

HRMR

HEALTHCARE RISK MANAGEMENT REVIEW

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OPPORTUNITIES IN CHANGE

Three years since Obamacare:
the healthcare sector is still adapting

PATIENT SAFETY ORGANIZATIONS

A confidential way to report
and learn from errors

CONFERENCE WITH A CONSCIENCE

ASHRM's 2013 conference:
Everyone's a Risk Manager

LESSONS FROM NEW HAMPSHIRE

The dangerous problem of
staff members diverting drugs

PREVENTING COSTLY PATIENT FALLS

Why falls can be fatal
and how to avoid them

CAPTIVATING

THE CAPTIVE INSURANCE INDUSTRY



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GUARDIANS OF SAFETY

Welcome to the autumn edition of *Healthcare Risk Management Review*, the publication of which coincides with the opening of the Obamacare health exchanges and the complicated birth of a new era in US healthcare.

Technical glitches and government shutdown notwithstanding, Obamacare is without doubt the boldest and most revolutionary overhaul of US healthcare since the introduction of Medicare and Medicaid in the 1960s. This edition of *HRMR* explores the challenges and opportunities the Affordable Care Act (ACA) presents to healthcare providers, and the ways in which it will affect their insurance needs.

The overriding impression we gained was one of uncertainty; a new landscape is most definitely emerging but many insurance providers are waiting to see exactly what it looks like. In our Obamacare feature on page 6, Iain Newton, research and business development manager for Beazley, sums up the atmosphere by describing how Beazley has invested a lot of time and effort in developing a new ACO product but, met with uncertainty from their insureds about how their needs will change, it is yet to finalize its details.

While the current changes to healthcare have been felt as upheaval in recent weeks, we also use this issue to document the quiet and steady march of progress experienced by healthcare risk managers all over the US as they strive to engage all hospital staff in making their organizations a safer place for patients. We spoke to two risk managers who are leading the field in this respect, both heading towards the same goal by striving for a high reliability culture more commonly associated with high risk industries such as nuclear power or airlines.

Joyce Lahue of Baptist Health System in San Antonio, Texas, has helped her system achieve a greater than 80 percent reduction in serious safety events over the 2010 baseline, while Kathy Evans of Paradise Valley Hospital in Phoenix, Arizona, has seen her organization achieve 18 months and counting without a serious safety event.

On the subject of safety, we also explore the perennial problem of patient falls. A claim study by Sedgwick has revealed injuries from falls as a top claim cause and loss leader. In a special feature, two experts from Sedgwick explore the circumstances that can contribute to a fall, sometimes with fatal consequences, and ask what can be done to prevent falls occurring in the first place.

For those on a quest to boost safety, membership of a Patient Safety Organization (PSO) can prove invaluable, providing an opportunity for healthcare providers to report errors and near-misses in total confidence without the fear of legal repercussions. Information is then disseminated to other members of the PSO so that they can prevent similar problems occurring in their organizations.

Uptake of PSO membership is still relatively low but it's set to grow because the ACA stipulates that by 2015 hospitals with 50 or more beds can participate in a health insurance exchange only if the hospital has established a patient safety evaluation system (PSES) and participates in a PSO.

If you are aiming to implement further safety-focused initiatives, the 2013 ASHRM conference is the place to be. This year's theme is Everyone's a Risk Manager, and as president Andrew Oppenberg explains in our exclusive interview on page 14, the aim is to emphasize the role that all healthcare workers hold as guardians of patient safety.

As Lahue and Evans have shown, massive improvements in patient safety are achievable when you get everyone in your organization to be more safety-aware. While in years gone by risk management was often about dealing with the aftermath of errors, we can take pride in the fact that more and more risk managers are using their position to prevent problems from occurring—and in the process, they are saving lives.

Wyn Jenkins, Managing editor



6 **Obamacare: change afoot**

Over three years since the Patient Protection and Affordable Care Act was signed into law and with new provisions steadily becoming effective, we ask how the insurance and reinsurance industry has met its challenges and provided solutions.

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Linking with a Patient Safety Organization is a way to drive up safety in your own organization and in other organizations too by reporting errors without fear of legal repercussions. *HRMR* investigates.



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Ever since the attacks of September 2001 the threat of terrorism has been taken very seriously in the US, with the majority of hospitals taking out terrorism insurance cover. In December next year the government backstop for terrorism coverage, originally enacted in 2002, comes up for review. *HRMR* asks what effect this will have on hospitals' insurance.



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It is sometimes said that the hardest things to do reap the most benefit. Is this true for the practice of apology and disclosure in healthcare? Pamela Popp, executive vice president/chief risk officer for Western Litigation, offers her perspective.

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Joyce Lahue, director of risk management for Baptist Health System in San Antonio, Texas, and president of the South Texas Society for Healthcare Risk Management, has helped drive a reduction in safety events at her hospital system. She tells *HRMR* how this was accomplished.



22 **Reaching zero**

Kathy Evans, director of risk management at Paradise Valley Hospital in Phoenix, Arizona and treasurer of the Arizona Society for Healthcare Risk Management, has helped to slash safety events at her hospital, achieving 18 months and counting without a serious safety event. She told *HRMR* why she has found her niche as a healthcare risk manager.

24 Managing the risk of drug diversion

The recent case in New Hampshire of a technician stealing drugs and infecting patients with hepatitis C in the process has placed the issue of drug diversions in the forefront of many risk managers' minds. Michelle Foster Earle, president, Omnisure Consulting Group, offers her advice and insights on the topic.

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A claim study by Sedgwick reveals injuries from falls as a top claim cause and loss leader. Ann Gaffey, healthcare risk management and patient safety at Sedgwick, and Jayme Vaccaro, director, professional liability claims, report.

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As new research shows that companies now rank data breaches as a more serious risk than natural disasters, *HRMR* asks why the threat is so great and what can be done about it.

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As the healthcare industry is increasingly faced with regulatory changes and widening risk exposure, the manner in which such risk is dealt with is requiring new tactics and tools. Bonnie Clark of Delphi Technology discusses the innovations being used to respond to this rapidly developing environment.

36 Healthcare workers top injury stakes

A new study by consumer advocacy organization Public Citizen has exposed the frequency and severity of workplace illness and injury suffered by healthcare workers each year. *HRMR* asks what can be learned from these findings.

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With the advent of drug-resistant bacteria, hospital-acquired infections are a growing threat to patient safety. They can also result in costly lawsuits. What is the best way to fight the problem? *HRMR* investigates.

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FATAL FLOORS

A claim study by Sedgwick reveals injuries from falls as a top claim cause and loss leader. *Ann Gaffey*, SVP, healthcare risk management and patient safety at Sedgwick, and *Jayme Vaccaro*, director, professional liability claims, report.

Injury from patient and visitor falls continues to be a source of professional and general liability claim activity that challenges and frustrates risk management and patient safety professionals across the continuum. While not always the most significant claims on the organization's books, there are still many of these events that result in debilitating fractures, neurological damage, and death.

An analysis of protected data in the Sedgwick study revealed some big numbers that stood out. Focusing on healthcare clients, more than 10,000 or almost 17 percent of the 62,000+ claims and suits analyzed for this study were attributed to injuries from falls—the number one injury cause, as noted in Chart 1.

In addition, even though fall injuries are not always considered high severity cases, they were among the top five based on indemnity costs and allocated loss adjustment expenses (ALAE) paid, as shown in Chart 2.

The combined indemnity and ALAE payments associated with the most frequent results from falls—fractures, hematomas, and death—came in at \$145.8 million. Looking at all fall claims and lawsuits in the Sedgwick claim study, that number exceeded \$254 million (Chart 3).

When considering the financial loss an organization can experience from Medicare non-payment of hospital-acquired conditions (HACs) associated with falls (fracture, dislocation, intracranial injury, and more), this patient safety issue must remain top of mind. For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the HACs was not present on admission.

Specifically, the case would be paid as though the secondary diagnosis were not present¹. Examination of data from the Centers for Medicare & Medicaid Services from an April 2012 analysis by the Research Triangle Institute (RTI) showed the estimated cost to Medicare per episode for a

hospital fall with a fracture was \$7,198². Loosely associating that to the Sedgwick data, this adds a potential cumulative loss due to Medicare non-payment to facilities of \$34 million.

These significant findings are enough to move any risk management and patient safety professional into high gear to evaluate their existing fall prevention programs. The need to take a closer look at which risk reduction initiatives are working and which are not is evident. Medicare’s position of not paying for an injury that could reasonably have been prevented through the application of evidence-based guidelines should motivate risk management and patient safety professionals to benchmark facility practices against those supported by strong clinical evidence.

One should not assume, however, that all falls occur in a specific segment of the population, such as the elderly. Often overlooked patient demographics include obstetric and postpartum patients, as well as infants who may experience falls when new parents fall asleep while holding them in their arms. Equally important is the acute rehabilitation patient who believes s/he has progressed further in rehabilitation than s/he has and then falls while attempting to walk unaided, or the outpatient who has a radiology test and falls while getting off the X-ray table. To address risks across these widespread populations, there are extensive resources available for assessing and benchmarking a facility’s existing fall prevention tools and programmes.

TWO CASE STUDIES: FALL PERILS IN PROVIDER AND PATIENT OVERESTIMATING

The ‘perfect storm’ fall

An elderly inpatient with a catheter was being assisted during a shower by a certified nursing assistant. The patient fell in the shower. While the patient appeared to be fine after the fall, X-rays 24 hours later showed a left hip fracture. The patient underwent surgery and, during her long recovery, experienced skin tears and ulcers. An ulcer on her left calf

“Risk identification efforts should include an event reporting system that collects detailed information specific to each fall, such as time of day, location, and activity at time of fall.”

progressed and this ‘perfect storm’ of complications eventually took the patient from her daily shower to her death.

What perils can you anticipate, and why?

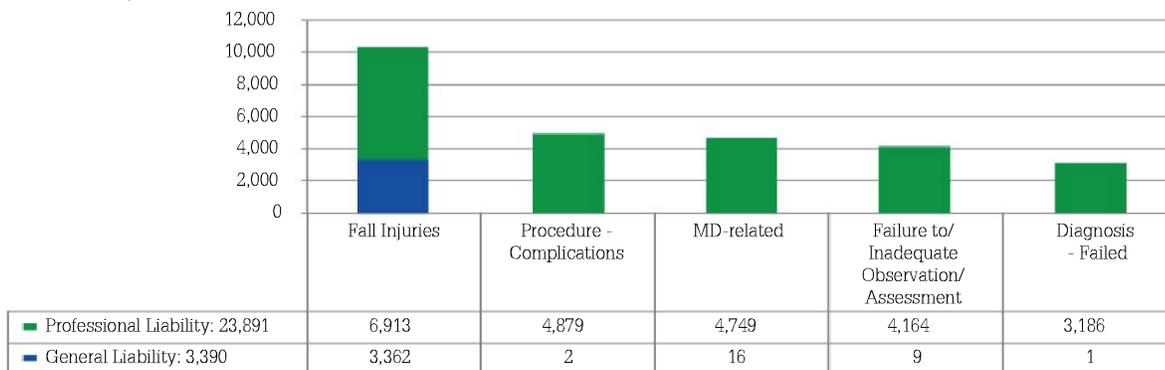
The attending physician documented there was a shortage of staff and this supported that, while the patient needed two attendants to shower, only one was available. In addition to underestimating the help needed for the patient, the delayed diagnosis/treatment and the avoidable fall created a perfect storm—catastrophic for the patient, most importantly, and also an expensive claim for the facility. While some falls are unavoidable, it is hard to defend financial incentives named as motives for not properly staffing a facility.

What else should the staff have done differently?

The 24-hour delay in diagnosing the hip fracture was unacceptable. After a fall, an immediate, thorough assessment done by a nurse or physician is an essential step and ensures timely clinical decision-making. In this case, sending the patient for an X-ray immediately would have mitigated the length of ‘pain and suffering’ and initiated treatment sooner.

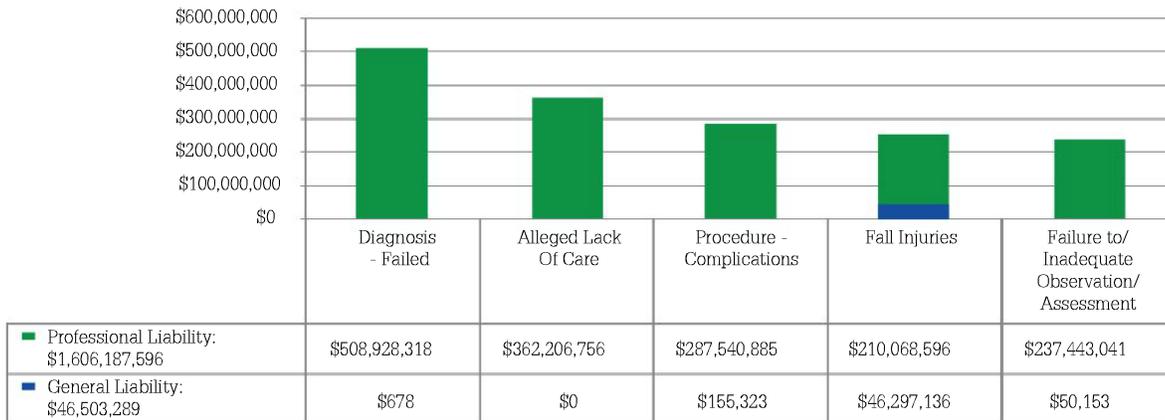
The number of bed sores and the eventual infection from a bed sore contributed to the patient’s death. Bed sores must be treated in a timely and proper manner.

Chart 1: Sedgwick claim study top five causes by file type



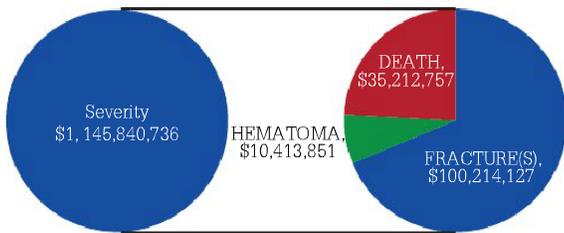
Source: Sedgwick

Chart 2: Sedgwick claim study indemnity and ALAE paid for top five causes by file type



Source: Sedgwick

Chart 3: Sedgwick claim study indemnity and ALAE paid for top three injuries correlating to fall injuries



Source: Sedgwick

The ‘environmental awareness’ fall

A female patient underwent an emergency appendectomy. Due to a shortage of rooms, the patient was placed in a shared room on a nonsurgical recovery floor with a patient who had pneumonia. The patient did not void urine in the first 24 hours post-surgery. The nursing staff told the patient to try to use the bathroom. The path to the bathroom was a short distance from the patient’s bed, and included an IV and dinner cart; the patient had to open a large bathroom door that knocked into both. She was thereby required to move the items so she could open the door. On pain medication and still groggy, the patient attempted to use the bathroom on her own.

What perils can you anticipate and why?

Once back in bed, the patient later told the nurses she fell while trying to use the bathroom, but she appeared to be fine. The patient still did not void urine so she had a catheter placed. Within the next few hours, the patient began to experience a headache and an altered mental state.

The patient, who was married with three children, later suffered massive bleeding in the brain and died.

What should the nurses have handled differently?

Placing this patient on a nonsurgical floor exposed her to an inattentive nursing staff unfamiliar with basic postsurgical considerations, like the inability to void urine and the need for a catheter.

The size of the room and the ‘obstacle course’, as well as sharing a room with a potentially infectious patient, created a dangerous environment for this patient.

While the patient overestimated what she could do, the nursing staff’s overestimation of what a postsurgical medicated patient can do was unforgivable.

Not to be forgotten is the important analysis to be done after a patient or visitor falls. Risk identification efforts should include an event reporting system that collects detailed information specific to each fall, such as time of day, location, activity at time of fall, medication changes, environmental factors, etc.

In partnership with quality and patient safety professionals, analyzing rate-based fall data on a regular basis for trends and risk control opportunities will round out a fall prevention programme. If patient falls are a significant problem in the facility, consider a weekly dedicated ‘fall team’ meeting to analyze the details of every fall. This multidisciplinary forum can include therapy and pharmacy professionals, housekeeping staff, nutrition services, social services, physicians, and others as needed to improve facility performance in mitigating these high-risk incidents.

As highlighted in the Sedgwick claim study findings, injuries from falls in all types of patient care facilities can significantly impact the

bottom line when frequency or severity is an identified problem. Using the resources noted here, along with facility-specific fall and claim data, opportunities exist to improve patient safety and ensure robust fall prevention programmes are in place.

For more information about the Sedgwick claim study and ways to reduce the most common risks, join Ann Gaffey and Jayme Vaccaro on Monday, October 28, 2013 at the ASHRM Annual Conference & Exhibition in Austin, Texas when they present Driving Down Claims: Tackling the Top Ten. ■

1 Department of Health and Human Services and Centers for Medicare & Medicaid Services. Hospital-Acquired Conditions (ILAC) in Acute Inpatient Prospective Payment System (IPPS) Hospitals Fact Sheet, October 2012. Found at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/downloads/hacfactsheet.pdf>.

2 Centers for Medicare & Medicaid Services Analysis Report: Estimating the Incremental Costs of Hospital-Acquired Conditions (ILACs), April 2012. Found at: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/HospitalAcqCond>.

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L O C K T O N C O M P A N I E S

Data breaches



UNDER ATTACK: DATA AS THE NEW TARGET

As new research shows that companies now rank data breaches as a more serious risk than natural disasters, *HRMR* asks why the threat is so great and what can be done about it.

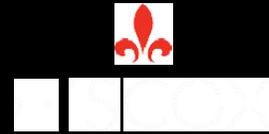
A new study by Experian Data Breach Resolution and the Ponemon Institute shows that companies now rank cyber security risks as greater than natural disasters and other major business risks.

The August 2013 report, *Managing Cyber Security as a Business Risk: Cyber Insurance in the Digital Age*, is one of the first to examine corporate adoption and attitudes about the rapidly evolving cyber security insurance market and how companies are managing the potential financial damage of breaches. Respondents include senior privacy and compliance professionals involved in evaluating cyber insurance policies and corporate risk management. The top industries represented are retail, public sector, health and pharmaceuticals, and financial services.

Companies surveyed acknowledged the potential financial impact associated with security breaches. For the 56 percent that experienced breaches, the average cost of these incidents was \$9.4 million in the last 24 months.

However, these costs are only a fraction of the average maximum financial exposure of \$163 million that the companies surveyed (breached or not) believe they could suffer due to cyber incidents.

“We are reaching a tipping point where the majority of companies we surveyed now rank cyber security risks as being as high as other major insurable business risks,” says Michael Bruemmer, vice president at Experian Data Breach Resolution. “We anticipate that demand for cyber security insurance is likely to increase to meet evolving breach response policies.”



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don't fly.



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