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Healthcare Risk Management™

INSIDE

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Get ready for a bigger role in risk financing, prepare for more scrutiny

The continuing malpractice insurance crisis is putting more pressure on risk managers to present the best possible image to underwriters, according to representatives from the insurance and risk management fields who recently gathered to discuss how to best respond to new demands.

Risk managers must become directly involved in risk financing, they say, even if that task had been the province of the health care organization's financial leaders.

That role may be unfamiliar and even daunting to some risk managers, but it is absolutely necessary in light of triple-digit insurance rate hikes, carrier pullouts, increased litigation, and other headaches, says **Monica Berry**, BSN, JD, LLM, DFASHRM, CPHRM, vice president of risk management and loss control for the Rockford (IL) Health System. Berry also was 2002 president of the American Society for Healthcare Risk Management (ASHRM), which sponsored the recent roundtable. ASHRM gathered the experts to discuss how risk managers can get more involved in the financial aspect of risk financing, an area traditionally left more to the chief

Audio conference tackles HIPAA privacy concerns

The recently released final privacy rule under the Health Insurance Portability and Accountability Act (HIPAA) makes significant changes to the existing regulations. With the April 14, 2003, compliance deadline fast approaching, are your staff receiving the proper training?

The American Hospital Association says implementing HIPAA will require "sweeping operational changes" and will take "intense education of hospital workers and patients." To help you and your staff prepare, American Health Consultants offers **HIPAA's Final Privacy Regulations: What You Must Know to Comply**, an hour-long audio conference on Dec. 4, 2002, from

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financial officer and other financial experts while the risk manager concentrated more on decreasing risk and handling litigation.

Risk managers must break out of that box and use their unique expertise to help the organization acquire better risk financing, Berry says. The insurance crisis is so bad that the risk manager's skills could prove to be the only way a health care provider will be rescued from ridiculously high rates, she says.

"Our collective expertise in finance, law, caregiving, patient safety, and advocacy gives us a unique perspective as we experience this challenging insurance market," Berry says. "There is an absolute need for a unified approach to risk financing. Risk managers, CEOs, CFOs, and COOs must collaborate to meet insurers' needs and expectations. A team approach is essential to a successful renewal."

The team approach was not considered necessary in previous years because the financial experts could handle the negotiations with the insurer on their own, says **Matthew Dolan**, senior vice president for OneBeacon Professional Liability Partners, an insurer in Boston. But as the insurance market hardens beyond what anyone can remember in recent history, insurers are demanding that providers demonstrate much more how they are a safe investment. Every insurer is seeking those providers who can prove they are the lowest risk possible.

"From an underwriting perspective, the state of the union is grim," Dolan says. "The state of the liability market is in profound disarray."

Dolan notes that medical malpractice loss ratios are worse in states transitioning to managed care, and the long-term care industry continues to demonstrate "a woeful inability to address the rapidly aging patient population." Nursing homes typically contribute only 10% of a malpractice premium but will contribute well over 30% of the eventual acts and year loss ratios.

The median malpractice jury award increased 42% from 2000 to 2001, and defense verdicts now occur in about 62% of trials. Indemnity claims are up 9%, he says. Many A-rated insurers and reinsurers have been downgraded, and many have disappeared altogether, Dolan says.

"The result is that carriers who are staying in this business are desperately trying to return to profitability," he says. "Most carriers have a very slim margin for error. They are reevaluating their risk appetite and constructing the box. You will either fit in the box or they will not offer you terms."

As premiums increase, limits are decreasing and other coverage terms are becoming more restrictive. **(See story on p. 124 for on what changes you can expect in insurance coverage.)** The hard market is likely to continue for at least two or three years, Dolan predicts. It is against this bleak backdrop that risk managers find themselves being drawn more deeply into risk financing. And he says it is not merely a good idea for risk managers to get involved — the underwriter will expect it.

"It is essential that an effective tripartite relationship be established between the risk manager, the broker, and the underwriter. You must understand the mindset of the underwriter and understand that now, more than ever, the underwriter is evaluating the risk manager as much as the risk," Dolan says.

One underwriter confirms that she demands

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much more of hospitals and other health care providers than in recent years. **Donna Croix**, assistant vice president for health care facilities with GE Medical Protective, a medical liability insurer in Fort Wayne, IN, says the higher standards are all part of an effort to differentiate hospitals in a search for the best risk.

"An area of major focus is the quality, scope, and overall effectiveness of the hospital's risk management program," she says. "Do only obstetricians perform deliveries? Does the risk management department report directly to senior management? Is the ER staffed by physicians board certified in emergency medicine?"

Croix says she also asks about whether the medical staff bylaws clearly require adequate medical malpractice insurance for physicians and what initiatives have been taken to address patient safety, medication errors, and fall prevention. **(For more advice on how to present your risk management program to an underwriter, see story on p. 125.)**

Dolan cautions that it is not enough to have good policies, such as one requiring adequate insurance for physicians. Most hospitals will have the policy, so the bigger issue is how to enforce them.

"I'd rather hear a discussion of how you are managing your risk profile to make sure these policies and procedures are actually performed," he says. "That is probably more important than the policies and procedures themselves."

The organizational structure in the provider can be critically important, says **Susan R. Chmieleski**, JD, BSN, APRN, CPHRM, assistant vice president and director of health care risk management for Chubb Specialty Insurance. She says her underwriters routinely request organizational charts. They look at not only to whom the risk managers reports, but how they report.

"The kind of access she has to not only the CEO, but the also the CFO and the board of directors. We're currently asking very specific questions about how and when she reports," she says. "We're also looking at high-risk areas like obstetrics and scrutinizing things like whether your OB department performs vaginal birth after cesarean. And we expect risk managers to have infinite knowledge of the policies and procedures in these areas."

You also may hear underwriters requesting more data than ever before, says **Nancy Hacking**, CPHRM, FASHRM, director of risk and safety management at Concord (NH) Hospital and Capital Region Health Care. Previously they commonly requested five years of data on losses; now they want 10 years of data with an explanation for any significant claim.

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There also are links to every article published in *Healthcare Risk Management*'s *Patient Safety Quarterly* and *Patient Safety Alert* supplements from January 1999 to present.

HRM's 2001 salary survey also is available in its entirety.

Find links to other web sites that are essential references for risk managers. There also is a guide to upcoming conferences and events of interest to risk managers. Click on the User Login icon for instructions on accessing this site. ■

Beyond the numbers

With all this information exchanging hands, some risk managers might become anxious about incident reporting. For instance, how much do you disclose? Dolan says incident reporting is becoming more important because it is a way for underwriters to dig deeper, to learn more about your organization than what numbers reveal. Not only do they want that deeper view, but they also want to know that you, the risk manager, are using the incident reports for the same purpose.

"Whether these events ultimately evolve into claims is a secondary issue," he says. "But every underwriter is attempting to determine whether the risk manager has that view to the bottom of their organization, has those feelers out to be able to proactively identify events that could turn in to claims, because that is the only way you can muster the most effective, proactive defense."

The underwriter also looks for confidence about the provider's incident reporting trigger, Dolan says. A high number of incidents is not necessarily a bad thing, he says, and many insurers will even see that as a positive sign that your

incident trigger is set low enough to capture all the events that need your attention. **Bruce Burns,** vice president of finance and chief financial officer at Concord Hospital, says underwriters have responded favorably when presented with a thorough incident report.

"As CFO, I like it too when the risk manager has a good long list of incident reports because it's a good sign that our risk management department is in touch and knows what's going on," he says. "You're less likely to get surprises."

Dolan cautions that a long list of incident reports, *by itself*, can turn off an underwriter.

"When reporting incidents, you need to be very effective in providing the information and then managing the information they take from that," he says. "An uninformed view by the insurance company, if not properly managed, can result in them putting a lot of loss dollars on these incidents that should not ultimately emerge, and that will obviously skew your loss profile. So reporting of incidents is critical, but reporting incidents with proper information about why you think this is nothing but a proactive reporting of claims that probably do not have significant potential is just as important."

Important for risk manager to report to the top

Burns and Hacking work closely and they say underwriters are pleased to see the risk manager not only reports to the CFO but that they actually work side by side on many risk management issues. Hacking says that has been a key to the success of their risk management program. Part of their collaboration included a formal review of policies and procedures that resulted in a significant overhaul. Multiple volumes of policies and procedures were reorganized into a five-volume set, which is available to all staff both in hard copy and on-line.

"It makes it easier for staff to know what the policies and procedures are," Hacking says. "That's the kind of thing an underwriter needs to know about if you've done something like that. During a recent risk assessment by our insurer, that was highlighted as an outstanding process."

Hacking also advocates risk managers integrating risk and safety whenever possible. She takes advantage of the clinical management orientation meetings for physicians to deputize every clinician as a risk manager. The idea is to get the message to physicians and staff early and to convince them that you want to identify risk early, before a patient or staff member is harmed.

"We also have our risk management department located near the administration offices," she says. "This is a signal to the organization that there is value to the risk management activities within the organization. Reporting to the CFO has enhanced the significance of risk management in the organization, indicating that it is not just another function in the organization but is one of bottom line importance."

Risk consultants are a more common part of the underwriting process than in years past, Hacking says. It now is common for an insurer to send a risk management consultant, often with a background as a hospital risk manager, to assess the provider. Insurers often send risk consultants prior to offering a new policy and before renewal.

"We also see much more request for documentation, much more than what we say five years ago. There are more site visits, and more extensive recommendations for what needs to be done," she says. "The consultants are looking for more beyond documentation. Things like whether the risk manager is well received in the facility when we do a tour of the organization. How often can a risk manager demonstrate that they are consulted by physicians when faced with a difficult situation?"

Consultants also look closely at the relationship between risk management and patient relations. More evidence shows that a close relationship can improve patient safety, Hacking says. ■

Top of the tips: Prove that your program is low risk

When it comes time to meet with the underwriter and insurance broker, your risk management program is in the spotlight. How you perform could make the difference in whether your organization receives favorable terms from the insurer. So where in the world do you start?

The risk manager should show that the provider is already on top of all the concerns running through the mind of the insurer, says **Matthew Dolan**, senior vice president for OneBeacon Professional Liability Partners, a Boston insurer. He offers this advice:

- **Explain your role as risk manager.**

Discuss your responsibilities, your department structure, and how you report to senior leadership.

• **Explain your organization's approach to risk management and how that view is supported.**

Ideally, you should show that risk management is integrated throughout the organization and supported from the top. If you have changed your approach to risk management in recent years — by changing to a proactive emphasis or a blame-free culture, for instance — show how you did that and what effect it had.

• **Differentiate your risk from other providers.**

What makes you different from other providers the insurance might cover instead? Do you carry less risk because of the services you offer or don't offer? Do you have a track record that is better than average in terms of past claims or payouts? Can you show that your staff is better trained or more experienced? Do you have fewer nursing vacancies than the national average of 13%? Have you implemented a program to retain experienced nurses?

Anything that can demonstrate you are a lower risk, even small points in your favor, will add up.

• **Show your organization's success record and possibly your own.**

Unless you have a terrible record, you should volunteer to show the underwriter your actual record in terms of malpractice premiums and losses. Nothing reassures an underwriter like a history of low premiums, few claims, and minimal losses. If those numbers are lower than the typical figures for a comparable organization with similar demographics, highlight them and emphasize that they were no accident; your successful risk management program kept those numbers low.

And if you can attach those good numbers to your own career as risk manager, highlight that association for the underwriter. For instance, you might be able to show that the statistics improved once you were hired or when you implemented a certain risk strategy. If the numbers support it, you can even point to your favorable statistics from a previous job. The point is that the underwriter can see that you personally played a role in achieving those good numbers for the organization, and your continued presence will be seen as an asset.

• **Anticipate any questions or concerns from the underwriter**.

While it is important to promote all your accomplishments, you also should be prepared to explain any weaknesses. Consider what the underwriter may have gleaned from Joint Commission reports, for instance, and have a good explanation. In many cases, you'll fare better by offering the explanation before the underwriter asks. ■

Hard market causing more restrictions and demands

The hard insurance market is leading to major changes in the insurance policies offered to health care providers, says **William McDonough**, MPAH, ARM, FASHRM, segment leader-manager for health care and senior vice president and national practice leader for Marsh, a major insurance broker in New York City. Carriers generally are offering less and charging an arm and a leg if you want higher limits, he says.

McDonough says you can expect to see these trends in malpractice insurance:

• **Restrictions on capacity:** Primary carriers still committed to the health care industry remain wary and have reduced how much they are willing to expose themselves to any one risk. In some cases, the insurers are halving previous maximums, or even worse.

• **Reinsurance:** Due to the lag time in reporting of claims, which can be three years or more, reinsurers now are being hit severely for losses from past years. In response, most reinsurers are cutting back on limits and have substantially increased prices.

• **Claims reporting:** Specific conditions are being imposed on the reporting of excess losses and potential excess losses. Settlement offers that may affect excess carriers need to be reported in a detailed fashion to ensure that no conflicts arise from late notice.

• **Tail/extended reporting period (ERP) provisions:** Many policies had specific provisions for options that would extend reporting periods. When triggered, these provisions allowed clients to evaluate the financial ramifications of tail options at a fixed cost while locking into place a self-insured retention on all incurred-but-not-reported losses. Now, McDonough says, most carriers either refuse to commit to a predetermined cost for ERP or establish parameters that protect them with a lesser benefit to insureds.

• **Terrorism exclusions:** Many January 2002 renewals contained new policy language on terrorism. The language is not industry-specific, which raises questions about applying it to health care clients even though it has been approved by the National Association of Insurance Commissioners.

• **Increased deductible levels and self-insured retentions:** Very few accounts with first-dollar coverage still exist. In many cases, deductibles are

increasing so much that they are being converted to self-insured retentions, which carriers prefer as a matter or risk sharing.

• **Collateralization for retentions:** Carriers are becoming more stringent in requiring collateralization for even small retentions at levels close to the aggregate retention amount. Required levels of collateralization also are rising.

• **Shorter ERP term for long-term care:** ERP provisions are generally not given at policy inception anymore, and terms of only one or two years have become standard in long-term care.

• **Limited coverages, reduced limits, and higher deductibles in long-term care:** Carriers often are unwilling to negotiate coverage terms for long-term care, adhering strictly to their own forms and conditions. The punitive damages exclusion usually is mandatory, and coverage for sexual abuse or molestation is usually difficult to obtain. Most carriers are not offering per-location limits in long-term care, moving more toward aggregated limits and unaggregated deductibles.

Many carriers now have long term care minimum deductibles of at least $25,000, and they will offer quotes for deductibles as high as $500,000. ■

RMs tackle rough edges of smallpox vaccination issue

Risk managers face a host of unanswered questions and potential liabilities as hospitals gear up for the smallpox vaccinations recently urged by advisors to the Centers for Disease Control and Prevention (CDC) in Atlanta.

The CDC's Advisory Committee on Immunization Practices (ACIP) approved a plan that calls for smallpox immunization of some 510,000 health care workers. As outlined at the meeting, all hospitals should designate a "smallpox care team" that will be immunized prior to any release of the virus. ACIP recommends that the team include about 40 health care workers per hospital, including the epidemiologist, infection control staff, 15 emergency department physicians and nurses, eight intensive care unit (ICU) nurses for adult patients, eight pediatric ICU nurses, one infectious disease consultant, one dermatology consultant, four respiratory therapists, four radiology technicians, two engineers, and selected staff from the security and housekeeping departments.

"ACIP will provide guidance for developing a hospital care team prepared to respond and take care of the first smallpox patients," says **Jane Siegal**, MD, who advised ACIP on the issue as a member of the CDC's Healthcare Infection Control Practices Advisory Committee. "[This is the] suggested composition of the team. I think individual hospitals have to look at that and look at the types of patients they see, the type of care they provide, and decide who will be [on the team]. This provides some guidance."

Health care risk managers will face a number of potential problems related to the smallpox vaccinations, says **Gina Pugliese**, RN, MS, vice president of the Premier Safety Institute in Chicago and a risk manager. Further guidance expected from the ACIP may make the job easier, but she says the smallpox vaccination will be a major undertaking for any hospital. For starters, risk managers should involve themselves in the multidisciplinary committee that will decide exactly which health care workers get vaccinated, Pugliese says. That group will be different at each facility, but she recommends thinking beyond just the obvious choices. Key security personnel and even some housekeeping staff might need to be included, she adds.

"There will be lots of issues to consider because we're doing this for the first time," Pugliese says. "I wouldn't waste any time before starting to think about these issues."

Employee furloughs could be the biggest and most immediate problem for hospitals, says **Denny Thomas**, director of risk management for St. Joseph's Hospital in Marshfield, WI. Because employees could spread the virus to others for up to 19 days after vaccination, the hospital must take some sort of precaution. That most likely will mean sending the employee home with pay.

"In an industry that is already facing horrendous human resources shortages, this will greatly compound that," he says. "This is going to be a major project to implement, and there are right now a lot of questions about how to do it."

Pugliese and Thomas raise these points to consider:

• How will you screen employees for a history of eczema or immunosuppression, or for a current pregnancy, all of which can make them ineligible for the vaccination? If you don't screen them properly and harm results, the hospital could be held responsible.

• Can you maintain confidentiality? If the employee or a family member is HIV-infected, for instance, you must know that before allowing the

vaccination. Do you have a system for protecting that information?

• Informed consent must be obtained, but that means you must adequately disclose the potential complications from the vaccination. Remember that many people are wary of smallpox vaccination because of hype about the risks, so that could produce lawsuits from any adverse outcome. A hospital should protect itself up front with a thorough informed consent process.

• How far does the hospital's potential liability extend? In theory at least, the hospital could be liable for harm extending far beyond its own employee. If the employee sheds virus in the days after vaccination and infects a family member or even a complete stranger, the hospital can be accused of wrongdoing for not taking adequate steps to prevent the transmission.

"We haven't seen a case of smallpox on this planet in 25 years," warns **Paul Offit**, MD, ACIP member and infectious disease chief at the Children's Hospital of Philadelphia. "Would it not be reasonable to put this system in place — make the vaccine and get it out there under lock and key, make guidelines [stating] clearly who should be vaccinated — [and then implement it] following a single documented case?

"If you immunize 500,000 people, there will be people who have serious adverse events. There will be contacts of [immunized] people who will have serious adverse events," he adds. "We will do more harm. I wonder if we could jump with a [safety] net a little bit by waiting for just the first confirmed case, but be ready when that happens."

However, other committee members warned that last year's anthrax attacks showed how vulnerable the nation is to agents of bioterrorism. The prevailing opinion is the price of unpreparedness against smallpox would be immense. Offit's was the only dissenting vote on the 12-member panel. ■

Audio conference

(continued from cover)

2:30-3:30 p.m., Eastern Time. You'll learn detailed information on changes to the privacy rule, as well as practical methods to implement new procedures within your facility. Also learn how to successfully manage privacy issues with business associates, and how to spot and avoid costly HIPAA violations. Do you know what your enforcement priorities are? Do you need real-world examples? Our expert speakers, **Debra Mikels** and **Chris Wierz**, BSN, MBA, will help you understand your responsibilities and identify potential liabilities. This will allow you to develop a HIPAA compliance strategy with a rationale behind it.

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For more information or to register for the HIPAA audio conference, please call American Health Consultants' customer service department at (800) 688-2421. When ordering, please refer to effort cod **65151**.

Safety hotline, new staff improve care, reduce errors

The addition of a patient safety specialist and a safety hotline for reporting potentially dangerous situations improved the quality of care dramatically at a Missouri hospital, so much so that it is the first hospital honored by the American Hospital Association with its Quest for Quality prize.

Missouri Baptist Medical Center in St. Louis recently earned the award for its leadership and innovation in patient care quality, safety and commitment. Initiatives addressing quality and patient safety have been an important part of the hospital's mission for years, says **Mark Eustis**, senior executive officer at BJC HealthCare, the hospital's parent organization. He says he began emphasizing quality and patient safety when he first joined the system as president of Missouri Baptist Medical Center in 1996.

"The management team, including physician

leaders, developed a focused management strategy to define what's important to the organization and our patients," Eustis says. "Improving clinical outcomes and patient safety have been the foundation of this effort for more than six years. It's gratifying to know that by clearly defining our goals, developing measures of performance and specific initiatives to improve performance, the patients of Missouri Baptist have benefited from our efforts."

Max Cohen, MD, vice president for clinical quality and effectiveness and chief medical officer at Missouri Baptist Medical Center, says the support of BJC leadership was important in the hospital's success. Many ideas sound great until you try to implement them, he says, and top-tier support can make the difference in whether you see any real results.

"But also, this is not something that the president handed down to us and said, 'Do it,'" Cohen explains. "The president and vice president have taken personal responsibility to ensure that we have a blame-free culture and that safety is a priority."

Many new strategies in place for patient safety

Missouri Baptist Medical Center implemented several strategies in the last three years in an effort to improve quality and patient safety, says **Carolyn Roth**, RN, JD, director of risk management. She says the hospital leaders immediately realized that the patient safety effort had to include a wide range of staff members at the hospital, not just a few key leaders.

"When we first set out to make some improvements, we got feedback early on that it looked like a three-man show and that wasn't going over well. The staff thought it was just another case of somebody telling them what they were doing wrong," she says. "So we pulled in the directors of nursing and other supervisors to show that this was a hospitalwide effort and we had commitment from the top."

Among the first tasks was the addition of the position of "patient safety specialist" in 2001. As patient safety specialist, **Nancy Kimmel**, RPh, has focused on developing and implementing programs such as:

- An innovative blame-free culture, within which staff are more comfortable reporting areas needing improvement without fear of retribution.
- The "We Heard You, We Acted" e-mail newsletter, which addressed reported problems and how management addressed the systems responsible for creating these issues. All employees have access to this newsletter.

In addition, unit safety briefings, during which nurses share and discuss safety concerns identified in the past eight to 12 hours, are incorporated into the beginning of every shift.

- The Patient Safety Hotline, which fields nearly 200 calls per month.
- A Staff Patient Safety Award that offers rewards of up to $5,000 to staffers who submit ideas on how to improve patient safety.

Patient safety specialist added to staff

Once Kimmel was hired as patient safety specialist, the hospital set about organizing two new teams: the Medication Safety Team and the Patient Safety Council. The hospital's Medication Safety Team began meeting in March 2000. The group of physicians, nurses, pharmacists, risk management staff, clinical educators and performance improvement staff worked to significantly enhance the "culture of safety" and the processes used by the hospital's employees to dispense medications to their patients. In addition, Missouri Baptist Medical Center developed the Mind Your Meds program for patients, which features a brochure with a tear-off, wallet-sized card that can be used to help keep track of their prescriptions and therefore prevent problems with drug interactions. More than 35,000 brochures have been distributed in the first 13 months of the program, which spawned similar programs at many other hospitals (including six within BJC HealthCare).

The hospital's Patient Safety Council began meeting May 2001. This group was composed of physicians, nurses and staff from departments ranging from pharmacy to infection control to marketing. The Patient Safety Council is charged with creating a blame-free, nonpunitive culture that allows the staff to understand that, though they are accountable, many of the problems are process-related rather than entirely human error, says **Kathy Benage**, RN, director of performance improvement at Missouri Baptist Medical Center.

"The number of staff-reported problems has increased tenfold during the last 18 months," she reports. "We're thrilled, and we've accomplished a lot, but we also realize that we have a long way to go, and we'll continue to keep working to create an environment that is as safe for our patients as we can make it."

Roth and Benage both report directly to Cohen, which he says offers a tremendous advantage

when coordinating patient safety improvements. When they hired Kimmel as patient safety specialist, they had to decide whom she should report to. The risk manager? Benage, the quality professional? Directly to Cohen?

They decided to have the patient safety specialist report directly to Benage, the director of performance improvement, largely because Kimmel's role includes a great deal of data management, and that fits better with Benage's department.

"She is able to access a lot of data and start working on safety issues that derive from that data. That's a valuable part of what she does for us," Roth says. "Before this, one of our biggest concerns was medication errors and it was historically a nursing function to look at that. But Nancy put together a multidisciplinary task force to look at this problem in a more circular way, rather than just from one view point."

Trigger for concerns

Managing the patient safety hotline is an important part of Kimmel's job, as well. When the hotline was first introduced, she received about 15 calls a month. Now that number is up to about 200 calls a month, and Benage says that's a good thing. More calls means the staff is using a lower trigger point for reporting their concerns, which is exactly what the teams wanted. Cohen says he is "absolutely thrilled with the huge increase in hotline calls and also with total event reporting across the organization. That's also increased about tenfold as a result of letting the staff know we're just as interested in near misses as in errors that have reached the patient and caused harm."

The hotline started out as a way to report only medication safety issues, but it wasn't used very much. Roth says the hospital conducted focus groups with staff and found out that they would use the hotline much more if they could report other safety concerns.

The hotline is promoted to staff in many ways, and the phone number reaches an answering machine dedicated to nothing but hotline calls. Staff are told that they can leave information anonymously if they choose, or they can leave their name for follow-up purposes.

"The anonymity was a concern of mine because I need those names in case a lawsuit comes out of the event. I need witnesses," Roth says. "I was uneasy about that, but it has turned out fine. Some calls sound much worse at first, before you investigate it. You have to be careful not to take all the calls at face value."

Kimmel monitors the hotline recordings and ensures that action is taken within 24 hours of when the call was received. That action may include a preliminary investigation and a report to other supervisors who can take action. If the hotline caller leaves his or her name, Kimmel always reports back to that person within 24 hours to explain what is being done. She puts all of the hotline calls on a spreadsheet and sends that summary to both the risk manager and the director of performance improvement. They can select out any calls for immediate action and look for trends. Data also are sent to department managers so they can be aware of concerns in their area and watch for trends.

"The information that comes in is analyzed, and we're looking for multiple things," Kimmel says. "Did the error reach the patient? If so, that report goes right to the risk manager. If not, I look at whether there is a high risk for an adverse outcome. Those we deal with immediately with a root-cause analysis or a performance improvement team. And if it's a problem that can be fixed right away, we do that."

She says the culture of safety has generated support from all the managers in the hospital so that when she needs expedited action on a safety issue, there usually is no grumbling or hesitation.

The hotline calls range from the obviously serious medical error to the "small things that someone has noticed for a while and then they decide to pick up the phone," Roth says. "It could be something like a door that swings back too hard and could really nail someone. It's a real risk, and it's so easy to fix if you know about it. But before the hotline, there wasn't really a vehicle for reporting that kind of concern."

Roth recounts one example in which a hotline caller reported a problem with the delivery of patient specimens to the lab. Glass bottles were found broken at the lab's receiving station, and the staff initially attributed the problem to poor packaging by those sending the specimens. But Kimmel noticed a trend in the hotline reports and investigated further. Kimmel and Roth determined that the problem was not poor packaging by the staff, it was faulty specimen containers. Their investigation actually led to a national recall of the specimen bottles by the manufacturer.

"If not for the hotline, and if we didn't have someone who was watching for trends in the reports, that might never have been discovered. It would have been blamed on poor performance by the staff," Roth says.

Many of the patient safety improvements required significant changes in policies and procedures, but Benage says the hospital tried to implement some changes gradually so that efforts could be refined before the entire hospital was affected. They refer to the process as "small tests of change."

"We wanted to improve the process by which we reconcile the drugs a patient takes at home and their drugs on admission, so we did a small test of change to try that process on one unit," she says. "When it worked there, we spread it to other units. It's a concept that allows us to test the idea first, learn more from it, then spread it through the system. It also allows us to take action right away instead of studying something forever."

Change can be daunting

Cohen says that gradual process was important in achieving some of the major changes that improve patient safety at the hospital. Changing any documentation, for instance, was a daunting task because changes had to be approved by the forms committee, a process that always took longer than the patient safety teams were willing to wait.

"We got the forms committee to agree that we could change it, test it and change it over and over again, *then* get their formal approval. We got that agreement up front that the form wasn't really changed until we tested it to death," he says. "This whole effort at improving patient safety is a lot more difficult than it sounds. There is a tendency to be impetuous, and think one can move quickly and accomplish a lot, but huge culture changes take a lot of time. You need a lot of patience."

Other finalists for the AHA prize included Children's Hospitals and Clinics of Minneapolis/St. Paul and Fairview Hospital in Great Barrington, MA. Brigham and Women's Hospital in Boston received a Citation of Merit. For earning the Quest for Quality Prize, Missouri Baptist Medical Center will receive $75,000 to be used toward furthering current and developing new patient safety initiatives. ■

JCAHO warns of bedrail-related entrapment

Since 1995, the Joint Commission has received reports of seven deaths or injuries related to bedrails, leading the accrediting body to issue a warning about this hazard.

Bedrail-related entrapment deaths were the subject of the most recent *Sentinel Event Alert* from the Joint Commission. Three of the seven reports were from hospitals, two were from long-term care facilities, one was from a behavioral health care facility, and one involved a patient receiving home care services.

The hospitals sent root-cause analyses to the Joint Commission, and that information provides guidance on how to avoid these deaths. All five hospital cases involved patients or residents who were 65 years of age or older, and all resulted in death by asphyxiation. Of the patients/residents, four were mentally or behaviorally impaired; three were at risk for falling; two had limited mobility in bed; one was on psychoactive or sedative medications; and one had a physical deformity.

The Joint Commission reports that asphyxiation was caused by one of the following: being caught between the mattress and the bedrail; being caught between the headboard and the bedrail; getting his or her head stuck in the bedrail; or being strangulated by a vest restraint between the rails. No particular bedrail configuration was implicated in these cases. The beds involved included some with upper rails only, upper and lower rails, both upper rails and one lower rail, or continuous full-length rails. However, the data indicate that none of the cases involved the use of only lower rails.

"Recognizing the limitations of the small sample of cases, certain findings were recurrent in the root-cause analyses," the Joint Commission reports. "All five organizations cited a breakdown in communication, most often among staff (two cases) or with or between physicians [two cases], as well as with

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administration [one case]. Four of the five organizations cited equipment factors, including side rail protector pads not being used [four cases] and problems with the bed / mattress / side rail configuration [one case]."

Other problems included patient / resident assessment (three cases), including adequacy of assessment, scope and timing of reassessment, and patient / resident observation; human factors (three cases), including staff orientation and use of an agency nurse; and leadership (one case).

Based on the analysis of those seven incidents, the Joint Commission urges providers to orient and retrain staff regarding safe bedrail use. Equipment redesign also should be considered, with emphasis on the use of bedrail protector pads, re-evaluation of beds for entrapment potential, replacing beds, replacing or modifying side rails with gaps greater than five inches, removing side rails from the bed, installing a positioning bar, or using lower beds.

Hospitals can redesign processes to reduce the risk, taking steps such as patient assessment for risk of entrapment (including confusion, sedation, restlessness, lack of muscle control, size), patient observation, resident / family education about bed rails, and improving communication policies.

Based on the information from the seven incidents, the Joint Commission recommends these safety precautions be implemented immediately:

1. Provide orientation and training to staff about entrapment dangers with bedrails and assessment of patients / residents for entrapment risk, as appropriate to the patient population and the care environment.
2. Assess patients / residents for risk of entrapment, including physical, mental, behavioral or medication impairment.
3. Re-evaluate beds for entrapment potential, including "gap" measurement and appropriate sizing of mattresses for bed frames.
4. For individual patients / residents at risk for entrapment, implement appropriate changes to beds (for example, the use of retrofit kits, bedrail netting, clear padding, Velcro or anti-skid mats) to reduce the risk of entrapment.
5. When possible, keep patients / residents with risk factors for entrapment under more frequent observation. ■

Report: Expect 40 serious errors daily

Potentially deadly medication errors are so common that a typical 300-bed hospital experiences 40 every day, according to a new report.

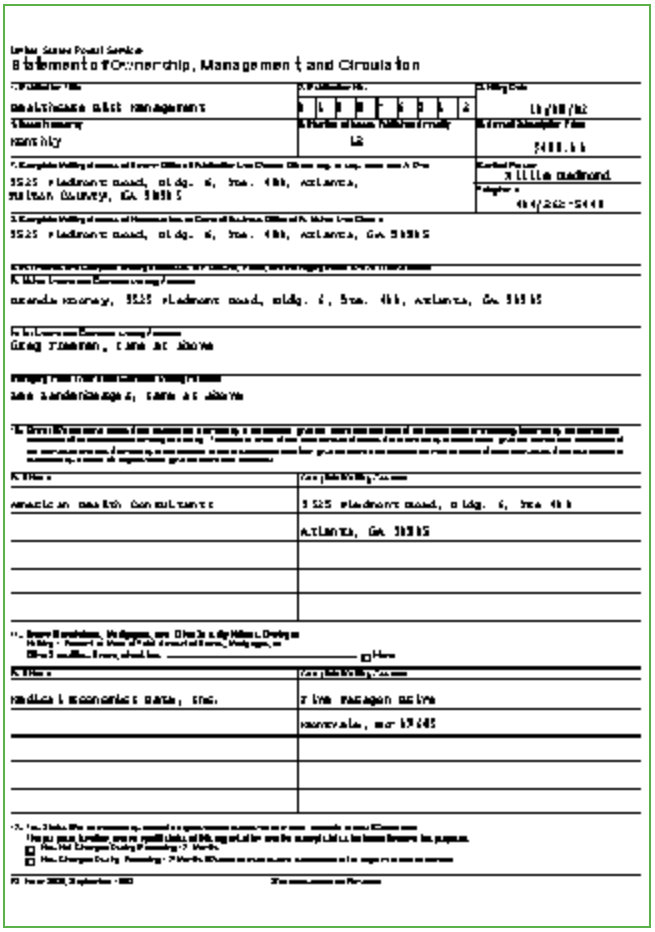
The errors include giving patients the wrong drug dose, delivering medication at the wrong time, administering an unauthorized drug, or forgetting to give patients their medicine. Those life-threatening mistakes occurred in almost one out of every five medication doses given in the hospitals and nursing facilities included in the study.

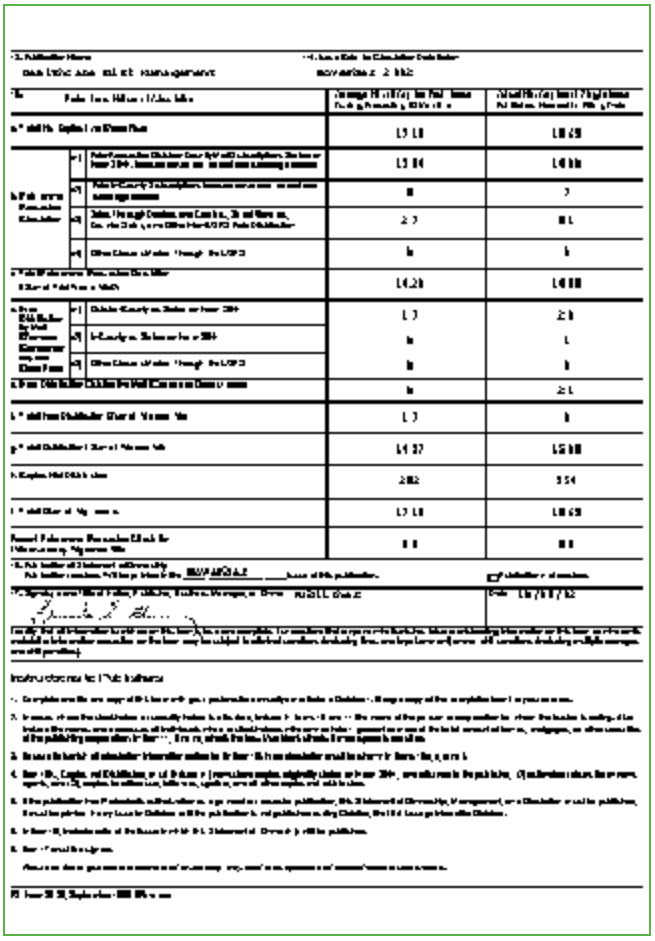
Kenneth N. Barker, MD, and colleagues from Auburn (AL) University report that 7% of the errors could be could lead to serious medical consequences. That 7% translates to more than 40 mistakes per day in a typical 300-bed facility, Barker says. (*Arch Int Med* 2002; 162:1,897-1,903.)

The study included potential adverse drug events such as giving insulin nearly three hours after it was due, or giving double the ordered dosage of verapamil, a drug that lowers blood pressure. The authors of the study say the findings

underscore the need to improve the medication delivery and administration systems in health care facilities.

Barker studied observations from 36 hospitals and nursing facilities in Colorado and Georgia. A research pharmacist assessed the observations. Mistakes were made in 19% of doses given, or 605 of 3,216 doses. The most common error was giving medication at the wrong time (43% of errors), omitting medication (30%), giving patients the wrong dose (17%), and giving patients a drug that had not been authorized (4%). ■





Healthcare Risk Management's
Legal Review & Commentary™
A Monthly Supplement

Medical records: To have and to hold? Or to release when told?

By **Jan J. Gorrie**, Esq., and **Seema Patel**
Buchanan, Ingersoll Professional Corp.
Tampa, FL

News: A female hospital patient accused a male patient of sexually assaulting her. She brought a civil action against the health care providers and criminal suit against the other patient. During court proceedings, the woman requested the male patient's medical records. Though he refused, she took the issue to court and won. The court ruled that the doctor-patient privilege had been waived by the accused and ordered the hospital to release his medical records.

Background: Following surgery, a bedridden female patient was recuperating in her hospital room. She claimed that a male patient entered her room and sexually assaulted her. She brought suit against the hospital and physicians, saying the man was under psychiatric observation during his stay and would not have been able to commit the assault but for their negligence. She also claimed the hospital negligently failed to repair a defective emergency call button that she tried to use to summon help.

She also brought a criminal suit against the man for sexual assault. In his counterclaim, he said that if he was found to be liable, the hospital should be liable in the same respect and to the same extent as he was by virtue of their negligent care and treatment of him.

Prior to either matter coming to fruition, she died as a consequence of medical problems unrelated to the assault. Her father continued the actions against the health providers and male patient.

The male patient ultimately was convicted of sexual assault and appealed. However, the appeal was unperfected; moreover, there was no factual support for his contention that his conviction was unwarranted and should be reversed.

During appeal, the plaintiff's attorney sought the male patient's consent for the release of his medical records. He refused. Having failed to obtain the records voluntarily, the plaintiff brought a motion to compel the hospital to release the records without the consent of the patient. In the jurisdiction, there are three key statutory elements necessary to establish the existence of a doctor-patient relationship: 1) there must have been a doctor-patient relationship; 2) the information must have been obtained during the course of treatment; and 3) the information must have been necessary for treatment. In addition, for the privilege to be honored, it must not have been waived.

The court conceded that the first three required elements had been satisfied but found that statutory privilege had been waived. By advancing his cross-claim, the male patient had unquestionably put into issue the psychiatric care and treatment that he received from the hospital and his physicians, and therefore, his mental condition. The court ordered the hospital and physicians to

release his medical records, finding that even if acquitted of the crime, the medical records were important to the discovery process in the civil suit against the health providers.

What this means to you: Risk managers often are confronted with discovery issues and this case posed an interesting fact pattern. The hospital held on to the records until told by the court to do otherwise, "and rightfully so. Medical records are considered confidential and in most jurisdictions psychiatric records are deemed superconfidential. Therefore regardless of the circumstances, any time a third party requests such records, the request should be reviewed in light of the prevailing law and jurisdictional interpretation," notes **Jane M. Koubek**, RHIA, manager of clinical documentation at St. Joseph's Hospital in Tampa, FL.

To release medical records to someone other than the patient poses potential risk to the facility. If confidential records, much less superconfidential records, are released without proper waiver or consent, the facility may be held liable and that liability may be compounded by any finding of medical negligence within those records.

"Accordingly, coordination between the medical records department and risk management is critical. As seen with this case, both areas needed to be engaged in the situation both as to the request for the records and potential suit against hospital that the records might have presented. Although, the court in this case said to release the files, if faced with a similar fact pattern, it would probably be advisable to hold the records until ordered by a court to relinquish them," concludes Koubek.

Reference

• U.S. District Court of Appeal (Southern District New York), Case No. 01, Civ. 8386 (June 6, 2002). ■

Failure to diagnose, treat jaundice: $10.66M verdict

News: Several days after its birth and discharge from the hospital, a couple's child developed jaundice. The condition was reported, and the child seen by several nurses at a hospital, but all failed to inform the family's physician or direct the parents to the emergency department (ED). Eventually, their physician learned of the gravity of condition and sent them to the ED. Shortly after their arrival, the newborn suffered severe brain injury. After adjusting for the contributory negligence of the parents, the jury award stood at $10.66 million.

Background: Nathaniel was a healthy baby born to a 38-year-old mother and a 37-year-old father. The child was discharged home with his mother the day after delivery. Over the next several days, the mother began to think that Nathaniel had developed a breast-feeding problem. She called the hospital's lactation service for advice. The lactation nurse who took the phone call recorded that the baby was "really jaundiced, lethargic, and fading fast." The nurse told the mother to report the symptoms to her doctor arranged for an in-person lactation consultation.

When the mother arrived the next day at the hospital for the consultation, a second nurse said that this was the most jaundiced baby she had ever seen. She did not direct the parents to the hospital's ED, she failed to contact the physician, and did not tell the parents the child was in jeopardy. The second nurse has assumed, incorrectly, that the mother was going to follow up with the pediatrician later that day. She drew blood for a routine bilirubin blood for review by the pediatrician the next day.

The lab did page the pediatrician with test results later that day because the reading of 29.2 was extremely high. Since he had not heard from anyone regarding Nathaniel's condition, he suspected a laboratory error. The pediatrician arranged for a home health nurse to go to the baby's home for another blood draw and start phototherapy to the treat jaundice. The second blood result was about 32. The pediatrician was so alarmed that he told the parents to take the child immediately to the children's hospital.

At the hospital, while preparing for a blood transfusion, Nathaniel suffered severe brain injury. The child sustained kernicterus with athetoid cerebral palsy and severe motor impairment. At the time of the trial, he was 4 years old and believed to be cognitively normal.

The plaintiffs alleged that the hospital nurses were negligent in failing to call the baby's doctor, failing to direct the parents and baby to the emergency department sooner, failing to tell the parents that their child was in grave danger, and failing to properly respond to what the health

practitioners knew was clearly a medical emergency. In addition, the plaintiffs alleged the hospital was corporately negligent in failing to develop and implement policies and procedures for handling newborn jaundice in the course of their lactation services. Finally, the plaintiffs alleged that under these extraordinary circumstances, the hospital failed to obtain informed consent for the lactation services. The plaintiffs' experts testified that the delay in communication among the providers impeded the appropriate treatment and caused the brain damage.

The defendant denied liability, asserting that its nurses met the standard of care because they had advised the parents to call or see their pediatrician. The hospital denied any obligation on the part of its employees to call the pediatrician directly or send the baby to the ED. The defendant further asserted that the pediatrician, not an ED physician, was the proper person to handle this problem and that it would have made no difference if the pediatrician or ED physician had been called because nothing would have been done until the blood test result came back. The hospital also claimed that the parents were contributorily negligent for not following their advice to call or see the pediatrician. In addition to the kernicterus (jaundice) with athetoid cerebral palsy, Nathaniel also has a kidney disorder, congenital nephritic syndrome, which the defendant initially argued was a contributing factor to the kernicterus, but this theory was abandoned during trial.

After four days of deliberation, the jury found the hospital negligent and had failed to get informed consent for the outpatient services. The jury awarded $10 million to the child and $665,000 to the parents. The jury found the hospital 80% at fault and parents 20% at fault.

What this means to you: With a verdict of this magnitude there are usually multiple issues at hand, including a horrific outcome and a sympathetic plaintiff.

"Patient education for the prenatal and postpartum periods is the generally the responsibility of nurses," says **Joan Bristow**, vice president of risk management at The Doctors Company in Napa, CA. "With the shorter length of stay for delivery, the need for more patient education is great. While the breakout of the award and assignment of 20% of the fault to the parents indicates that some of the responsibility for the education does lie with the parent, anyone who has had a newborn around knows — and certainly health care providers to these new parents — should know that new, first-time parents need some additional assistance."

Mediums other than personal face-to-face contact are increasingly used to triage and transmit medical advice. These alternative delivery mechanisms should have the same risk management protections afforded to them as the traditional face to face encounters.

"Triage phone calls should be governed by written protocols approved by the obstetricians. And those calls should be answered by an RN who is following those protocols, with documentation of the questions posed and responses received by the RN," Bristow says. "Obstacles to good and or adequate follow-up take the form of the nurse responder not having protocols for emergencies such as a really jaundiced baby, who was lethargic and fading fast. It is also recommended that these logs be reviewed at regular intervals to allow for improvements to be made to the system, as well as check

on the quality of RN responses. Annual review and approval by the obstetricians should be written into this process."

As with most medical encounters, documentation is key.

"It is likely the separate medical encounters were documented but not documented in a central location," Bristow says. "If the triage call observations were entered into different medical records, this effectively eliminated an opportunity for timely intervention by a physician. It would be difficult for me to envision that the hospital's lactation service makes entries into the in-patient medical record when a phone call is received. So, who would have even known about the call? Often these separate nurse obstetrical services assume a distinct division of accountability, and response to potentially emergent situations should be built into the protocols.

"At this point in the patient's care continuum, it is not clear who was captain of the ship. There must have been an attending physician somewhere in this care who would have had the full and complete responsibility for follow-up, regardless of the source of information. Good follow-up care might take the shape of after-delivery conferences with all disciplines meeting to discuss the overall care of the patient. This provides an opportunity for the health care team to improve on their services without spending more money, but merely spending a few minutes for every patient. Benefits are greater when the multidisciplinary team is together. I have witnessed firsthand the value of the after-delivery conference and its effectiveness. The attendees were those who had any part of the patient's care, not only past care but future care as well. For example, the conference to which I was invited included the obstetrician, nurse midwife, RN, NP, aide, social services, and home care nurse. They were very well prepared to follow up on any unusual event that occurred during the delivery plus were quick to identify opportunities for additional intervention needs."

Once a critical situation is identified, the label should stick.

"With regard to the lab results, crisis results are well known in every lab, and every health care provider should be aware of those tests that affect their particular area of service. Lab personnel have a responsibility to recognize critical levels and alert the attending physician or the physician who ordered the test. The alert should be made by phone to ensure that a living, breathing body hears the message. Backup for lab personnel's identification of critical results rests with the nursing personnel who receive the results. That nurse has the same responsibility as the lab — direct communication with the attending physician. Written policy and procedures will help to solidify this process," Bristow says.

"Finally, once the gravity of the situation was realized, it seems that the parents were simply advised to go the hospital, not necessarily the emergency department. Under the circumstances, the parents should have been directed to the ED and a phone call made to alert the facility and the attending physician. Any health care provider who recognizes an extremis situation has the added burden of follow through. The average layperson isn't knowledgeable of the intricacies of hospitals and EDs in particular. A phone call to the ED physician gives the ED time to prepare. More crucial time may have been lost if the parents went to admissions in lieu of the ED," concludes Bristow.

Reference

• *James A. Degal, guardian of the estate of Nathaniel Johns, a minor, and Douglas Johns, individually v. Franciscan Health System West,* King County (WA) Superior Court, Case No. 99-2-04211-5 KNT. ■

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2002 SALARY SURVEY RESULTS

Healthcare Risk Management™

While income is stable, the future offers many paths for RMs

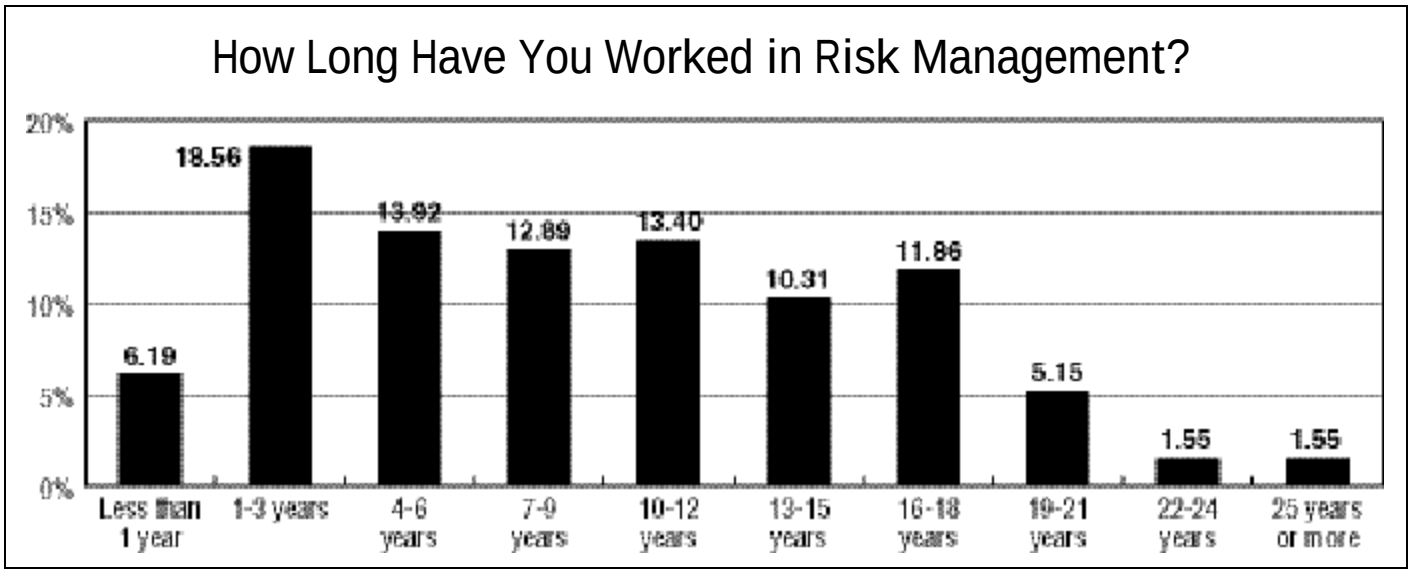
Liability crisis puts more emphasis on financial aspects, insurance

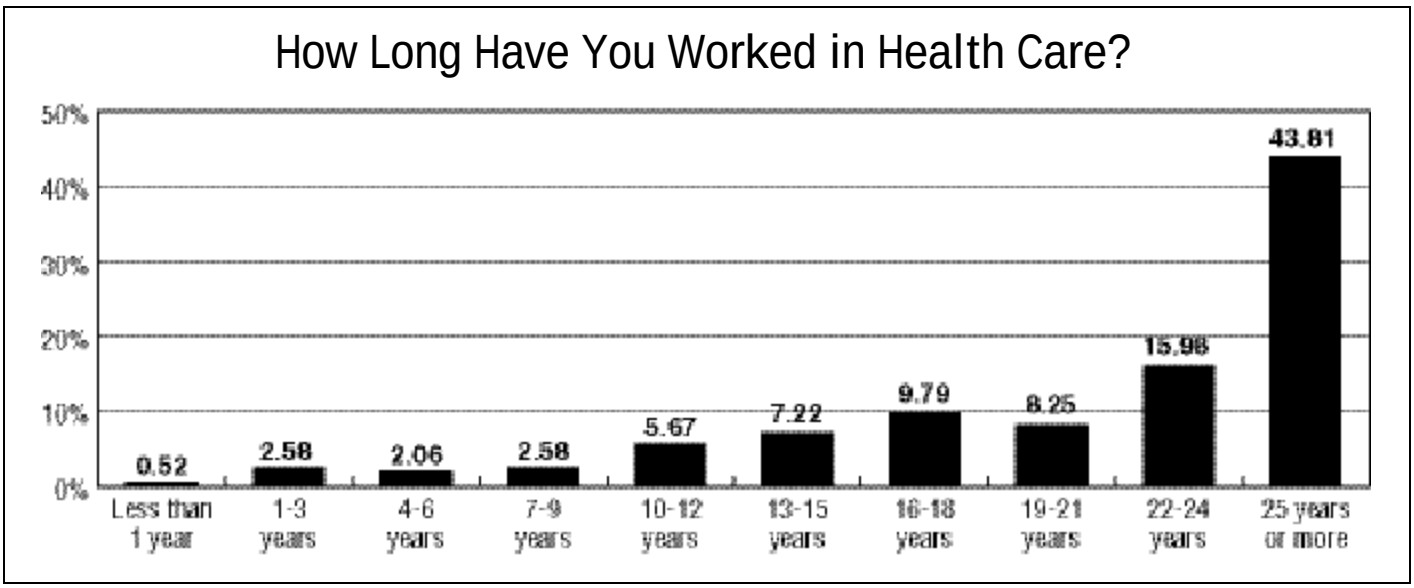
Incomes held steady for health care risk managers this year, according to results of the 2002 *Healthcare Risk Management* salary survey. Some observers say that holding on to a good income in the future may require taking steps now to ensure you're a key player in your organization and not relegated to a support position.

The median income for health care risk managers in this year's survey is $65,000, the same as the previous two years. Before that, the *HRM* salary survey had shown an upward trend in income. In 2000, the median income was $62,500, the same as for 1999. Prior to 1999, the median income for directors of risk management was in the upper $50,000 range.

Consistent with the flat income levels, the survey shows that the median salary increase over the past year was only 1% to 3%. This year, 40% reported increases in that range, almost identical to last year's 39%. Another 34% reported increases of 4% to 6%, up slightly from last year. Eleven percent reported higher increases, including one lucky reader whose income increased 21% in the past year. Ten percent report no change in their income, and 2% reported a decrease.

Long hours continue to be standard for risk





managers. Thirty-five percent reported working 46-50 hours per week, and 13% reported working 51-55 hours per week. Four percent say they worked more than 65 hours per week.

Don't let yourself be marginalized

The salary survey figures support a trend that has worried some risk management leaders for a while now. **Grena Porto**, RN, ARM, DFASHRM, senior director of clinical operations at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management, says she thinks many risk managers are being marginalized within the organizations that employ them. Any risk manager who still is trying to do the same job he or she did five years ago is falling behind, she says.

"Some risk managers have been marginalized because they have not gotten on the patient safety wagon and also because their skills are not where they need to be if they don't have performance improvement skills," she says. "Hospitals are now doing a lot of research work with focus groups and data management, and risk managers are not a big part of that. They're almost never in the lead with those things. I worry about that."

If risk managers are resisting the new emphasis on patient safety because it doesn't seem like traditional risk management, Porto says, that is a big mistake. In many ways, patient safety is a more genuine part of risk management than the issues that often take up so much of your workday.

"The focus on loss control and claims litigation has distracted people in many ways from the real work of preventing patient injury," she says. "Patient safety is the new focus, and I worry that if that's what the skills of today and tomorrow are, risk managers will be reduced to low-level positions because they don't have those skills. You can end up as just the person who manages claims."

Porto advises sharpening your performance improvement skills, and she says you should pay particular attention to redesigning clinical procedures and systems to compensate for work force issues. With every health care provider facing shortages of nurses, pharmacists, and other staff, risk managers can play an important role by combining clinical knowledge with a patient safety emphasis to help the organization cope with fewer staff.

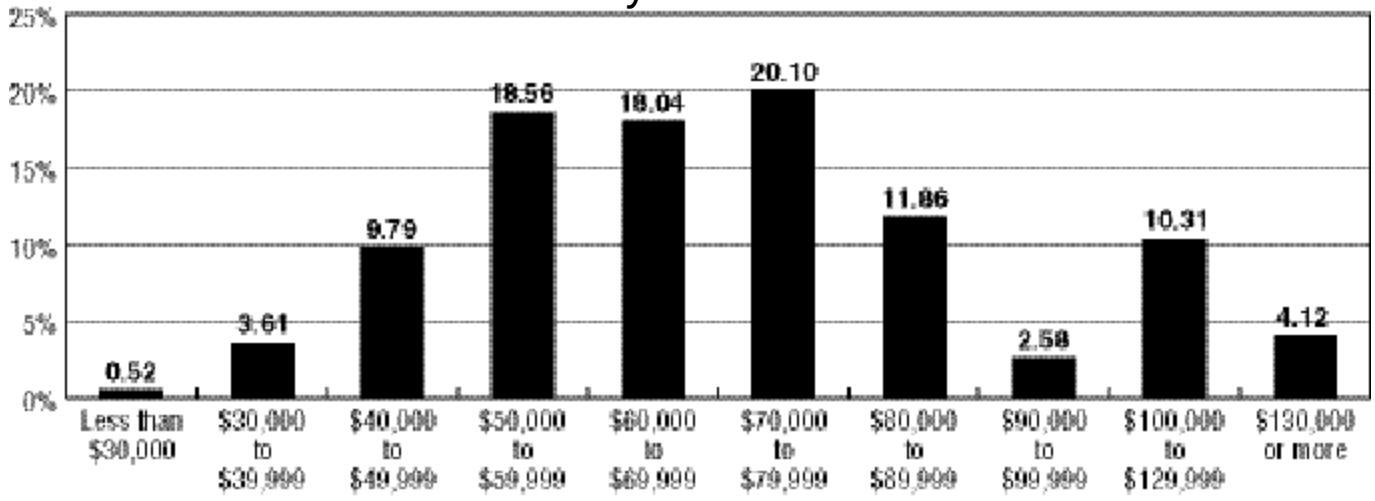
Overall a good time to be a risk manager

Despite all the challenges and the changing career path, this is "an outstanding time to be a risk manager," says **John Metcalfe**, vice president or risk management services with Memorial Health Services in Long Beach, CA. The hard insurance market, the patient safety emphasis, and changing accreditation requirements all make the risk manager an important resource for health care providers, he says.

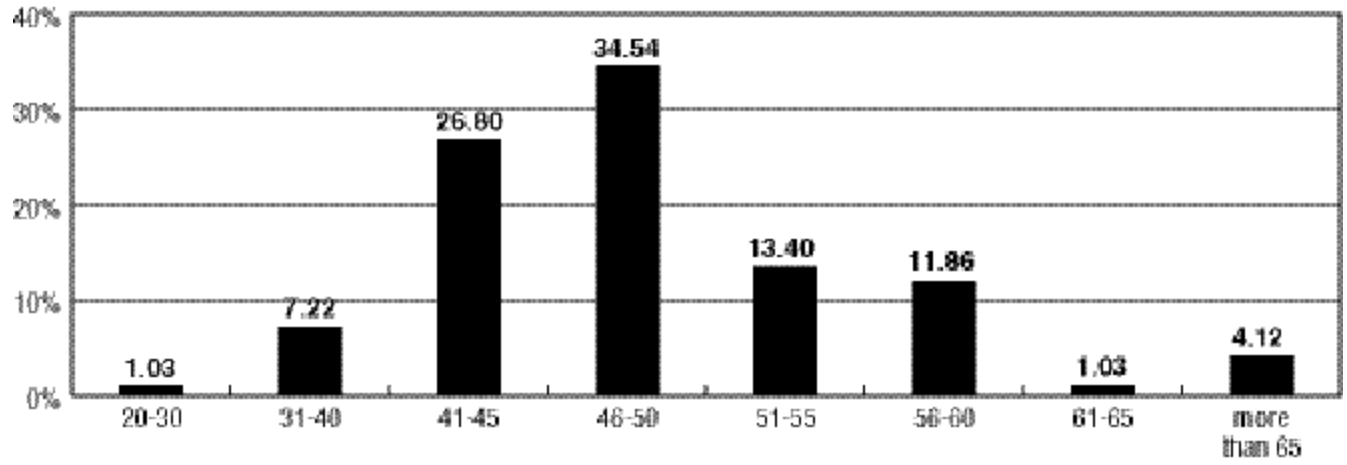
"All risk managers have to be tuned in to changes in the marketplace and various patient safety issues. Risk managers have to carefully monitor the sentinel event reports that the Joint Commission distributes, other clinical issues that influence patient care outcomes, and what's going on in the legal community," he says. "You also have to be tuned into union activity, anything that contributes to employee dissatisfaction and unrest."

(Continued on page 4)

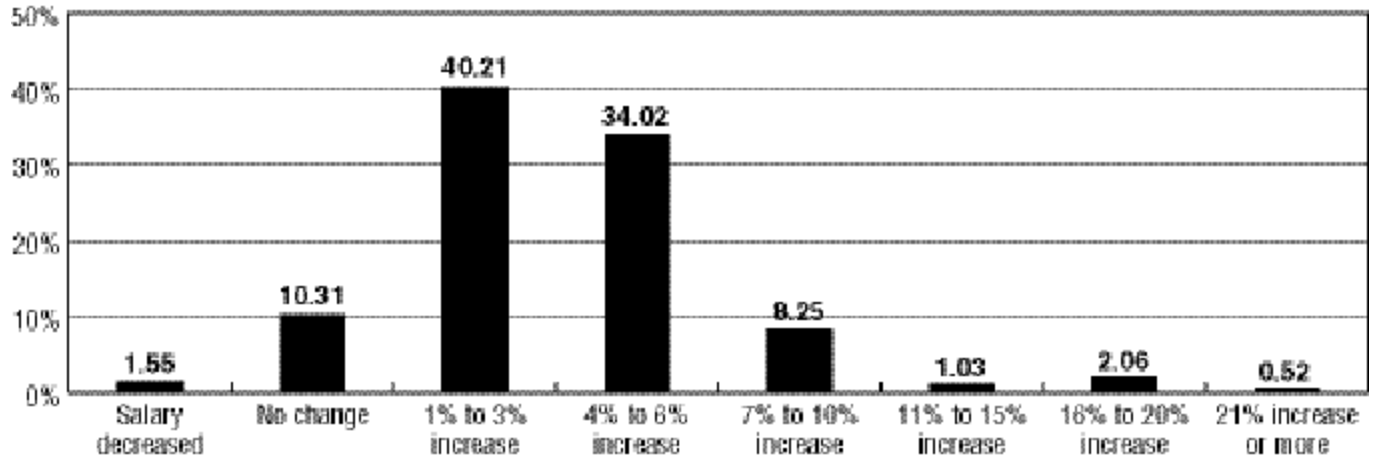
What is Your Annual Gross Income from Your Primary Health Care Position?



On Average, How Many Hours a Week Do You Work?



In the Last Year, How Has Your Salary Changed?



Staying on top of all those topics requires ongoing education, so Metcalfe says risk managers should routinely pursue seminars, conferences, professional publications, and other resources that help them stay abreast of rapidly changing issues. Metcalfe and his staff participate in a number of satellite audio conferences every year and attend both national and local meetings of their professional societies.

"There's always lots of networking, making sure we take everything into consideration before making a decision," he says. "That's one thing that highlights my career. I've always been eager to bounce things off of people — lawyers, physicians, some people in government that I'm close to. I'm always measuring my biases and prejudices against theirs."

Metcalfe says he is pleased with what he sees in income levels for health care risk managers, though the outlook is better for upper-level risk managers. That's all the more reason to improve your skills and seek a higher position in the organization, he says.

Risk financing is an increasingly important area for risk managers to explore, says **Nancy Hacking**, CPHRM, FASHRM, director of risk and safety management at Concord (NH) Hospital and Capital Region Health Care. For most risk managers, however, risk financing is not familiar territory. That means you can't just walk into a meeting and join the discussion tomorrow.

"You may have to convince senior management about the value of having the risk manager participate in insurance discussions," she says. "The risk manager needs to ensure that the risk management program is discussed and financial accomplishments are highlighted on a regular basis. Then when insurance renewal time rolls around, the risk manager is in the position of having the most intimate knowledge of the program, the program's strengths and weaknesses, and areas where improvement is being sought."

With that knowledge, and with upper management aware that you are the best source for that information, the risk manager can participate in the discussions with the underwriter. Once you're involved in that process, you should be the called on to address concerns of the underwriters such as past claims issues. You also can promote programs that have been put in place to address areas of concern.

Remember that involvement in these financial meetings may take time, and you can encourage that change by developing a relationship with the CEO or CFO. Volunteer to serve on board committees and other programs that will let you work more closely with financial matters, she suggests.

Porto agrees that risk managers should become more involved with risk financing, but she cautions that you should not see that as your one and only new goal. Risk financing can help get you involved with key functions of your employer, but don't forsake your primary role in patient safety, she says.

"We've done ourselves a disservice by saying that you know you're really big and important when you're doing risk financing, but it's not such a big thing if you're working with patient safety because that doesn't take so much skill anyway," she says. "That's a terrible attitude that we hear too much these days as people start to realize that risk financing is something they should get involved in. You can get involved in it, but don't forget everything else you do."

The 2002 *HRM* Salary Survey was sent to about 1,200 readers in the June 2002 issue. A total of 194 were returned, for a response rate of 16%. The results were tabulated and analyzed by American Health Consultants, publisher of *HRM*. ■