AMERICAN HEALTH CONSULTANTS®

Healthcare Risk Management

Inside: 1999 salary report

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Final word from government on EMTALA means trouble

Feds: Anti-dumping regs trump managed care rules

The final version of the special advisory bulletin on the anti-dumping rule may not offer anything new in terms of compliance advice, but it does make one thing crystal clear: The federal government does not care if managed care rules or any other financial concerns conflict with the anti-patient dumping rule.

No matter how much you find the two concerns conflicting in the emergency department, the Department of Health and Human Services' Office of the Inspector General (OIG) and the Health Care Financing Administration (HCFA) say you must comply thoroughly with the federal rule. Period. End of story. No more debate.

"This guidance makes clear that despite the terms of any managed care agreements among plans, hospitals, doctors, and enrollees, federal law requires that a medical screening and stabilizing treatment be provided in an emergency," Inspector General June Gibbs Brown said when releasing the bulletin.

Under the 1986 patient anti-dumping law, also known as the Emergency Medical Treatment and Labor Act (EMTALA), all Medicare-participating hospitals with emergency rooms must provide all patients requesting emergency care with an appropriate medical screening to determine if the person has an emergency medical condition. If the person has an emergency medical condition, the hospital must provide stabilizing care within its capabilities. A transfer of an unstable patient to another facility is allowed only when an informed patient requests the transfer or a physician certifies that the medical

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benefits of the transfer outweigh the risks. Hospitals may not delay providing medical screening or stabilizing care to inquire about a patient's insurance or other payment arrangements.

The OIG and HCFA issued the special advisory bulletin after receiving inquiries from the medical community for clarification of the law and complaints that some managed care patients have been improperly denied emergency care. The bulletin was first published in draft form in the Dec. 7, 1998, *Federal Register* and had a public comment period. More than 150 comments were received. The final special advisory bulletin was published in the Nov. 10, 1999, *Federal Register*.

"We want to provide clear guidance to hospitals and physicians about their obligations to provide emergency care to managed care enrollees," Brown said. "While hospitals may feel caught between the obligations imposed under the law and the expectations of managed care plans, hospitals clearly must follow the law."

Dilemmas still will occur: No easy answers

The bulletin could be a source of frustration for health care risk managers, says **Grena Porto**, RN, ARM, DFASHRM, director of clinical risk management and loss prevention services at VHA Inc. in Berwyn, PA, and past president of the American Society for Healthcare Risk Management. Many risk managers were hoping the feds would come forth with some practical solutions to the dilemmas inherent in EMTALA, but Porto says there are not many in the final bulletin.

"This is more of what we already knew. The bottom line is that the rules are pretty clear," she says. "But they're difficult to live with, and that's why everyone keeps talking about it and debating it and trying to find another way to do it. But there truly isn't another way."

HCFA acknowledges in the bulletin that hospitals face a number of dilemmas in trying to comply with EMTALA, says **Lynn Tenerowicz**, RN, JD, risk manager at Baystate Medical Center in Springfield, MA. But the clarifications offered by HCFA only emphasize that the EMTALA requirements supersede any financial concerns, and that's not really news to anyone. **(See p. 4 for some of the potential dilemmas.)**

"Most of this information was provided in the draft bulletin last year, and I don't see much here to really provide any assistance in complying," she says. "It's good that they've responded to people's concerns and comments, but in the end

we're just told to follow the rules and work out the details on our own."

The bulletin stresses that hospitals cannot allow patients to walk out of the emergency department before receiving treatment, but some risk managers may wonder just what they are supposed to do with those patients. After all, the patients are not prisoners; they can get up and leave whenever they want. The problem is that HCFA may see that as a violation of EMTALA if the patient left because the wait was too long.

That warning is worrisome for **Mark Cohen,** ARM, RPLU, a risk management consultant with Sutter Health in Sacramento, CA. While he says he understands HCFA's concern that patients not be allowed to leave when they need care, Cohen says the realities of a hospital emergency department can thwart the staff's best efforts.

"They don't always tell us they're going to voluntarily withdraw," he says. "HCFA wants you to keep track of patients and not just let people slip through the cracks as they wait in line. That's fine, but in a lot of cases the staff has no control over whether they leave or not. When you're using normal triage procedures, some people are going to have to wait, and some of them will leave."

HCFA provides guidelines for situations in which staff know the patient is about to leave. The provider should assure the patient that he or she will be treated and explain the risks of leaving. If possible, the provider should get the patient to sign a form acknowledging that treatment was offered and he or she is leaving anyway.

"If you can't get that, HCFA wants you to make a note that you made the effort and recognize that the patient's no longer there," Cohen says. "That's good that they acknowledge that reality. The real problem they're trying to avoid is patients just leaving and nobody even knows."

Tenerowicz also expresses frustration about that part of the bulletin. Long waits are a problem despite efforts to reduce them, she says. Now HCFA is putting more pressure on providers by saying long waits can be EMTALA violations. "There are factors beyond the control of any emergency department, and some waits are to be expected," she says. "And how can we be accountable for patients who walk out? HCFA wasn't very realistic in acknowledging that patients will continue to walk out despite our best efforts."

'Prudent layperson' is still elusive

One issue that remains problematic is the "prudent layperson" standard, Cohen says. "The hospital emergency department has to see all comers, but a managed care plan can deny reimbursement for care if they don't think the patient met the prudent layperson standard by seeking care somewhere else," he says. "It's patently unfair to us because we have to take them all if we want to comply with EMTALA. The bulletin acknowledges this, but that's all."

Another difficult situation involves "dual staffing" arrangements. Some managed care organizations (MCOs) and hospitals enter into an arrangement in which the hospital permits the MCO to station its own physicians in the hospital's emergency department, separate from the hospital's emergency physician staff, to screen and treat MCO patients. That can mean there are two separate groups of physicians providing emergency care, sometimes with different approaches. Questions have been raised about how dual staffing affects compliance with the anti-dumping statute because the MCO patient is separated from the normal track in the emergency department.

Back in December 1998, the draft version of the bulletin called dual staffing questionable. The practice creates "difficult questions and we have not yet determined how to treat issues related to dual staffing under the patient anti-dumping act," HCFA said at that time. With the release of the final version, it seems HCFA still is uncomfortable with dual staffing.

"They don't say it's not allowed, but they say it could lead to some problems," Cohen says. "They're still nervous about it, and that means risk managers should be, too."

COMING IN FUTURE MONTHS

- Joint Commission offers ways to avoid drug errors
- Whistle-blower lawsuits, qui tam provision challenged in court
- Nursing facility compliance guidelines issued
- Choosing an attorney: Here's what to avoid
- New certification for risk managers

Sources

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One of Tenerowicz's concerns involves the retrospective nature of any investigation regarding EMTALA. In hindsight, it may be much more clear that the patient required stabilization before providing financial information, she says. "It's still frustrating to have this type of retrospective review that will say the health care provider delayed medical screening. In retrospect, once everyone knows what the problem is, it's easier to argue that the patient needed stabilization, but that may not be apparent at the time."

She also expects difficulty with the bulletin's emphasis on delaying any discussion of financial responsibility until after screening and stabilization. The bulletin stresses that, even when the patient asks about costs and possible personal financial responsibility, the provider should avoid such discussions until after screening. That may be well-intended, she says, but it is not realistic.

"We have seen cases where we told patients they could talk to a financial counselor after treatment, and they leave before treatment," she says. "People can be very concerned about being left with a bill, and if we just refuse to tell them anything right away, they will just avoid treatment because they're scared of the cost."

That is unfortunate, Tenerowicz says, because the hospital often would be able to work out arrangements to defray the cost. The time spent waiting in the emergency department could be used to fill out the necessary paperwork, but the EMTALA bulletin says that is not allowed.

Violators of the anti-dumping law face significant penalties. Large hospitals and doctors who negligently violate any requirements of the law are subject to a civil money penalty of up to $50,000 for each offense. The penalty for hospitals with fewer than 100 beds is $25,000 per violation. Hospitals also can face termination from the Medicare program, and physicians found responsible for repeated or gross and flagrant violations can be excluded from participation in all federal health care programs. In recent years, the OIG and HCFA have stepped up enforcement of the patient anti-dumping law, devoting increased resources to the investigation and resolution of alleged violations. In fiscal year 1999, the OIG executed 60 settlements and received one default judgment for total recoveries of more than $1.7 million.

"HCFA is turning up the heat on this. They are empowered with more financial resources to seek compliance, they're certainly better staffed to do so, and they've told us they're going to do it," Cohen says. "If you've not been surveyed in response to an anti-dumping claim, you should shake yourself awake and conduct an audit now. The implications to your hospital are devastating." ■

Patient departures pose EMTALA dilemmas

The Department of Health and Human Services (HHS) acknowledges that hospitals face several dilemmas in trying to comply with the Emergency Medical Treatment and Labor Act (EMTALA). In its recent bulletin, HHS discusses the following issues:

• **Prior authorization before screening or commencing stabilizing treatment.**

It is not appropriate for a hospital to seek, or direct a patient to seek, authorization to provide screening or stabilizing services from the individual's health plan or insurance company until after the hospital has provided (1) an appropriate medical screening examination to determine the presence or absence of an emergency medical condition, and (2) any further treatment necessary to commence stabilization of an emergency medical condition. The hospital may seek authorization for payment for all services after providing a medical screening examination and once necessary stabilizing treatment is under way.

• **Use of advance beneficiary notices (ABNs) and other financial responsibility forms**.

A hospital would violate the patient anti-dumping statute if it delayed a medical screening examination or necessary stabilizing treatment to prepare an ABN and obtain a beneficiary signature. It normally is permissible to ask for general registration information prior to performing an appropriate medical screening. In accordance with

Health Care Financing Administration guidelines, a hospital may continue to follow reasonable registration processes, including asking whether an individual is insured and, if so, what that insurance is, as long as the inquiry does not delay screening or treatment.

• **Medical screening examinations by qualified medical personnel and transfer authorization by physicians.**

A hospital should ensure that either a physician or other qualified medical personnel provides an appropriate medical screening examination to all individuals seeking emergency care. If the individual has an emergency medical condition and the individual requires a transfer, only a physician, or if a physician is not physically present in the emergency department at the time, a qualified medical person in consultation with a physician, may authorize a transfer.

• **Patient inquiries about financial liability for emergency services**.

If a patient inquires about payment obligations for emergency services, the discussion should be deferred until after treatment whenever possible. Such an inquiry should be answered by a staff member who has been well-trained to provide information regarding potential financial liability. This staff member should clearly inform the patient that, regardless of the patient's ability to pay, the hospital will provide a medical screening and stabilizing treatment, if necessary.

• **Voluntary withdrawal**.

If a hospital is aware that an individual intends to leave prior to the screening examination, it should take the following steps: 1) Offer the individual further medical examination and treatment within the facilities available at the hospital as may be required to identify and stabilize an emergency medical condition. 2) Inform the individual of the benefits of such examination and treatment and of the risks of withdrawal prior to receiving such examination and treatment. 3) Take all reasonable steps to secure the individual's written informed consent to refuse such examination and treatment. ■

Source

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Reader Question

Early hospice referrals can suggest fraud

Admitting physicians, hospitals may be at risk

Question: We have had several patients referred to hospices who did not die as soon as expected, and now the referring physicians have raised the question of what that means in terms of Medicare requirements. Is it possible that the physician could be charged with improper referral if the patient hangs on longer than anyone expected?

Answer: Yes, it is possible for the physician to get caught up in charges of fraud in such a situation, says **Timothy Jost**, JD, professor of law and health services management at Ohio State University in Columbus. He has studied the issue of fraud in hospice care, and he tells *Healthcare Risk Management* that physicians can find themselves in a seemingly no-win situation.

The federal government's continuing crackdown on health care fraud has placed an emphasis on hospice care, Jost says. In the Office of the Inspector General's "Compliance Program Guidance for Hospices," regulators make it clear that there are many ways hospice programs can result in fraud charges, but the guidance document specifies one risk area as "admitting patients to hospice care who are not terminally ill."

(The compliance guide can be found on the Internet at http:/ / www.hhs.gov / progorg / oig / modcomp / hospic99.htm.)

A six-month window

For a hospice patient to receive reimbursement for hospice services under Medicare, the patient must be "terminally ill." That generally means the patient is expected to die within six months. For some patients, particularly those dying from something other than cancer, even the most experienced physician can find it difficult to pinpoint the time remaining.

The OIG acknowledges the problem, but the compliance guide says "it is important to make a distinction between admitting a patient to a

hospice program and certifying a patient for the Medicare Hospice Benefit. Based on an individual hospice's admission criteria, some patients may be admitted to hospice care prior to an estimated six months before death, as long as the hospice is paid fair market value for its services.

Regardless, patients can be certified for the Medicare Hospice Benefit *only* when it is reasonable to conclude that a patient's life expectancy is six months or less if the illness runs its normal course. In other cases, alternative modes of reimbursement, often provided through community support, should be sought outside the Medicare Hospice Benefit."

While he knows of no actual fraud charges resulting from a patient's unexpected survival in a hospice, Jost says he sees the risk as more than theoretical. If the OIG had not already made it clear that it has its sights on hospice care, the risk might not be worth worrying about, he says.

Document reason for referral

With the government's emphasis on all types of fraud, and hospice as a specific area, Jost suggests that physicians and hospitals should take extra care in documenting hospice referrals. "The compliance program focuses on hospices to make sure patients are terminally ill, but a doctor who knowingly referred a patient to a hospice who is not terminally ill could be guilty of providing a false statement to Medicare," he says.

"The hospice can be in trouble for accepting the patient, but the doctor can be questioned as to why [he or she] referred the patient if [the patient] was not within six months of death," he notes.

Physicians should do their best to provide an accurate prognosis for the patient, of course, but they have been doing that all along. The best defense for physicians and hospitals is to document, as thoroughly as possible, the reasoning for the hospice referral, Jost says.

"The main thing you can do is document very carefully that this referral is in compliance with those OIG guidelines," he explains. "Fully explain the reasoning for why this patient is a good hospice referral. If the patient lives longer than expected, you want to be able to show that your assessment was based on those criteria, that you did your best to comply." ■

Poor handwriting on scrip brings negligence ruling

The poor handwriting of physicians is such an ingrained part of American culture that most people do not even consider whether doctors should take any substantial steps to improve the legibility of what they write. A recent case in Texas, however, suggests that physicians' poor handwriting is a serious matter that can lead to a patient's death, or at the very least, a financial liability for the doctor and possibly the hospital.

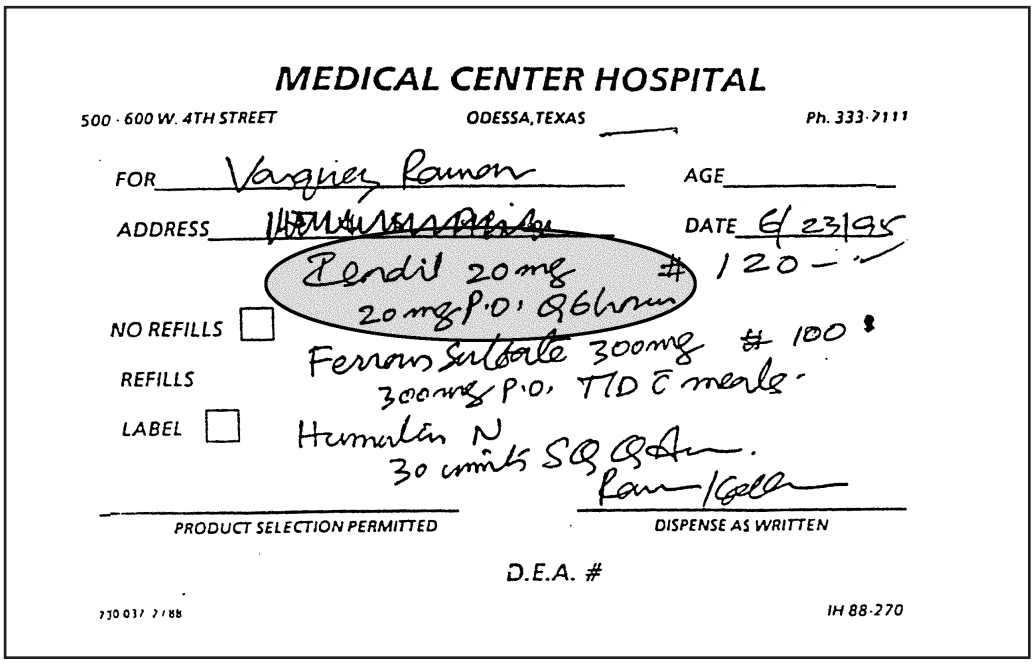
In what is believed to be the first such verdict, a Texas jury attributed the death of a 42-year-old man to an illegible prescription and ordered the doctor and pharmacist to pay $450,000.[1] The physician's attorney tells *Healthcare Risk Management* that the case is much more than just a fluke; he says the case should be a clear warning to risk managers that juries will not tolerate sloppy handwriting that puts a patient's life in danger.

The Texas case should not have hinged on the prescription itself, according to **Max Wright**, JD, the malpractice defense attorney in Midland, TX, who represented the doctor. Though the plaintiff argued otherwise, Wright insists the misfilled prescription did not lead to the man's death. Other problems caused the man's death, he says, but the jury latched on to the poorly written prescription and clearly indicated contempt for such sloppy work. "I think that this jury looked at this prescription, decided they couldn't read it, and decided the case on that basis. I interviewed them, and they said everybody testified that this prescription led to a great big overdose and so that must have had something to do with his death. I think they were wrong about that, but

Executive Summary

Subject:
A doctor has been found negligent in a patient's death because of poor handwriting on a prescription that was filled incorrectly.

Essential points:
- ❑ A jury awarded $450,000 to the man's family.
- ❑ The defense attorney says the verdict should be a warning to other health care providers.
- ❑ Juries may be sensitive about the handwriting issue to the point that they ignore other causes of death or injury.



MEDICAL CENTER HOSPITAL

500 · 600 W. 4TH STREET ODESSA, TEXAS Ph. 333-7111

FOR Vasquez Ramon AGE

ADDRESS DATE 6/23/95

Plendil 20mg # 120
20mg P.O. Q6hrs

NO REFILLS ☐

REFILLS Ferrous Sulfate 300mg # 100
300mg P.O. TID C meals.

LABEL ☐ Humulin N
30 units SQ QAM.

PRODUCT SELECTION PERMITTED DISPENSE AS WRITTEN

D.E.A. #

IH 88-270

Can you read this?

Here is a copy of the actual prescription written by the defendant physician, who was found culpable in the patient's death, along with the pharmacist.

Note the top line of the prescription (circle added). The doctor contends it says, "Isordil," the intended drug, but the pharmacist filled it as "Plendil."

they indicated that the prescription was something they just could not excuse."

The incident began when Ramachandra Kolluru, MD, a cardiologist, wrote a prescription for Ramon Vasquez. The prescription was supposed to be for 20 mg of Isordil every six hours to treat Vasquez's angina. Because the prescription was written poorly, the pharmacist provided Vasquez with Plendil, normally used to treat high blood pressure, at the 20 mg every six hours dosage. The maximum *daily* dosage of Plendil is only 10 mg. **(See copy of the prescription, above.)**

One day after taking a 16% overdose of Plendil, a drug he was not supposed to be taking at all, Vasquez had a heart attack. He died several days later. When the Vasquez family sued the physician and the pharmacy, the jury ordered them to share equally in the $450,000 verdict. After the case, the jurors indicated to the attorneys that they would have been willing to award a higher amount if the plaintiff's attorney had requested a certain figure.

Overall care not an issue

At trial, the case centered almost exclusively on the handwriting on the prescription even though Wright says the prescription error did not directly cause the man's death. The overall care provided by Kolluru was not challenged, and Vasquez's widow even indicated in court that she intends to continue seeing the cardiologist for her own care and would recommend others to him. The only problem, according to the widow and her attorney, was the prescription that was filled incorrectly.

The plaintiff's attorney, **Kent Buckingham**, JD, focused on the prescription during the trial as the cause of Vasquez's death. Buckingham argued that it was time for society to stop tolerating poor handwriting as just a quirky part of the medical system and hold Kolluru, as well as the pharmacist, responsible for the prescription error.

Though he acknowledged that the prescription was filled incorrectly, Wright says he argued that the man's death was the result of the pharmacist's error or natural causes that had nothing to do with the prescription. He says he was very surprised by the verdict finding the physician responsible. "No matter how much we talked about the real cause of the man's death, they had that prescription in front of them and couldn't forget it," he says. "The medical testimony was complicated sometimes, but the prescription was something they could really grasp and understand. He got the wrong medicine — easy to understand."

Even the prescription itself was the subject of some debate in the courtroom. Wright provided an expert witness, a physician, who looked at the prescription and testified that he could understand it and would have filled it properly if he had been the pharmacist. Wright acknowledged that the witness could read the prescription much better than any layman, simply because he is familiar with the expected medications and dosages, but he says he expected that to be a positive point. He hoped the testimony would show the jury that medical professionals can read prescriptions that look like gibberish to others.

Instead, the testimony backfired.

"The jury said that as soon as my witness said he could read the prescription, they dismissed the rest of his testimony," Wright says. "That's how strongly they felt about it. They figured that if he said he could read it, he must be lying, so there goes his credibility with that jury."

The case might be just one bad episode for a single doctor and pharmacist, but Wright says he fears otherwise. The Texas case received so much publicity that juries may be sensitized to the issue, he says, and the reaction of the Texas jury suggests bad handwriting can be a red herring for plaintiffs' attorneys to throw in front of a jury. "This verdict does have implications. The case proves that bad handwriting is more than a theoretical problem. It certainly should put health care professionals on notice of how the public views this problem."

Wright says that, as a malpractice defense attorney, he has long been concerned about the poor handwriting of physicians. Most physicians will admit they have poor handwriting, even on crucial medical documents like prescriptions, but they are not compelled to do anything about it, he says. "So many hospital records are poorly written, more by physicians than by nurses. It represents a real risk management problem. I've had cases were the medicine was easy to defend, but it was made hard to defend because the poorly written record was so hard to read. It happens more often than people might think."

Wright says he divides poorly written records in to three types: illegible, scrawled, and cryptic. The first can't be read by anyone, even the doctor who wrote it. Scrawled records sometimes can be deciphered, but they are unnecessarily difficult to read. And cryptic records can be clearly written but don't give enough information.

"The cryptic writer doesn't write down much on the record," he says. "Maybe it's enough for him to understand, but it doesn't do much for anyone else. And three years later when you're in court, it's not much help to anyone at all."

Reference

1. *Teresa Vasquez, et al v. Ramachandra Kolluru*, Ector County (TX) District Court, Case No. A-103,042. ■

Source

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IOM calls for major effort to reduce medical errors

Reducing the unacceptably high rate of medical errors will require major changes throughout the health care industry, including mandatory reporting requirements, according to a new report from the Institute of Medicine (IOM) of the National Academy of Sciences in Washington, DC. The report lays out a comprehensive strategy for government, industry, consumers, and health care providers to reduce medical errors, and it calls on Congress to create a national patient safety center to develop new tools and systems needed to address persistent problems.

The report recommends a four-part plan designed to create both financial and regulatory incentives that will lead to a safer health care industry. The major component of the plan is a new federal agency devoted to medical safety.

The IOM said health care is a "decade or more" behind other high-risk industries in addressing consumer safety, and it suggested using the successful federal regulation of the airline industry as a model for a new medical safety agency.

"Using that model, Congress should create a center for patient safety within the U.S. Department of Health and Human Services [HHS]," the committee says. "This center would set national safety goals, track progress in meeting them, and invest in research to learn more about preventing mistakes."

Mandatory reporting proposed

The center is proposed as part of the HHS Agency for Health Care Policy and Research; Congress would need to spend $30 million to $35 million to set it up, the committee says. That estimate is based on the kind of work the center would perform and on investments in issues of similar magnitude, as well as safety research by the public and private sectors. Funding would need to grow to at least $100 million, a little more than 1% of the $8.8 billion spent each year as a result of medical errors that cause serious harm.

The committee defines "error" as the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim, and notes that not all errors result in harm. To learn about medical treatments that lead to serious injury or death and to prevent future occurrences, the committee

recommends establishing a nationwide mandatory public reporting system. Hospitals first, and eventually other places where patients get care, would be responsible for reporting such events to state governments. Currently, about a third of the states have their own mandatory reporting requirements.

Copies of the report, "To Err Is Human: Building a Safer Health System" are available by calling (202) 334-3313 or (800) 624-6242. The cost of the report is $45 (prepaid) plus shipping charges of $4.50 for the first copy and $.95 for each additional copy. ■

Feds offer safe harbors for anti-kickback statute

The Department of Health and Human Services' (HHS) Office of the Inspector General announced eight new final regulatory "safe harbors" to the federal anti-kickback statute, which prohibits the knowing payment of anything of value to influence referral of federal health care program business, including Medicare and Medicaid.

The new safe harbors, which protect certain arrangements from prosecution under the anti-kickback statute, address those payment or business practices: investments in underserved areas, practitioner recruitment in underserved areas, obstetrical malpractice insurance subsidies for underserved areas, sales of physician practices to hospitals in underserved areas, investments in ambulatory surgical centers, investments in group practices, referral arrangements for specialty services, and cooperative hospital service organizations.

On the books since 1972, the federal anti-kickback law prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business. Violations of the law are punishable by up to five years in prison, criminal fines up to $25,000, administrative civil money penalties up to $50,000, and exclusion from participation in federal health care programs.

Because the law is broad on its face, concerns arose among health care providers that some relatively innocuous — and in some cases even beneficial — commercial arrangements are prohibited by the anti-kickback law. Responding to those concerns, Congress in 1987 authorized the HHS to issue regulations designating specific safe harbors for various payment and business practices that, while potentially prohibited by the law, would not be prosecuted.

The Office of the Inspector General has previously published 13 regulatory safe harbors, 11 in 1991 and two in 1992. A new final rule published in the Nov. 19, 1999, *Federal Register* establishes eight new safe harbor provisions and clarifies six of the original 11 safe harbors published in 1991.

The 1991 safe harbors addressed the following types of business or payment practices: investments in large publicly held health care companies, investments in small health care joint ventures, space rental, equipment rental, personal services and management contracts, sales of retiring physicians' practices to other physicians, referral services, warranties, discounts, employee compensation, group purchasing organizations, and waivers of Medicare Part A inpatient cost-sharing amounts. The 1992 interim final safe harbors, which were issued in final form in 1996, addressed the following practices in managed care settings: increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans to beneficiaries; and price reductions offered to health plans by providers.

The new final rule clarifies aspects of the original safe harbors for large- and small-entity investments, space rental, equipment rental, personal services and management contracts, referral services, and discounts. ■

Joint Commission ends commendation award

The Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL, has eliminated the "Accreditation with Commendation" category and increased the fee it charges health care providers for an on-site survey.

Accreditation with Commendation was introduced in January 1991 to recognize exemplary performance in accredited organizations at a time when performance reports — which give consumers and providers detailed information about how health care organizations compare with each other — were not available. Performance reports now provide up-to-date, understandable data

about the performance of all health care organizations accredited by the Joint Commission, says **Dennis O'Leary**, MD, president of the Joint Commission.

In addition, recent experience had suggested that the Accreditation with Commendation decision category was leading organizations to place undue pressure on their senior management staff to attempt to influence surveyors not to cite them for insufficient compliance with Joint Commission standards. Department of Health and Human Services Inspector General June Brown Gibbs had suggested earlier this year that the decision category be made more meaningful or be done away with altogether in the report, "The External Review of Hospital Quality."

"The time for Accreditation with Commendation has clearly passed,"O'Leary says. "We need to assure that the focus is where it belongs — on improving the safety and quality of health care across all accredited organizations."

Survey fees hiked

The Joint Commission sought input from both consumers and health care organizations earlier this year regarding the possible elimination of Accreditation with Commendation. It also announced that it is increasing the fees for its periodic full surveys by 3.25% in all but its ambulatory care and home care programs. The fee increase, which became effective Jan. 1, 2000, was approved by the Board of Commissioners at its November 5-6 meeting. The board also acted to re-establish a $2,500 fee for follow-up focused surveys to offset the actual costs of conducting these surveys.

The Joint Commission last adopted an across-the-board survey fee increase in 1994. The overall fee for a full survey is generally derived from a base fee, a service-volume-related fee, and the application of a survey price ceiling. The price increase will apply to all of those fee components.

In 1995, the Joint Commission eliminated its separate charge for focused surveys but did not increase overall fees to cover the costs of these surveys. About 10% of accredited organizations are expected to require a focused survey next year. In reinstating a charge for those follow-up surveys, the Board of Commissioners determined that the related costs should be borne principally by those organizations requiring focused surveys, rather than spreading the costs across the fees for all accredited organizations. ■

Suicides, med errors top sentinel events list

There have been 655 sentinel events investigated since 1995, according to the latest information released by the Joint Commission on Accreditation of Healthcare Organizations in Oakbrook Terrace, IL. Patient suicides and medication errors account for the most common types of sentinel events.

There were 127 patient suicides, making up 19.4% of all sentinel events. The next largest category was medication errors, with 89 cases making up 13.6% of the total. These were the other categories:

- operative or postoperative complications — 70 cases, 10.7%;
- wrong-site surgery — 50 cases, 7.6%;
- delay in treatment — 31 cases, 4.7%;
- patient death or injury in restraints — 30 cases, 4.6%;
- patient falls — 28 cases, 4.3%;
- assault / rape / homicide — 26 cases, 4%;
- patient elopement — 23 cases, 3.5%;
- transfusion error — 18 cases, 2.7%;
- infant abduction / wrong family — 17 cases, 2.6%;
- fire — 15 cases, 2.3%;
- medical equipment-related —- 13 cases, 2%;
- perinatal death / loss of function — 12 cases, 1.8%;
- maternal death — 10 cases, 1.5%;
- ventilator death / injury — 11 cases, 1.7%;
- utility system failure — 9 cases, 1.4%;
- death associated with transfer — 6 cases, 0.9%;
- infection-related death — 6 cases, 0.9%;
- dialysis-related event — 3 cases, 0.5%;
- inpatient drug overdose — 3 cases, 0.5%;
- various other types — 58 cases, 8.9%.

The statistics show that 417 cases, 63.7% of the total, occurred in a general hospital setting, while 108, or 16.5%, occurred in a psychiatric hospital. Another 46, or 7%, took place on a psych unit in a general hospital. Long-term care facilities made up 27 cases, or 4.1%. These were the other settings:

- emergency department — 19 cases, 2.9%;
- behavioral health facility — 17 cases, 2.6%;
- home care — 11 cases, 1.7%;
- ambulatory care — seven cases, 1.1%;
- clinical laboratory — two cases, 0.3%;
- health care network — one case, 0.2%.

Most of the sentinel events, 393, or 60%, were

self-reported by the providers. Another 140, 21.4%, were discovered in media reports, and 77, 11.8%, were identified during a Joint Commission survey. Patients and families reported 26 cases, 4%, and reports from other professional groups accounted for 14 cases, or 2.1%. Employees of the health care provider reported five cases, or 0.8%.

Seventy-eight percent of the sentinel events, 562 cases, resulted in the patient's death. Another 45 cases, 6%, resulted in loss of function. The total number of patients affected by the sentinel events was 722.

The number of sentinel events investigated by the Joint Commission has risen steadily since 1995, partly because of the way it has defined the events and increased attention to them. There were 23 sentinel events investigated in 1995, 33 in 1996, 138 in 1997, 180 in 1998, and 280 in 1999. ■

HCFA: Watch for racial bias in kidney transplants

Health care providers could risk federal sanctions if they do not ensure that all patients with renal failure, regardless of race or ethnicity, are being evaluated for kidney transplantation, according to a warning issued recently by the federal Health Care Financing Administration (HCFA) in Washington, DC.

HCFA is taking steps to provide improve enforcement and provide technical assistance to dialysis centers, which must assess all patients for transplantation as part of the patients' long-term care plans.

"Medicare rules require that all patients with kidney failure be evaluated and informed about transplantation," says HCFA administrator **Nancy-Ann DeParle**. "We want to be sure this is happening and be sure there is equal opportunity for transplantation when needed, regardless of a patient's race."

Medicare provides insurance coverage for most Americans with permanent kidney failure, paying for dialysis treatment and transplantation. HCFA's warning came in conjunction with the release of a study by **John Ayanian**, MD, and colleagues at Harvard Medical School in the *New England Journal of Medicine.* The investigators interviewed a sample of patients with kidney failure and found that black end-stage renal disease (ESRD) patients were less likely than white ESRD patients to want a transplant (76.3% vs. 79.3% among women, and 80.7% vs. 85.5% among men).

DeParle says Medicare will take a three-pronged approach to addressing transplant assessment disparities. The program will remind all certified dialysis facilities of its requirements that all ESRD patients are to be assessed for and fully informed about transplantation as part of the patient's long-term care plan.

HCFA also will work with the state survey agencies in evaluating the study findings and paying particular attention to dialysis facility compliance with regulations. State survey agencies inspect ESRD and other health care facilities to determine their compliance with Medicare certification requirements.

Medicare also will work with the ESRD network organizations to identify ways that the networks can work with the patients, the renal community, and the dialysis facilities in their area to increase transplant assessment rates. ESRD network organizations monitor the quality

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of care provided in dialysis facilities and assist facilities to improve patient care as opportunities present themselves.

"All three approaches will enforce and reinforce Medicare's commitment to its ESRD beneficiaries by assuring that they will receive the quality of care that they depend on, including the opportunity to be fully informed about and assessed for transplantation," DeParle says. ■

Penicillin alternatives pose risk of drug error

A drug recommendation from the federal Centers for Disease Control and Prevention in Atlanta could lead to dangerous drug errors, says the nonprofit Institute for Safe Medication Practices (ISMP) in Huntingdon Valley, PA.

Severe shortages of penicillin G sodium and penicillin G potassium recently led the CDC to issue a recommendation that specifically mentions penicillin G procaine and penicillin G benzathine as appropriate alternatives under certain circumstances. The ISMP, however, cautions that because those alternatives (procaine and benzathine) have been associated with repeated medication errors and because the CDC recommendations are likely to increase their use, "all health care professionals [should] exercise great caution in using these alternatives."

An alert from the ISMP explains that procaine and benzathine are long-acting forms of penicillin G that must be administered intramuscularly (IM) only. Reports to the ISMP have shown that the drugs often are confused with other forms of penicillin G and administered intravenously instead.

"Name confusion, lack of general familiarity with these specific drugs among some health care professionals, ambiguous or misleading reference texts (particularly older/outdated texts), and a widely held but mistaken belief that these products may be administered IV, have typically led to the errors," the ISMP reports.

The ISMP cites this example: In 1998, three Colorado nurses were indicted in a baby's death because long-acting penicillin was given IV instead of IM after the nurses misinterpreted information in various reference texts about the route of administration.

The ISMP offers these tips to reduce the chance of an error from the CDC recommendations:

• Place a specific reminder warning in all medication administration records stating that "penicillin G procaine and penicillin G benzathine must be administered IM only." Also, implement a similar computerized order input warning for each of those drugs.

• Apply distinctive auxiliary warning labels to those products to warn practitioners that they are intended for "IM use only."

• Examine current reference texts used in the facility to assure that information about the proper route of administration for penicillin G benzathine and penicillin G procaine is clearly communicated and prominently placed.

• Discard outdated or unclear reference texts and provide patient care areas with up-to-date and clearly written texts annually.

• Make sure ongoing staff education activities include this topic.

• Have pharmacy dispense the drug whenever possible to assure that proper auxiliary labeling is affixed and computer screening takes place before the drug is used. ■

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

Patient burns to death: Jury awards $1 million verdict

By **Pearl Schaikewitz**, JD
Legal Consultant, Atlanta

News: A jury awarded $1.04 million to the family of a woman who died from burns she sustained in a California facility. The patient, who a history of bipolar disorder, was using a lighter to open a package of crackers.

Background: The 56-year-old woman had been admitted to the convalescent home on Sept. 1, 1996, for treatment of a recurrent leg infection. She was admitted with several diagnoses, including uncontrolled diabetes, obesity, hypertension, and a history of bipolar disorder. Her admitting orders allowed her to have two breaks per day to smoke. Eleven days after she was admitted, she used her cigarette lighter to try to open a package of crackers. When she set fire to the plastic wrap, it flashed, and her nightgown caught on fire. Staff put out the fire and called 911. The patient was taken to the hospital but died 10 days later from the burns.

The patient's family claimed the home should have known the patient was a danger to herself because of her history of bipolar disorder. The family also argued the home should have taken the lighter away from her; the home waited 17 minutes before calling 911 and then failed to report that a patient had been injured in the fire; and the home's failure to timely and accurately report the fire was evidence of a coverup, showing recklessness and neglect with fraud or malice.

The home denied any attempt to cover up the incident. It contended the patient's physician had attested she was capable of maintaining her lighter and staff called 911, an ambulance, the patient's treating physician, and her family as soon as possible after the fire was extinguished.

What it means to you: Residents in a long-term care facility are generally much less capable of self preservation than most hospital patients, notes **Steven S. Wilder**, BA, CHSP. He is corporate director of risk management for Provena Senior Services in Kankakee, IL, and a partner in Sorensen, Wilder & Associates, a safety / security consulting firm in Bradley, IL. He is also a founding member and past president of the Illinois Society of Healthcare Risk Management, as well as a deputy fire chief, an Illinois licensed paramedic, and a certified fire instructor with the Illinois State Fire Marshall.

He offers this advice: "Long-term care residents, in general, need more attention than most patients to assure their safety and survival. Additionally, we cannot lose sight that the long-term care facility is not just a facility for medical care. To the residents, it is home, and as such, efforts must be made to allow them to enjoy the same privileges any of us would in our homes, providing they do not present a risk of injury to themselves or others.

"The background on this case does not indicate where the resident obtained the lighter. I hope the staff did not give it to her. Given her history of bipolar disorder, I cannot imagine any professional health care provider allowing her to knowingly keep a cigarette lighter on her person or in her possession. While the physician's orders addressed the smoking issue, I would be equally curious to know if the facility had a policy or procedure in place that weighed the resident's right to smoke against the resident's right to be free from the risk of incendiary fires or similar hazards. Even if the physician felt the resident could maintain

her own paraphernalia, the facility still had the obligation to determine if the condition of the resident presented an unreasonable risk of harm to others, and if so, to act accordingly to prevent a loss from occurring.

"Certainly this resident was not the only one who smoked. Were all of the residents allowed to possess smoking paraphernalia in their rooms? If the facility had a policy prohibiting residents from keeping smoking paraphernalia in their rooms, did the facility have any method of monitoring compliance with the policy? Were residents who were known smokers monitored any more closely or more frequently than nonsmokers?

"I am also curious about the gown the resident wore. Was it a 'personal' gown, or was it issued by the facility? Did it meet any fire resistive standards? Accordingly, did the facility have any type of fire suppression or smoke detection system in place? If so, did it activate? If not, why not?

"Finally, I am concerned about the allegation that the home waited 17 minutes to call 911. That is an unreasonable amount of time to wait to summon help. In all disaster preparedness training, activating the emergency response system is one of the first things that should be done when an emergency is discovered."

Audit processes suggested

Wilder offered the following suggestions for facilities wishing to avoid a similar tragedy:

- Review existing policies and procedures on the storage and issuance of smoking paraphernalia to residents.
- Comply with Joint Commission standards on smoking.
- Develop "audit" processes to monitor efficacy of policies and procedures, and include appropriate corrective responses when policies are found to be ineffective, impractical, or unenforceable.
- Attempt to educate families of residents on all of the facility's safety policies and the logic and reasons behind them.
- Train staff members and physicians on safety policies and educate employees how to respond when physicians' orders countermand the best interests of the residents and the employees caring for them.

Reference

Livingston v. Grand Park Convalescent Hospital, Los Angeles County (CA) Superior Court, Case No. BC 177-783. ■

Magnesium sulfate OD causes coma: $7.4 million

News: A Chicago jury returned a $7.4 million verdict against a hospital in which a post-childbirth patient sustained severe brain damage due to an overdose of magnesium sulfate.

Background: The 19-year-old woman was admitted to the hospital in August 1996. She was diagnosed with preeclampsia, and Pitocin and magnesium sulfate were ordered IV. The drugs were administered through separate lines controlled by a double IMED pump. She gave birth to a healthy girl. After the placenta was delivered, the obstetrician ordered more Pitocin and left the room.

The nursing manager, who had been caring for the baby, went to the IMED pump to open the Pitocin line, then she left the room. Eight to 10 minutes later, an obstetric technician noticed the patient thrashing. The patient then became unresponsive, and the technician called the physician. The patient had no heart beat or respiration. The physician noted that magnesium sulfate was flowing freely into the patient. Calcium gluconate was administered, and a code blue was called. The patient was resuscitated but sustained profound anoxic brain damage and remains in a persistent vegetative state. She is in a nursing home.

The hospital admitted liability, but the nurse who removed the line denied making the error. The physician contended that he had no duty to supervise the nurse who carried out his orders or to inform her that the patient was on magnesium sulfate. The doctor won a defense verdict.

What it means to you: "Under the facts presented in this case, the nurse manager certainly had a responsibility to take a look at the lines running both the Pitocin and magnesium sulfate to assure the correct adjustment of the Pitocin flow rate, as ordered by the physician," says **Vivian B. Miller**, national account risk and safety manager for the PHICO Group Inc. in Mechanicsburg, PA.

However, the physician should have made sure the nurse knew that the patient was being given magnesium sulfate, in addition to the Pitocin, Miller believes. "A physician must oversee the care that is being provided, and as such, has an obligation to inform the nurse of all

actions he or she has taken on the patient's behalf. The fact that the jury found in favor of the physician still does not negate that responsibility."

Miller says the top five allegations in claims against all specialists, physicians as well allied health professionals, involve the failure to monitor or effectively supervise patient care. "Monitoring problems include lack of recognition of changes in the patient's condition, failing to ensure that the patient is on the proper medications at the proper dose, and the like," she explains.

The allegation that this patient was not adequately monitored was a major claim in the case, Miller feels. "Eight to 10 minutes is a long time to be out of the room of a patient who just had a baby. There are too many risks. Her blood pressure could have dropped suddenly, or she could have started hemorrhaging. Someone needs to be with the patient for a specified period of time post-delivery in case such events occur."

Miller notes that the hospital may have had a policy such that the patient was supposed to be monitored in the room by an RN or other qualified professional for a specified period of time after delivery. "If there was such a policy in place and it was not adhered to, then the hospital has learned a very hard lesson." Had the nurse stayed with the patient, she might have discovered the patient's change in condition much earlier, Miller says; also, administering calcium gluconate at an earlier point could have minimized the patient's injury.

Miller also wonders whether it is permissible or appropriate for an obstetric technician to monitor the patient after delivery. If so, there must be assurances that the person who is taking care of the patient is competent to do so, she adds.

Finally, what appears to be a glaring problem is the communication failure among the health care providers, she says. "Many people say that communicating with the patient is a key to preventing litigation. That is true, but as this case shows, communication is crucial between everyone who is involved with the patient's care. Explicit, clear, and concise communication between health care providers and hospital staff is vital to effective and appropriate patient care. It could have prevented this patient's resulting injuries."

Reference

Conley v. Advocate Health and Hospital Corp. d/b/a Bethany Hospital, Cook County (IL) Circuit Court, Case No. 97L-3535. ■

Patient's informed consent rights violated

News: The Wisconsin Supreme Court has ruled that a physician violated a laboring patient's informed consent rights when he continued to insist on a vaginal birth after cesarean (VBAC) delivery even though the patient repeatedly told him she had changed her mind and wanted a cesarean. The baby was seriously injured in the incident.

Background: In 1987, the patient was admitted to the hospital at 4:00 a.m. for the delivery of her third child. Her obstetrician had delivered her two other children by cesarean section, in 1981 and in 1984. The second cesarean was done based on the prevailing "once a cesarean always a cesarean" practice at that time. During the third pregnancy, the obstetrician and the patient had discussed having a vaginal birth after cesarean as well as the cesarean, and the obstetrician recommended trying the VBAC. The patient agreed.

As part of the hospital's admissions process, the patient signed consent forms for both a VBAC and a cesarean section. At 8 a.m., the patient told the obstetrician that she had changed her mind and wanted another cesarean. The obstetrician urged her to continue with the VBAC. About thirty minutes later, the physician broke the patient's amniotic fluid sac to try and speed up the labor.

An emergency cesarean performed

According to court documents, the patient began suffering "excruciating abdominal pains sharply different from her contractions and unlike anything she had experienced with her prior deliveries." The patient sent her husband to ask the nurse to inform the obstetrician again that she wanted a cesarean.

The obstetrician checked on the patient again at 1 p.m. He was unable to diagnose the source of the abdominal pains but determined that they did not put the patient or baby at risk. Again the patient requested a cesarean, but the obstetrician told her to be patient. He said that "if he performed a cesarean delivery on every woman who wanted one, that all deliveries would be by cesarean section."

At 3:40 p.m. the baby's heart rate dropped. The obstetrician performed an emergency cesarean section at 4 p.m., but the patient's uterus had ruptured, which deprived the child of oxygen. The child was born a spastic quadriplegic and cannot move below her neck, or speak. It was agreed that if the child had been delivered before 3:29 p.m., she would have been born healthy.

The parents sued the obstetrician and his insurance carrier, alleging that the doctor violated the patient's informed consent rights and committed malpractice when he misdiagnosed her abdominal pains. Before trial, the parents dropped the malpractice claim. The trial judge ruled for the defense on the informed consent claim. The Wisconsin Supreme Court sided with the parents. The court determined that the patient withdrew her consent to a VBAC during labor, requiring the doctor to hold a new informed consent discussion with her. The court remanded the case to the trial court to determine damages.

What it means to you: **Wanda L. Hurr**, RN, JD, an attorney with Michael Best & Friedrich LLP, Milwaukee, WI, offers this advice:

Most lawyers believe this case to be an aberration. However, it does have strong implications and serves as a reminder to risk managers and attorneys alike of the continued viability of the informed consent doctrine. Ultimately, the [Wisconsin] Supreme Court noted the sanctity of a patient's right to request and/or refuse medical treatment. The court said that the patient's repeated requests to cease the VBAC and perform a cesarean constituted a withdrawal of consent, removing the physician's authority to continue with the VBAC and obligating him to conduct another informed consent discussion.

While this case did not involve the hospital or its employees, it provides an opportunity to review the hospital employees' role in the informed consent process. *Once a patient categorically withdraws consent for treatment, it is the obligation of the pertinent health care provider to conduct another informed consent discussion, which clearly gives a patient the opportunity for choice of treatment.*

In most situations, the obligation to obtain informed consent for treatment lies primarily with the attending physician. However, it is also clear that most nurses and other hospital employees/health care providers have roles to play in this process. In this case, for example, there was testimony that one of the nurses was sent to find the attending physician to inform him that the patient no longer wished to proceed with the VBAC delivery. In such circumstances, risk managers and hospital staff would be wise to recall the following:

- Documentation is an extremely important strategy. Any time a patient withdraws consent for treatment, nurses should document very clearly the circumstances of the withdrawal and the attempts made to notify the physician.
- Documentation of discussions with the physician is absolutely critical. Communication issues on the basis of litigation often present temptations for staff and physicians to point the finger at one another.
- Staff should be adequately trained in what steps to take when a physician insists on proceeding with a treatment for which the patient has clearly withdrawn consent. In that situation, staff should be instructed to notify their immediate supervisor and obtain assistance. If a patient has clearly withdrawn consent to treatment, employees who continue to provide such treatment, even if following the direct order of the patient's attending physician, risk being sued. Indeed, some nursing practice acts require separate informed consent from patients before nursing procedures can go forward. Such nursing procedures need not depend on a physician's order.
- Educational programs addressing informed consent should cover this case for physicians and staff. For instance, the patient in that case never said the magic words, "I revoke," the court noted. But her repeated statements clearly indicated her withdrawal of consent, the court found. Staff members would be wise to address various scenarios, using role-playing and videotapes as training tools.
- Withdrawal of consent should be properly addressed in informed consent policies.

The court pointed out that the case does not alter the principles of informed consent. Rather, it "more fully articulates those principles by applying the doctrine in a factual context . . . not previously faced." As such, at least one state supreme court has refused to let health care providers "off the hook" simply because of uncharted territory or unusual circumstances. The decision should prompt risk managers to revisit policies, procedures, and informal staff responses to informed consent dilemmas.

Reference

Schreiber v. Physicians Insurance Company of Wisconsin (223 Wis.2d 417, 588 N.W.2d 26) (1999). ■

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1999 SALARY SURVEY RESULTS

Healthcare Risk Management™

Salaries look good as risk management jobs change

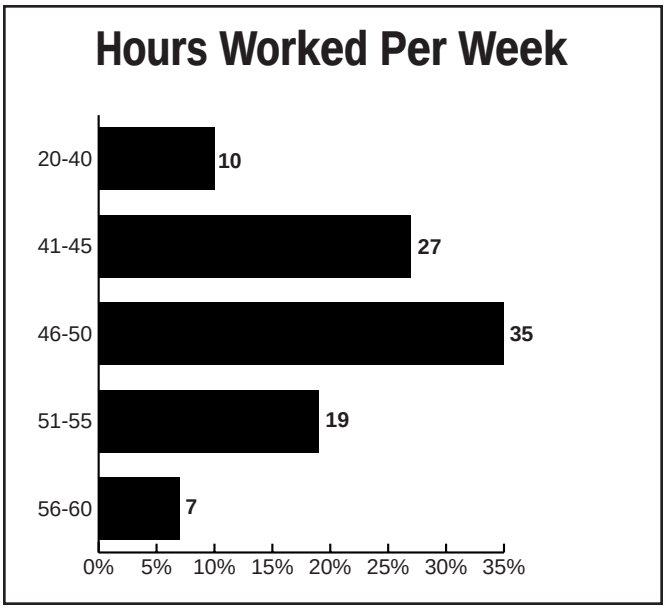
Health care risk management is an expanding field in which the best opportunities may not be found in the traditional roles, say leaders in the field. Income is holding steady for most risk managers, but there are some reasons to be optimistic, according to the exclusive 1999 *Healthcare Risk Management* salary survey.

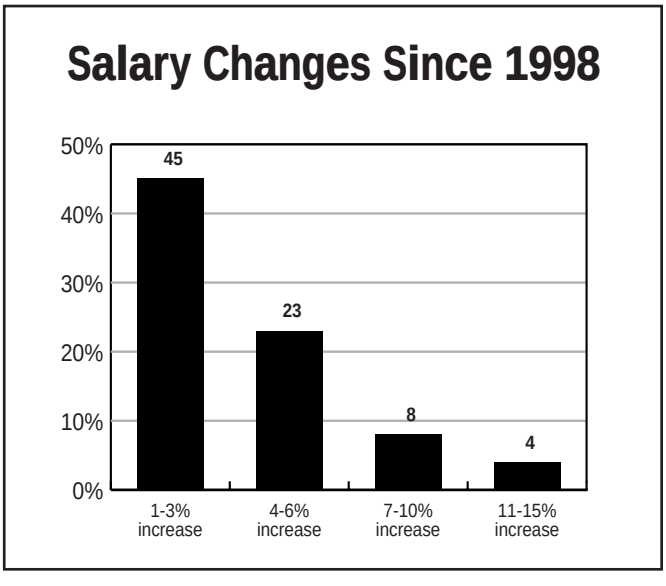
HRM mailed about 1,500 surveys in the July 1999 issue. A total of 140 were returned, for a response rate of 9%. The results were tabulated and analyzed by American Health Consultants, publisher of *HRM*.

Income plateauing

Income is holding steady this year, compared with upward trends of the past two years. Directors of risk management report a median income of $62,500, the same as last year. The median income for directors of risk management was $57,500 in 1997 and $52,000 in 1996. The 1998 survey results suggested that fast rise in income could be attributed to the dramatic changes in risk managers' job descriptions over the past few years. The same results this year could mean risk managers are seeing a plateau in those increases — the job changed, income changed, and now the deal is complete. The income level for those with the title of "risk manager" also was the same as last year, $62,500.

No matter what title they use, about half of the survey respondents reported an increase of 1% to 3% in income from the past year. About 15% reported no change, and the rest reported a decrease. About half report no change in staff size, with the rest split evenly between decreasing and increasing staff size. That is the same result seen last year and in 1997. In the 1998 survey, 55% said there had been no change in staff size, compared with 68% in





Salary Levels by Title

Annual Gross Income	Director	Risk Manager	Coordinator
<20,000	1.1%	1.5%	0%
$20,000 to $24,999	0%	0%	0%
$25,000 to $29,999	0%	0%	0%
$30,000 to $34,999	0%	1.5%	0%
$35,000 to $39,999	1.1%	3%	0%
$40,000 to $44,999	3.4%	14.9%	20%
$45,000 to $49,999	4.6%	9%	20%
$50,000 to $54,999	4.6%	23.9%	20%
$55,000 to $59,999	5.7%	11.9%	20%
$60,000 to $64,999	10.3%	13.4%	0%
$65,000 to $69,999	17.2%	9%	0%
$70,000 to $74,999	12.6%	3%	0%
$75,000 to $79,999	13.8%	0%	0%
$80,000 to $84,999	8%	1.5%	0%
$85,000 to $89,999	2.3%	0%	0%
$90,000 to $94,999	3.4%	1.5%	0%
$95,000 to $99,999	4.6%	1.5%	0%
$100,000 to $104,999	2.3%	1.5%	0%
$105,000 to $109,999	2.3%	1.5%	20%
$110,000 to $114,999	2.3%	0%	0%
$115,000 to $119,999	0%	0%	0%
$120,000 to $124,999	1.1%	0%	0%
$125,000 to $129,999	0%	0%	0%
$130,000 to $134,999	0%	0%	0%
$135,000 to $139,999	0%	1.5%	0%
$140,000 to $144,999	0%	0%	0%
$145,000 to $149,999	0%	0%	0%
$150,000 to $154,999	0%	0%	0%
$155,000 to $159,999	1.1%	1.5%	0%
$160,000 or more	0%	0%	0%

1997. In last year's survey, 23% reported an increase in staff size, compared with only 2% the year before.

You may not be quite as tired this year as in some previous years, if the survey results are any indication. Respondents report working a median of 46 to 50 hours per week. In the 1997 survey, 75% reported they worked 61 to 65 hours per week, way up from the 46 to 50 hours per week reported in 1996. Like the change in income, the change in overtime was attributed to the change in job descriptions that had risk managers taking on new duties that might have been assigned to several other people in the past. The 1998 survey suggested that risk managers had learned to accommodate those new tasks in their work schedules better, with a median reporting working 46 to 50 hours a week.

The 1999 survey also shows that, as in recent years, the typical *HRM* reader is a woman 46 to 50 years old, with a master's degree.

'A good time to be a risk manager'

Even without any dramatic increase in income, "this is a good time to be a risk manager," says **Sandra Johnson**, RN, ARM, FASHRM, regional manager of risk management at Imperial Point Medical Center in Ft. Lauderdale, FL. The many changes going on in health care, including an emphasis on compliance and fraud, make risk managers more valuable than ever to their institutions, she says.

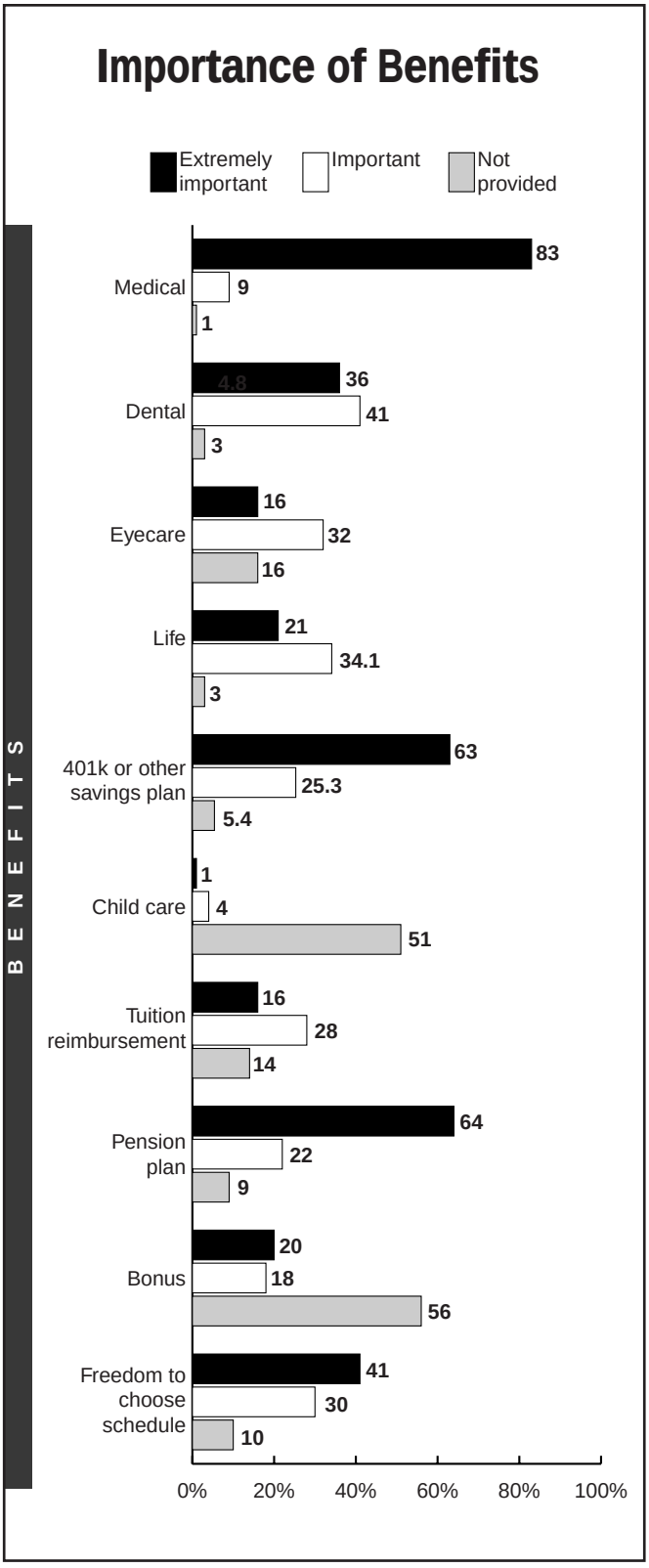
"Risk managers have always talked about fighting their way up from the cellar to a position where they can really be respected as part of the leadership team," Johnson says. "These changes and the emphasis on risk management put you right in the boardroom."

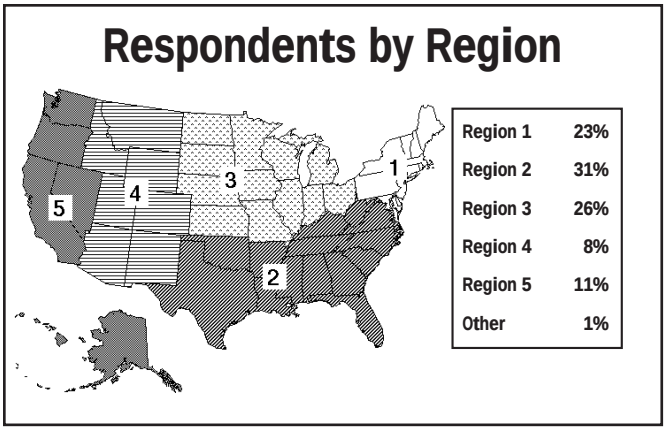
There has not been a corresponding increase in income for most risk managers, she says. That disparity is probably most obvious for risk managers who have taken on compliance responsibilities, as Johnson has. Even so, Johnson says there is reason to expect increased income for health care risk managers who continue to grow in their careers.

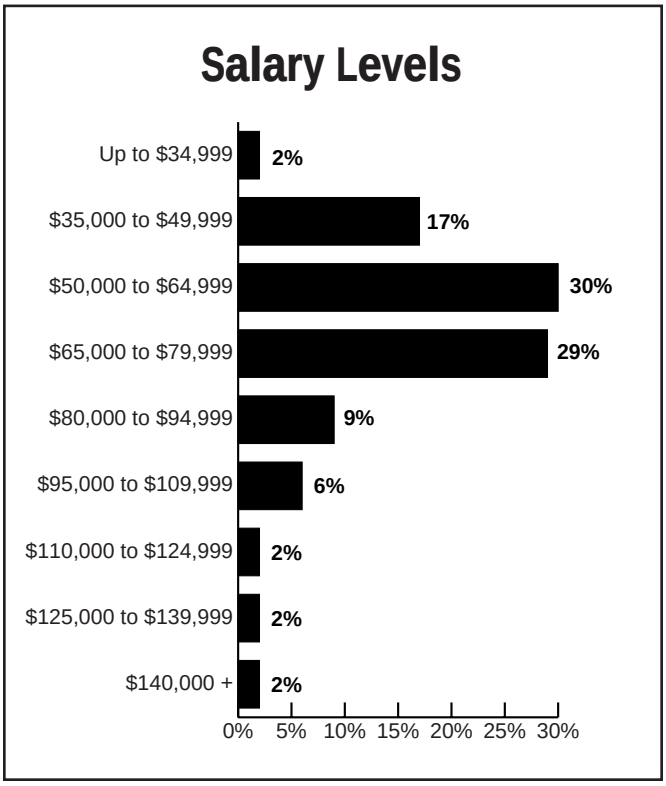
"I don't see it as a big negative that we haven't seen a significant increase in salary," she says. "I think in a lot of cases it's just that the hospital doesn't know yet what the job is going to entail when they put you in that compliance position. It will be obvious before long what these duties mean, and I think the compensation will catch up at that point."

Look for opportunities for more influence

One way to advance in your career as a risk manager is to look for ways to have more influence in the hospital, says **Jeanne Pores**, ARM, vice president of hospital affairs at Physicians' Reciprocal Insurers in New York, the second largest underwriter of physicians and hospitals in New York state. Pores worked for years in hospital risk management before taking her current position. Speaking at the recent meeting of the American Society for Health Care Risk Management (ASHRM) in Chicago, she







explained that risk managers should look for opportunities outside of the "typical" health care risk management concerns.

Many risk managers become so focused on the clinical concerns of their jobs that they can overlook some of the less obvious liabilities and exposures that have little to do with patient care, she says. Pores cites the hospital's workers' compensation program as an example. In some hospitals and other health care organizations, an employee's workers' comp claim is handled with little or no input from the risk management department. The claim is filed by the employee, approved the supervisor, and then human resources processes it, often with little input.

"That makes workers' comp an easy system to abuse," she says. "If you get involved and apply risk management concepts to that process, you can cut costs and show that your insurance premium went from $1 million last year to $800,000 this year, for example. That's not something you can do with bad baby cases. You may know that your efforts avoided five bad baby cases this year, but you can't show it."

As another example of how health care risk managers can improve their contributions by looking beyond patient care issues, Pores recounts an incident at a hospital where she used to work as risk manager. A prominent benefactor of the hospital, already responsible for several building projects, also had donated several original Andy Warhol prints to the hospital. They had been hanging in a public area of the hospital for five years when Pores thought to ask whether they were insured. They were not.

"Knowing that these prints were extremely valuable, I immediately became paranoid about them and obtained specialty insurance to cover them," she says. "Sure enough, about a week later someone stole one of them. The benefactor took the insurance money and bought another Warhol print for the hospital. Can you imagine the benefactor's reaction if we had to tell him that the print was lost and there was no insurance?"

The hospital also sought help from the art community to display the prints in ways that deter theft. Pores says she was proud to have saved the hospital from a significant financial loss while preserving the relationship with the benefactor.

"These are things you walk around and never pay attention to because it's not a patient care issue," she says. "But it's a loss to your hospital, so it's a risk management function." ■