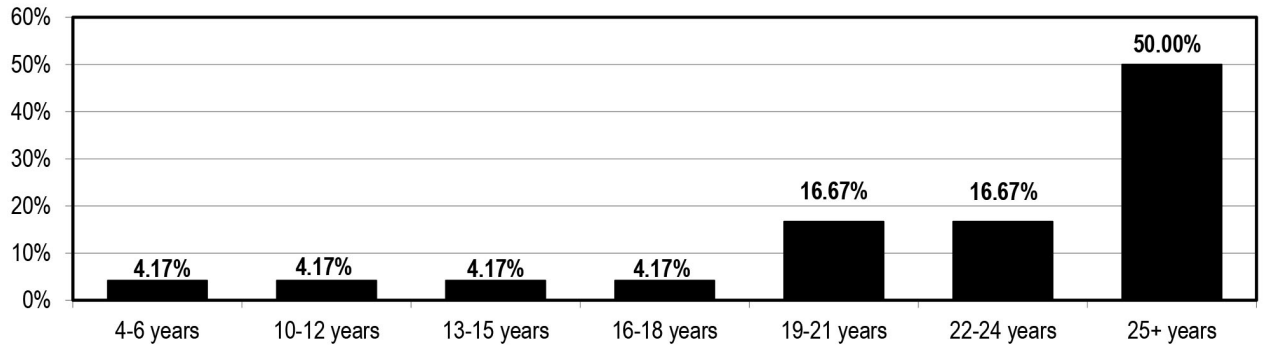
"They're looking for risk managers with experience and apparently that is not who is applying, so these employers are keeping these searches open until the right person is available," she says. "I've also heard that when people are applying for these positions, they are finding that the salaries are very disappointing. So that's a double hit when you're not experienced enough and the job wouldn't pay well anyway."

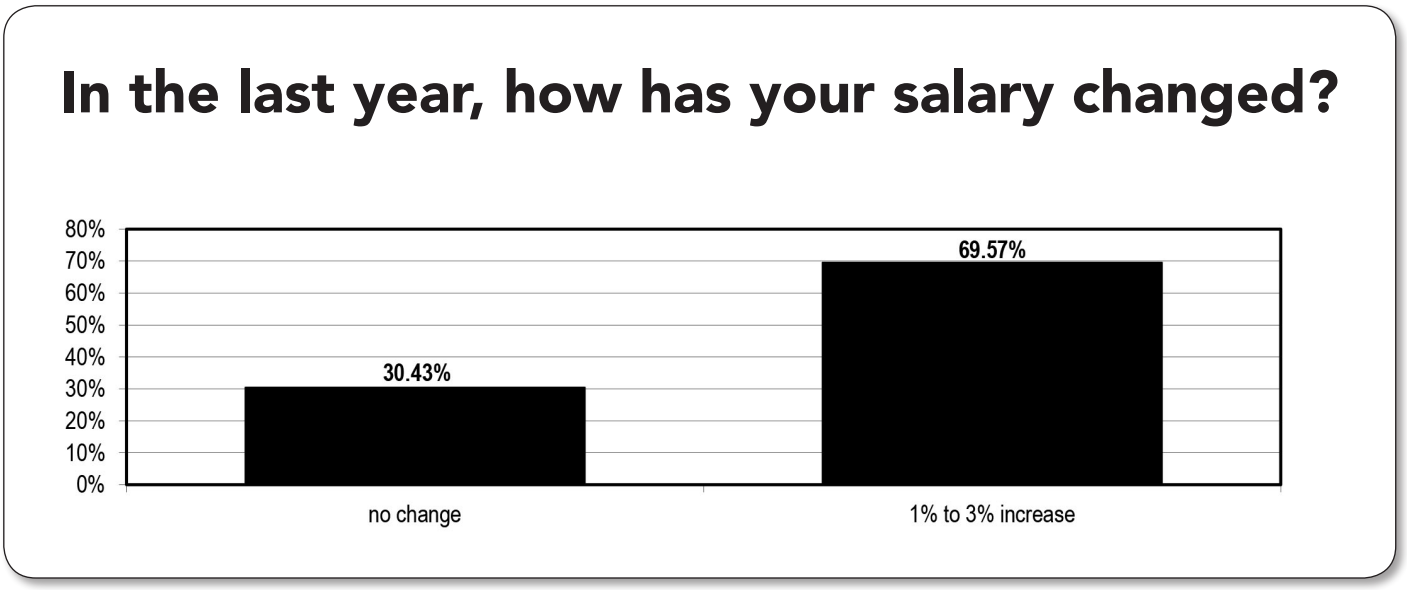
Be flexible for advancement

Younger risk managers will be more successful with job searches if they are flexible and can take advantage of opportunities that require moving to a different part of the country or taking up a facet of risk management other than what they originally planned.

"If I were younger and could pick up and move easily, I would be tempted to take on some of the opportunities that are out there," Kicklighter says. "When you are willing to bend to the employer's needs and help them fill a position that they might be

How long have you worked in healthcare?





struggling with, you will look like the better applicant and can hope for the best salary."

Good news for nonclinical employees

The demand for nonclinical healthcare professionals such as risk managers is high, according to a trend report from the workforce strategy team at nonprofit College for America, based at Southern New Hampshire University in Manchester.

Launched by Bill and Melinda Gates to work directly with employers and educators in preparing students to fill needs in the labor market, College for America regularly assesses demand for nonclinical and frontline skills in healthcare. Baby boomer retirements, new technologies, and the Affordable Care Act (ACA) implementation are redefining the nature of the patient care team, the report notes. The report reviews how the shift to team-based patient care and an increased focus on the patient experience demands more complex skill sets of nonclinical and frontline workers. It also identifies six of the fast-growing positions: patient representative, community health worker, medical records technician, office supervisor, medical office specialist, and medical assistant.

With the ACA's healthcare exchanges in full swing for more than a year, the pressure on healthcare systems to be competitive and efficient has been unrelenting, the analysts note. Growth in frontline and nonclinical healthcare jobs has continued, with some roles seeing a steep upward trajectory in demand and others undergoing a slow and steady climb in numbers. With almost 22 million workers in the healthcare industry projected by 2023, it's the largest segment of the United States economy.

The full report, *Nonclinical & Frontline Healthcare Roles Continue to Rise: Six growing roles and the 55 skills they have in common*, is available online at http://tinyurl.com/mdyfd9t.

SOURCE

• **Leilani Kicklighter,** RN, ARM, MBA, CPHRM, LHRM, The Kicklighter Group, Tamarac, FL. Telephone: (954) 294-8821. Email: lkicklighter@kickrisk.net. ■

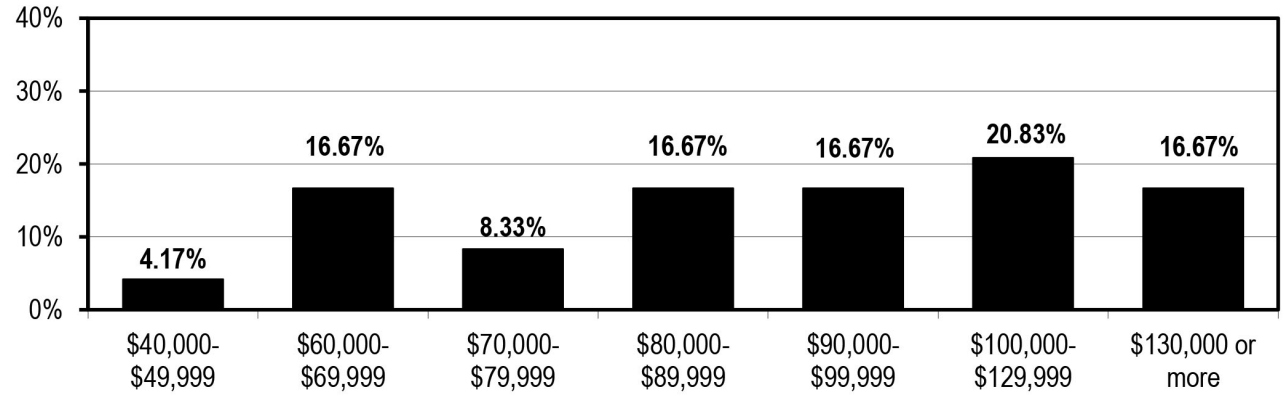
Risk manager incomes go nowhere for sixth year — Salaries hold steady yet again

When does "holding steady" turn into "stagnating?" How about six years?

For the sixth year in a row, the median income for healthcare risk managers in the 2014 *Healthcare Risk Management* Salary Survey is in the $90,000 to $99,999 range. *(See the chart, p. 3.)* In recent years, the consistency of that figure was considered a relatively good sign for risk managers, at a time when many professionals were losing their jobs or forced to take lower compensation. But with an improving economy, risk managers might wonder why they are still drawing essentially the same wages as six years ago.

A deeper look at the latest data adds to the disappointment. In 2013, just under 30% of

What is your annual gross income?



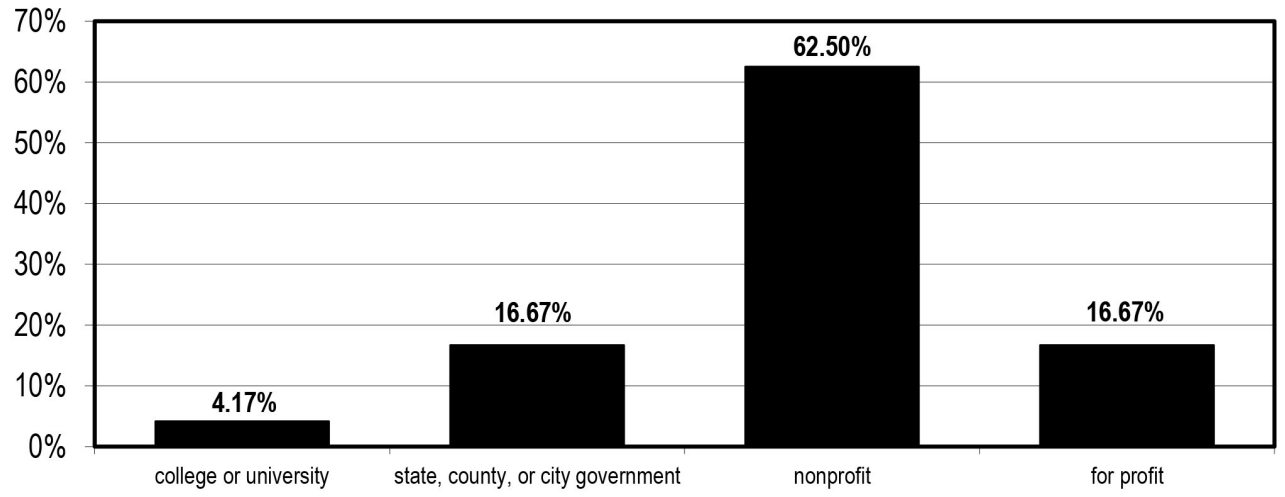
respondents reported income in the $100,000 to $129,999 range, but in 2014 that figure is down to 20.83%. The decline is explained by the fact that those reporting income in the $90,000 to $99,999 range jumped from 6% in 2013 to 16.67%. In 2014, another 16.67% reported income of $130,000 or more, which is down from the previous year's 19% and 18% for the year before that one.

The exclusive survey was sent to 350 readers in the September 2014 issue. A total of 24 were returned, for a response rate of 6.8%. The results were tabulated and analyzed by AHC Media, publisher of *HRM*.

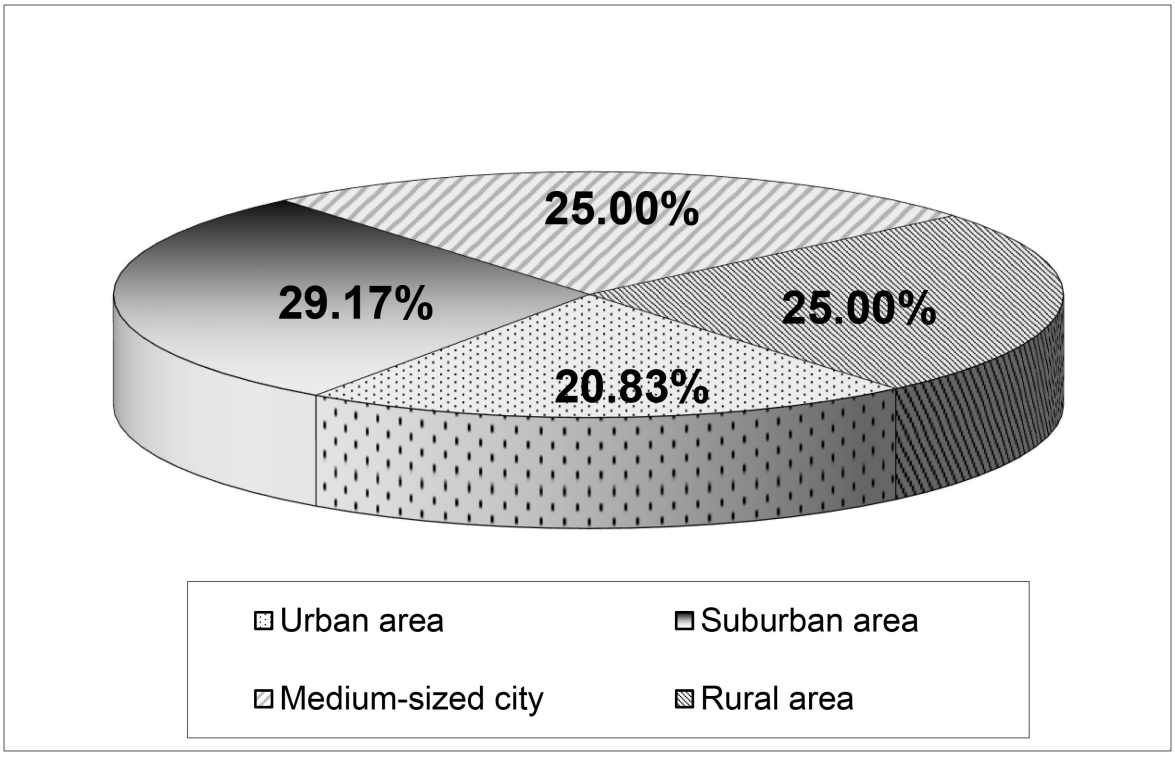
Most (70%) of respondents reported a salary increase in 2014 of 1% to 3%, similar to the previous several years. *(See the chart, p. 2.)* The number reporting no change in their income was down to 30% from the previous year's 38%.

Sixty-three percent of respondents work for nonprofit healthcare organizations, about the same as the previous year. Just under 17% work for for-profit providers, down from the previous year's 27%, with the remainder in educational or government settings. *(See chart, p. 3.)* Fifty percent of readers have worked in healthcare for more than 25 years, which is a 7 pecentage point drop from the previous year. *(See chart, p. 1.)* ■

Which best describes the ownership or control of your employer?



Where is your facility located?



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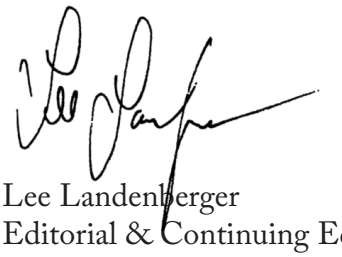

Lee Landenberger
Editorial & Continuing Education Director