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Enterprise risk management: A framework for implementing second curve strategies

By Kathleen Shostek, RN, ARM, BBA, FASHRM, CPHRM

Healthcare is undergoing dramatic change. The operating environment for hospitals is rapidly shifting from a volume-based delivery model to a value-based one. A road map[1] for hospitals to transform from the fee-for-service first curve to the pay-for-performance second curve system was set forth by the American Hospital Association, building on its foundational report, Hospitals and Care Systems of the Future (2011).[2] The top three high-priority strategies identified by the AHA for successful quality improvement and increased efficiency are:

1. **Alignment of hospitals, physicians, and other providers across the continuum**
2. **Utilizing evidence-based practices to improve quality and patient safety**
3. **Improving efficiency through productivity and financial management**

Risk management professionals are uniquely positioned to support implementation of these "second curve" strategies in their organizations. As hospitals and health systems seek to acquire non-hospital-based providers such as physician practices and other services as a strategy to increase competitive advantage, stabilize bottom lines, and improve market share, risk managers are often asked to assess the risks of the practices or services either before or immediately after acquisition. Alignment of risk management and patient safety programs necessarily follows.

Enterprise risk management (ERM) provides a framework for achieving safe and reliable healthcare delivery and can provide a structure to fully integrate risk management and patient safety across care settings. This entails an interactive – versus a reactive – approach to risk identification, analysis, and treatment through an entrenchment of risk management principles into corporate operations and strategic planning.[3]

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Managing risk with an enterprise-wide view allows a healthcare organization to use a cross-functional approach to assess, evaluate, and measure risks, and help guide decision-making within the organization's tolerance for risk as it implements plans to be strategically adept under Affordable Care Act reforms.

What is ERM?

Recent trends have stimulated a shift to ERM from the traditional "silo" approach to risk management in healthcare organizations. These trends include globalization of financial and business markets, continued integration of the insurance industry, increased regulation, and a greater focus on corporate governance.

Recognizing the need to develop an ERM framework, provide key principles and concepts, and adopt a standardized language, the Committee of Sponsoring Organizations of the Treadway Commission (COSO), a voluntary private-sector organization that focuses on improving the quality of financial reporting through more effective internal controls and improved corporate governance, published Enterprise Risk Management – Integrated Framework in 2004 to assist organizations in these endeavors.

COSO has broadly defined ERM as:[4]

"A process, effected by an entity's board of directors, management and other personnel, applied in strategy setting and across the enterprise, designed to identify potential events that may affect the entity, and manage risk to be within its risk appetite, to provide reasonable assurance regarding the achievement of entity objectives."

This definition recognizes that ERM is an ongoing process that is applied across the enterprise and is implemented by people at all levels. It assumes that the organization has both defined its tolerance level for risk (i.e., risk appetite) and communicated the tolerance level to every department and unit. Another definition of ERM simply states that ERM is "the culture, processes, and structures that are directed towards realizing potential opportunities while managing adverse events."[5]

ERM in healthcare has been described as identifying critical risks; quantifying their financial, operational, and strategic impact; and implementing risk management strategies to maximize enterprise value.

An ERM program can help healthcare leaders focus on better management of patient safety risks as well as business risks and, in turn, increase the value of their organizations through gains in reputation, prevention of financial losses, and investment in expanded healthcare services to benefit both the organization and the community. The following is an example of how ERM can be optimized by a healthcare organization.

A hospital specializing in bariatric surgical procedures finds that it has a high incidence of surgical incidents and postoperative complications. This has resulted in financial losses for this service line from reduced reimbursements from Medicare and private health insurers due to readmissions, "write-offs," and payments for liability lawsuits.

Instead of accepting the high rate of incidents, complications, and payment reductions as a consequence of performing a high number of procedures, the hospital puts an aggressive process in place to identify, evaluate, and improve the risk of adverse patient outcomes for bariatric surgery and to improve payment rates from insurers that reimburse at higher rates for quality surgical outcomes. This process includes an evaluation of surgeon credentialing procedures, quality of peer-review activities, effectiveness of physician and non-physician training programs, analysis of incidents and "near misses" with action plans for prevention, and sharing cost information to incentivize achievement of improved surgical patient outcomes. Measuring changes in the incident and complication rates for bariatric surgery against targets for lower rates, reduced lengths of inpatient stays, reduced re-admission rates and so forth, and matching the changes with improved revenues and fewer liability losses, the hospital's risk management efforts would be effective.

Using a traditional approach, the hospital might have assessed its risks separately. The medical staff would evaluate the credentials for professionals and procedures, peer-review committees would examine case complications, and education and training would continue "as is" without determining the effect on surgical outcomes and impact on net income. Using ERM, risks are assessed and treated and patient safety is improved across disciplines and service lines. As the hospital's quality measures improve, level of reimbursement and revenues improve. In addition to improving patient care and safety, a reduction in surgical incident and complication rates falls to the hospital's bottom line through lower overhead costs, such as reduced labor costs when the hospital staff spend less of their time managing incidents, possibly through reduced malpractice insurance rates, and other expense reductions. The hospital also gains competitive advantage by reducing adverse events and complication rates below national/regional average. This presents an opportunity to advertise and market bariatric surgery services above competing hospitals. It also makes the hospital attractive for providers seeking network opportunities for accountable care, medical homes, and other, coordinated care models with risk and/or gain sharing.

ERM goes beyond clinical risks

While liability risks associated with negligence and malpractice are of critical concern to healthcare organizations, other types of risks can be equally crippling to their financial and strategic

well-being when they occur. The following are examples of business risks that go beyond the traditional risk of malpractice liability in providing patient care:[6]

- An audit of a teaching hospital notes that not all funds from a research grant were used for the project; these funds were subject to unrelated business income tax, but the tax was not paid.
- A national competitor hires away the hospital's most highly regarded and profitable surgical team.
- A health system receives a request from a congressional task force for all records that might indicate excessive Medicare charges.

ERM provides a logical framework for identifying, measuring, and acting on the broad scope of potential risks facing healthcare organizations today. The benefits of ERM go beyond avoiding financial losses and legal entanglements and include enhancement of management effectiveness, increased value for all stakeholders (patients, staff, suppliers, and the community), better stability for the organization, protection of reputation, and increased board confidence.[7] However, the ability to implement an ERM program depends on information and support from accounting and finance functions to inform business planning and evaluate risks from operations and other areas.

In addition to an expanded view of risk, other essential notions under ERM are to recognize that relationships exist between risks (i.e., that they are interrelated) and that risks can be categorized into domains. Instead of dealing with risks separately or within the functional departments that comprise a healthcare organization, ERM seeks to manage a defined portfolio of risks across various domains. Under ERM, risk domains include the following:[8]

- **Operational risks** arise from the healthcare organization's core business: the delivery of healthcare services in all care settings.
- **Financial risks** are associated with an organization's ability to raise and maintain access to capital, contracting issues, cost of risk, and evaluation of supplier support. This domain includes risks eligible for risk financing techniques, such as insurance.
- **Human capital risks** include the organization's ability to recruit, manage, and retain human workforce. Workers' compensation, occupational hazards, turnover, workplace violence, harassment, and discrimination fall under this domain.
- **Strategic risks** are risks that have an impact on the growth of the organization and include mergers, acquisitions, joint ventures, and advertising liability. In addition, this domain includes reputational risk associated with community relations and performance expectations by patients and payers.
- **Legal and regulatory risks** are associated with numerous complex rules, regulations, statutes, and standards. In healthcare, these rules and standards are numerous and complicated. Examples include licensure, accreditation, and compliance with Medicare mandates.
- **Technological risks** include those associated with biomedical devices, telemedicine, electronic medicine, and information systems that support electronic health records.

ERM views risk as opportunity for gain

Where traditional risk management functions are organized mainly around the risk control activities of avoidance, control, and risk transfer through insurance and other means, ERM recognizes that risk is an asset and that risk-producing activities have the potential for gain as well as the potential for loss. This view embraces the relationship between risk and opportunity, such as that encountered when a healthcare organization establishes a new service, invests in new technologies, or acquires another company to expand its market share.

An example of this is the increase in for-profit hospital chains over the last decade and, with the Affordable Care Act, even more consolidation in the hospital industry. Millions more people with health insurance translates into the need to capitalize on size and ability to control expenses, improve bargaining power, and meet growing healthcare needs while remaining profitable.

The ERM process

Enterprise risk management begins with an assessment to identify the organization's risks. A risk assessment is generally conducted through the use of surveys, interviews, and observations to inventory and categorize risks by domain. For example, joint ventures would be categorized as strategic risks, and risk of employee injury or loss of key medical providers would fall under human capital risks.

Sedgwick healthcare risk management & patient safety consultants have a proven record of successful partnerships and collaboratives in conducting comprehensive risk assessments with prioritization and support for implementation of program improvements.

Identified risks are then analyzed and prioritized for action according to the level of impact they would have on the organization. Using one of the examples cited above, the risk

of a hospital's group of cardiac surgeons being recruited away to another facility would likely have a very negative effect on reputation and revenues and thus would receive a high ranking with regard to the severity of that risk. However, if the probability of the group leaving an established and profitable practice is low, the ultimate rank or "risk score" would be lower.

Risks can be prioritized through the use of a risk map or risk modeling software. These tools assign a score to risks by displaying the product of the risk's probability and severity. This aids in identifying those risks with the biggest impact on the organization. Risks that are likely to occur and are associated with the highest costs to the organization would be a high priority to prevent or control. Falls with fracture and certain medication errors could be considered priorities for prevention and mitigation activities.

Lower priority risks still require monitoring. If they have a relatively high probability of occurring, they are the most predictable risks and, thus, can be most adequately planned for. Lost patient belongings fall into this category. Unlikely risks that could threaten the operation of the hospital are typically transferred through the purchase of insurance whenever possible. For example, an explosion occurring in the hospital laboratory, causing severe injuries to staff and/or enough damage to require it to cease operating, would be such a risk.

Risk treatment options can be broadly categorized as risk control, risk financing strategies, or a combination of the two. Risk control involves loss prevention techniques aimed at reducing the frequency of occurrence and loss reduction techniques aimed at reducing the severity (cost) of losses when they occur. Implementing a barcoded medication administration system is a risk control strategy. Settling a patient's claim to avoid legal costs is a loss reduction strategy.

Risk financing options include funding losses through risk transfer (e.g., commercial insurance) or retention (e.g., self-insured trust funds, deductibles). Most healthcare risks are treated with a combination of risk control and risk financing techniques.

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RESOURCES FOR LEARNING ABOUT AND IMPLEMENTING ERM

By understanding and applying the principles of enterprise risk management, risk managers can help their organizations to more than just survive, but to thrive in the new world of healthcare. The resources below comprise a starter list for learning more about ERM and how to initiate this approach in a healthcare organization.

- American Health Lawyers Association
  - Wire K. Enterprise Risk Management for Healthcare: Where & How to Begin. 2011. www.healthlawyers.org.
  - Barton E. (ed) Risk Management Handbook for Healthcare Entities. 2012.
- American Society for Healthcare Risk Management | www.ashrm.org
  - A guide to starting a healthcare enterprise risk management program. Includes a self-assessment tool for risk management programs and functions.
  - Monograph: Value-Driven ERM: Making ERM and Engine for Simultaneous Value Creation and Value Protection.
- Risk Management Society www.rims.org
  - Strategic and Enterprise Risk Center: http://www.rims.org/resources/ERM/Pages/default.aspx.

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3. ECRI Institute. Enterprise Risk Management: An Overview. Healthcare Risk Control 2006 Risk Analysis Supplement A.
4. Committee of Sponsoring Organizations of the Treadway Commission. Enterprise risk management—integrated framework. 2004 Sep. http://www.coso.org/Publications/ERM/COSO_ERM_ExecutiveSummary.pdf.
5. Australian Standard 4630 Risk Management. http://www.riskmanagement.com.au/.
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Nurse staffing levels: Strategy and teamwork are keys to success

By Cynthia Hartsfield, BSN, RN, MA, CPHRM, JD

A recurring theme we hear from nurses around the country during our healthcare risk assessments is, "we are overworked," "it's chaos here," and "I never get a break." Is this perception or is it reality?

News reports suggest the problem is more than perception. A wrongful death suit filed by the husband of a nurse killed in a car accident while driving home after a 12-hour shift alleges that his wife and other nurses worked excessive overtime, never took their breaks and were literally "worked to death" because the hospital refused to staff adequately.[1] Another wrongful death suit was filed by the family of a diabetic patient who died in the hospital as a result of insulin overdose and failure to rescue. In her deposition, a nurse who cared for the patient complained about staffing levels stating that the nurses "were 99%of the time swamped and understaffed."[2]

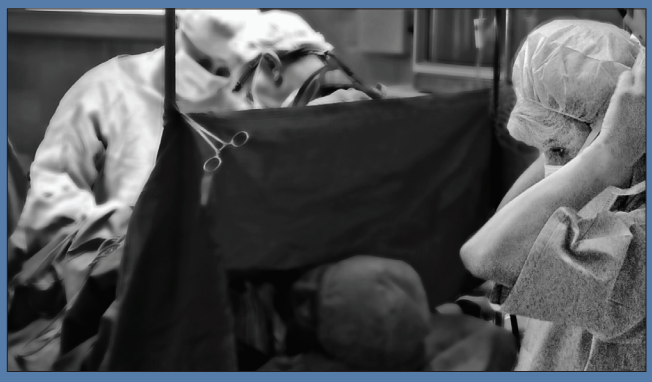
Whether perception or reality, it is important for risk and quality managers to be aware of concerns about staffing in order to support nurses and hospital management to develop solutions. Identifying and maintaining an appropriate number and mix of nursing staff is critical to the delivery of safe patient care. At the same time, massive reductions in nursing budgets have resulted in fewer nurses working longer hours caring for sicker patients.

Research suggests that improved nurse staffing has a beneficial effect on patient outcomes. Research also shows that the likelihood of patient mortality in the hospital following a complication associated with failure to rescue increases by 7% for each additional patient added to the average registered nurse workload.[3]

In a more recent study of 232,342 surgical patients in Pennsylvania, researchers found that 4,535 (2%) died within 30 days of discharge. The study suggests that the differences in nurse-to-patient staffing ratios (4:1 vs. 8:1) may have been a factor in patient deaths.[4]

What options are available to nurses who believe their assignment is unsafe? Some state boards of nursing have adopted rules of practice to protect nurses who object to an unsafe assignment. The Board of Nurse Examiners in Texas adopted Rule 217.20 Safe Harbor Peer Review and Whistleblower Protections to guide nurses when they believe an assignment is unsafe.[5] A request for Safe Harbor must be made in writing to the nurse's supervisor with details describing how the assignment is unsafe. Response from the supervisor is required and failure to acknowledge the request may result in disciplinary action by the board against the supervisor.

Legislation requiring adequate nurse staffing at state and



federal levels has been introduced. Fifteen states and the District of Columbia have enacted legislation and/ or adopted regulation to address nurse staffing.[6] The American Nurses Association advocates passage of House Bill 1821 or the Registered Nurse Safe Staffing Act introduced in April 2013. If passed, the bill will require Medicare-participating hospitals to establish unit-specific staffing plans utilizing a committee, comprised of at least 55% direct care nurses, and publicly report staffing plans.[7] It also provides whistleblower protections for nurses and others who file a complaint for inadequate staffing.

Hospitals and healthcare professional organizations have expressed concern about staffing. According to a report published by the American Hospital Association (AHA), "Workforce 2015: Strategy Trumps Shortage," hospitals face challenges in recruiting and retaining adequate numbers of qualified nursing and other staff into the next decade and possibly longer.[8] The AHA Long-Range Policy Committee developed recommendations and strategies for hospitals to implement in addressing staffing shortages that include:

- Hospital work redesign to maximize efficiency, effectiveness, and staff satisfaction;
- Retention of existing workers, some of whom are near retirement; and
- Attracting a new generation of workers to replace a large group of retiring workers.

Redesigned work models are most successful when developed by nursing staff at the bedside in collaboration with leadership, and consider patient care needs, staff skills, competencies, and hospital characteristics. In 2003, the Institute for Healthcare Improvement and the American Organization of Nurse Executives launched The Transforming Care at the Bedside Project (TCAB) funded by The Robert Wood Johnson Foundation in an effort to improve hospital patient care and work environment by empowering front-line nurses to implement innovative practices on their units.[9] Since that time, hospitals across the country and internationally are now

applying TCAB principles and processes in their work. A toolkit containing best practice policies to involve staff, generate ideas, and set goals to increase excellence of care and efficiency was created by 10 hospitals that participated in TCAB.[10]

The AHA report "Workforce 2015: Strategy Trumps Shortage" recommends hospitals help staff develop the skills necessary to work effectively in teams and encourages adoption of tools such as TeamSTEPPS® to improve communication and support redesigned healthcare teams to accomplish work in a more effective and efficient way.[11] TeamSTEPPS® is an evidence-based teamwork system to effectively improve communication and teamwork skills among healthcare professionals.

Sedgwick's healthcare risk management team provides TeamSTEPPS training for teams in hospitals, long-term care and outpatient facilities, and physician practices. Our consultants support long-term organizational rollouts through activities that include post-training telephonic coaching with Champion trainers, leadership training, and periodic webinars to address challenges, develop solutions and keep the momentum going, promote team engagement, and celebrate successes.

Whether perception or reality, hospital staffing concerns must be heard and resolved. Research demonstrates the strong correlation between lower nurse-to-patient ratios and improved patient and nurse satisfaction, better care outcomes, and error reduction. Healthcare leaders have an opportunity to collaborate with nurses at the bedside to create innovative strategies and develop solutions to build a safer environment for patients and nurses. Team training is a powerful strategy for improving efficiency, work workforce satisfaction, and patient outcomes.

Cynthia Hartsfield is a senior healthcare risk management consultant for Sedgwick.

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Perinatal falls: A tender time for prevention

By Ann Gaffey, RN, MSN, CPHRM, DFASHRM

Preventing patient falls is always a hot topic to discuss in healthcare, however these discussions generally focus on the elderly or confused patient, and rarely consider the broader patient population. Falls in the hospital are not isolated to the ill and infirmed, as many suspect. Indeed, each year between 700,000 and 1,000,000 people in the United States fall while in the hospital. That includes our healthiest patients – the ones coming in to give birth and the infants they deliver. They too are at risk for a fall that can be a significant harmful adverse event.

Less attention has been paid to falls suffered by women preparing to give birth, women who have delivered a baby, and newborn infants. Most are under the impression that falls involving these patients rarely happen, so why not focus our risk reduction efforts elsewhere? The same could be said for infant abduction, a low frequency occurrence, but what hospital would ever think of not having an infant safety and security plan and testing it over and over? In fact, while not to minimize abduction, according to the National Center for Missing and Exploited Children, there were only four documented abductions from healthcare facilities by non-family members in the United States in 2012 out of nearly 4 million births, or .01 abductions/10,000 births. When compared to newborn fall rates between 1.6 and 6.6 falls/10,000 births, the argument is more convincing that attention is needed in preventing patient falls in newborns and in obstetric units of hospitals.

How significant is the problem?

It seems logical that the majority of prenatal, postpartum, and newborn falls are preventable. There is a growing body of literature reporting the frequency of these events, a growing understanding of contributing factors, and more targeted interventions being developed to decrease and eliminate these falls, yet still there is no national benchmark for inpatient obstetric falls.

Taking a step back to the risk of falling during pregnancy, even before entering the hospital, Dunning et al. (2010) reported that 27% of women fell at least once during their pregnancy and, of those, well over a third fell two or more times. This compares to

a rate of 25% for a person 70 years or older. Falls are the most common cause of injury during pregnancy, and one of the top reasons for an emergency department visit by this group. Injuries range from minor ones such as sprains and strains, to much more severe injuries including rupture of internal organs, abruption placentae, rupture of the uterus and membranes, and in rare instances, death. Weiss et al. (2007) noted premature birth or low birth weight to be more likely in infants born to injured pregnant women. Women aged 20-24 had an almost two-fold risk of falling than those over 35 years of age, with the conclusion that younger patients are more active, thus more likely to fall. In considering the physics behind carrying a baby, increases in postural sway are seen during the second and third trimester, affecting a pregnant woman's balance and ability to catch herself when falling. The gestational month reported with the greatest number of falls was found to be in the seventh month of pregnancy, as reported by Dunning (2010).

Opportunities for patient education in fall prevention abound and include prenatal classes, during prenatal care in physician offices, and through public service announcements. Risk reduction interventions identified by Dunning, et al. (2010) included avoiding slippery floors, holding on to the railing when using stairs, and using caution when carrying children or performing any activity that obstructs their view of the floor or ground. By raising awareness of the potential risk of falling with patients even before entering the hospital in labor, physicians and nurses have a head start on fall prevention after admission.

Is there a need to worry? For those hospitals with an antepartum unit, the risk increases when the patient is placed on bed rest. On top of changes in balance, patients requiring bed rest during pregnancy can quickly become deconditioned. Studies have reported antepartum side effects of bed rest including loss of muscle strength and muscle atrophy, dizziness, headaches, and more. If these findings were noted during any non-obstetric patient's physical assessment in the hospital, they clearly would be identified as a high risk for falls. The risk of falling for antepartum patients is likely the same or greater, and continues after delivery. As reported by Brun, et al. (2012), during the first week post-partum, women who had been on complete or partial bed rest reported difficulty such as knees buckling, needing support to walk and sit, and difficulty using stairs.

The baby has arrived! Problem solved?

Both the U.S. Department of Health and Human Services Partnership for Patients (P4P) and the Joint Commission are targeting fall reduction as a major patient safety initiative in a National Patient Safety Goal. As previously mentioned, little effort has been made to address fall risk during labor and after delivery in the post-partum period for both moms and babies, and the common fall risk assessment tools are not always useful when assessing these typically healthy patients. For some P4P participating facilities, the problem grew to a noticeable level such that further evaluation and action needed to be taken. Indeed, one facility had a maternal post-partum fall rate of 16 falls/10,000 births, with another springing into action after experiencing more than 40 falls/10,000 births.

A team at Ronald Reagan UCLA Medical Center, responding to an increase in falls on their unit, undertook a quality improvement project to evaluate current evidence in the literature leading them to develop the Obstetric Fall Risk Assessment Score (OFRAS™) Tool. The developers sought to identify all the potential fall risk factors that might be encountered during a woman's obstetric hospitalization. The result was the OFRAS™ Tool that stratified risk across six categories: Prior History, Cardiovascular, Hemorrhage, Neurologic Function and Anesthesia, Motor/Activity, and Medication. Assessment of the patient within each of these categories results in a risk score and a subsequent designation of low, moderate, or high risk for falls. While some of the risk factors identified are common in general fall risk assessments, such as visual disturbance, hypotension, and history of a fall, other risks are more closely aligned with the obstetric patient, such as preeclampsia, epidural for pain control, post-partum hemorrhage, and sensory deficits related to pushing posture during the second stage of labor (Haefner, et al., 2013).

Certain medication can have a detrimental effect on a post-partum patient's ability to ambulate safely. Medications to manage blood pressure may cause hypotension or dizziness, pain medication may cause sedation or muscle relaxation, and medication for sleep can decrease balance. As reported in a recent study published by Kolla, et.al (2013) from the Mayo Clinic, the use of zoplidem, a sleep aid commonly prescribed and administered to post-partum patients, has been associated with a significantly greater fall rate – almost twice as high – as those hospital in-patients who did not take this hypnotic agent for sleep.

Consistently, in study after study, the event most commonly associated with a post-partum fall is a new mother's attempt at ambulating when she is not ready to do so safely. To assess risk, other leaders in this area have approached the problem by implementing egress testing to evaluate a new mother's ability to safety ambulate. Dionne's Egress test is a series of three tests completed at the patient's bedside prior to transferring them or allowing them to ambulate independently. It evaluates the patient's mobility to go from a sitting position to standing, march in place, and step forward and back. All three steps must be completed successfully to ambulate independently. In a study underway at Hartford Hospital (CT), staff has now hard-wired the Egress test into their patient assessment practices, and have significantly decreased falls to where the only ones occurring have been witnessed by staff with the patient lowered to the floor. A similar

strategy has also achieved success at Christiana Care Health (DE) who implemented the Egress test along with more frequent fall risk assessments and alternative nursing interventions, including the use of gait belts to assist patients while ambulating.

A newborn fall? But they can't even walk yet!

Reports in the literature have substantiated that newborn falls do occur, and may indeed be more frequent that what has been documented. Parents may be reluctant to report their newborn fell because they are ashamed or are fearful someone may take action against them for neglect, thus do not report the event. What has been seen as the most common scenario is that of a newborn falling out of the arms of a parent who fell asleep while holding them, more commonly occurring in the early morning hours. While some speculate adoption of the Baby Friendly initiative contributes to an increase in newborn falls – due to the fact the infant is always in the room and the new mother is more sleep deprived – data has yet been published to substantiate this hypothesis. Nonetheless, because of the more common finding of infants falling out of their parent's arms to the floor in the early morning hours, some hospitals are now increasing the frequency of their rounding during night and early morning hours from hourly to every 30 minutes.

In response to an increase in infant falls, Winthrop University Hospital (NY) instituted a Newborn Safety Partnering Agreement for Parents as an element of their infant fall prevention program. The agreement, along with the discussion with staff, raises parent awareness of the potential for falls and when and why they are more likely to occur. Implementation of the agreement was found to be most successful when it was initiated before delivery. Since implementation of this agreement, the unit has been successful in eliminating infant falls (Magri, et al., 2013). A similar initiative was undertaken at St. Francis Hospital (CT), where in addition to a Safety Pledge signed by the parents, they implemented hourly rounds, infant safety signage, promotion of maternal rest, and parent teaching (Galuska, 2011). They too have achieved success in eliminating infant falls through diligence, and staff and patient engagement.

While infants falling from a parent's arms seems to be the more common cause of falls, other contributing factors reported include falls from bassinets during transport, for example when wheels of the cart get caught in the gaps between the elevator and the floor when moving through the hospital, falls from scales when being weighed, and falls from swings or bouncy seats. By closely evaluating the events around the falls and other contributing factors, staff can generate fall prevention initiatives that address the primary factors affecting newborn falls on their unit. Equally important is establishing guidelines for evaluating an infant after an in-hospital fall. Injuries are reported to be more significant when the fall is from a distance greater than 4 feet (Duhaime, et al., 1992). At a minimum, as noted by Monson, et al. (2008), a post-fall evaluation for a newborn should include a physical exam, skull radiographs, and 24 hours of monitoring in the hospital.

Bringing it all together

There is clear evidence that attention must be paid to eliminating patient falls in the obstetric and newborn patient populations. Research findings by leaders who have recognized the importance of addressing this area of risk have demonstrated success in reducing falls with a variety of low-cost but high-return initiatives, including unique fall risk assessment tools, post-partum mobility assessments, and changes in patient rounding frequency. While not necessarily the highest risk on an organization's list, addressing this critical patient safety concern should be on the minds of all clinicians caring for this healthy, yet still vulnerable, patient population.

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SUCCESS STORY: The value of improvement collaboratives for patient safety and risk reduction

As Director of Risk Management and Education for the Michigan Professional Insurance Exchange (MPIE), Margaret Curtin, MPA, HCA, CPHRM, DFASHRM, has led multiple improvement collaboratives for MPIE-insured healthcare organizations focusing on the high-risk areas of emergency departments, perioperative services, and perinatal care. She has championed financial and educational support for projects aimed at making healthcare safer for patients and reducing the risks of liability for insured facilities and providers. Sedgwick healthcare risk management and patient safety (HCRM) has been a partner with MPIE in these collaboratives, conducting risk assessments and providing benchmark data, tools, and solutions for identified risks. Margaret recently shared her experience and insights with Kathy Shostek, Sedgwick Senior HCRM Consultant, on the value of improvement collaboratives for patient safety and risk reduction.

Kathy: How do you (MPIE) secure executive commitment (and funding) for participation in improvement collaboratives by insureds?

Margaret: Expectations are set in incentives. It is an expectation of our insured physicians to participate in loss reduction activities if they want to earn a premium discount. We have the same incentive type program for our hospitals – both are tied to their premium charge.

MPIE is composed of physician and hospital owners (we are not a stock company), so each insured has a personal stake in the wellbeing of their insurance company. The philosophy of this company is built on personal responsibility to learn and do all that we can to provide the best care and control your loss potential. Based on this philosophy, financial support for our risk management program is always highly supported.

Kathy: Margaret, what drives your focus on these particular clinical areas (ED, OR, OB)?

Margaret: Both claim trend analysis and interviews with insured risk managers point to these three areas as tops for claim loss and patient safety risk. But they are also key business lines for hospitals. The emergency department is often the patient's first exposure to and impression of the hospital. The operating room is usually one of, if not the highest revenue center for the hospital. Obstetrics provides a community tie to families – "Come here to have your baby and become a patient of this hospital for life..."

Kathy: How has your background in healthcare risk management and patient safety enabled you to facilitate engagement in these improvement collaboratives?

Margaret: My early background is set in social science and anthropology and, believe it or not, learning about cultures and society has had a significant advantage for me in understanding healthcare as a subset of our society – the hierarchy, the gender mixes, high stakes/high stress environment. This has enabled me to better understand the complexity and imperatives around patient safety. I think I do a pretty good job at helping our executives and providers see the best and worst alternatives of engagement from a personal, "what's in it for me" perspective that can be very persuasive. Also, my many years of being in the business has brought experience and personal confidence that go a long way in helping people trust your wisdom.

Kathy: Do you see yourself as a change agent, providing support for leaders and clinicians in insured organizations in understanding needed changes, reasons for change, and the change process?

Margaret: Yes – absolutely! Every risk manager better see themselves as a change agent if we are going to be successful in making healthcare safer for our loved ones, friends, community, colleagues, and ourselves.

Kathy: Has the use of expert consultants helped you/your insureds to design safer clinical systems, processes, policies, and procedures?

Margaret: Absolutely. As a solo risk manager in my company I am responsible for on-the-ground risk management service support as well as the larger initiatives around safety and loss control. While this is a definite advantage for a small company, to be successful and remain cutting edge you have to seek out

partners that you can be absolutely sure will deliver the high-quality services your insureds deserve. Sedgwick has delivered such services time and again for MPIE.

Kathy: What results from the collaboratives can you share in terms of risk exposures, incidents, and/or claims experience?

Margaret: Our first OB initiative was on reduction of shoulder dystocia claims. We did simulation and team training. This collaborative is still remembered today and it was five years and four collaboratives ago! As a result of that collaborative, our shoulder dystocia claims dropped to zero in the first year and have remained low since. Giving the OB teams an ability to practice drills and create a symmetrical process for handling such a low frequency but high risk event resulted in better team management and improved outcomes for patients. Where we did have a claim, we had fortified the documentation of the areas often found lacking to improve defensibility.

Kathy: What are the benefits of participating in patient safety and risk management improvement collaboratives for MPIE insureds?

Margaret: They have gained much teamwork and collaborative learning resulting in sharing best practices and connections between facilities at both the staff and risk manager level – we have become a community around the safety work – not just hospital A or hospital B.

Individuals and teams have also expanded their professional body of knowledge through participation. This was most evident to me in the OR collaborative. It was really amazing having perioperative experts and past presidents of AORN speaking to the OR directors, promoting their involvement to ensure they can provide the best care within their scope.

Kathy: With the continued shift to wellness and outpatient care, how important will it be to focus on patient safety and risk management in ambulatory care/physician practices?

Margaret: We are crafting a risk collaborative for 2014 with Sedgwick right now. This one is focused on large multidisciplinary subsidiaries of larger hospital systems. The project will look at risk and safety in the ambulatory setting, how that structure is most successful, and how that would best tie into the structure of the hospital/system level risk structure. They are very different but have synergies that must be identified and capitalized on in our new age of ACOs.

Kathy: What professional and personal growth have you experienced in your tenure at MPIE?

Margaret: I have gained the independence to be able to identify and follow an initiative from start to finish and see that your knowledge has improved patient safety and reduced the loss potential of your clients. That is by far the best experience since working here at MPIE.

Kathy: You have served as a role model and mentor for the risk management and patient safety professionals in MPIE-insured organizations. What advice for the future would you give to this dedicated group of practitioners?

Margaret: I would tell them not to get discouraged when they see or hear the same or similar event happening over and over. As hard as that is, we have to remind ourselves that turnover in healthcare happens at such a rapid rate that nearly every 6 months we have a whole new group of providers to train and teach and mentor. The goal for us, regardless of how long we have been in risk management, is to teach lessons and lead improvement strategies that will be sustainable and repeatable. Communicating successes lends support and fosters engagement – and that is best done through storytelling.

Also, our accomplishments in the field of risk management are not achieved alone. They come through mentorship and networking at local, state, and national levels and through professional societies like the American Society for Healthcare Risk Management (ASHRM). It falls to us to bring up new talent and being willing to teach and guide them in advancing safe and trusted healthcare and in maximizing their organization's value by managing risk.

Margaret Curtin – Director, Risk Management and Education at Michigan Professional Insurance Exchange talks about the partnership between MPIE and Sedgwick.

Click here to watch the video interview with Margaret at the 2013 ASHRM Annual Conference: http://youtu.be/GmB7zxQo3zg.

TeamSTEPPS®: Helping healthcare organizations enhance safety

TeamSTEPPS, or Team Strategies and Tools to Enhance Performance and Patient Safety, is an evidence-based framework developed by the Department of Defense's Patient Safety Program in collaboration with the Agency for Healthcare Research and Quality (AHRQ). The system was built on 20 years of research and lessons on teamwork application from different industries.

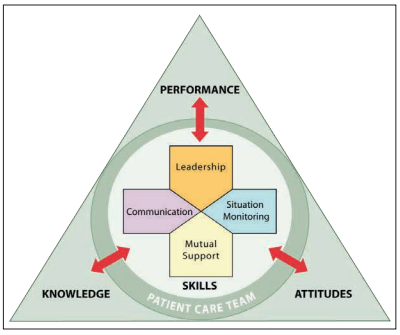
TeamSTEPPS training includes the materials and curriculum to successfully integrate teamwork in all areas of the healthcare system. It is designed to teach doctors, nurses, and all staff members who come in contact with patients how open communication and mutual trust can result in safer, higher quality patient care.

At Sedgwick, we are proud to have a team of eight nationally known physicians and nurses who are Master TeamSTEPPS Trainers. Our experts assist with all phases of training for our healthcare clients.

The key strategies in the program aim to remove possible barriers such as the hierarchy between doctors and nurses, and empower all caregivers to speak up and influence actions to facilitate safety. The results include teachable skills, such as improved leadership, improved efficiency, and stronger team collaboration. In turn, it changes attitudes toward sharing knowledge and gaining trust, resulting in improved patient care.

Our training and support – putting the spotlight on reducing risk

TeamSTEPPS is a powerful solution that includes strategies for enhancing teamwork, reducing medical errors, and building a culture of safety. Safer care means less risk to patients, and reduced liability for medical providers and facilities.



TeamSTEPPS training includes leadership, communication, situation monitoring, and mutual support. Competency in these core skills can enhance outcomes related to performance, knowledge and attitudes.

The system is designed to:

- Produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes for patients
- Increase awareness, and clarify roles and responsibilities
- Resolve conflicts, enhance working relationships, and improve information sharing
- Eliminate barriers to quality and safety

Sedgwick's team provides TeamSTEPPS training for large groups and small teams in hospitals, long-term care and outpatient facilities, and physician practices; and has trained over 2,500 healthcare professionals in the past 18 months. Our consultants have also supported long-term organizational rollouts and implementations for single hospitals and large healthcare systems.

The Sedgwick TeamSTEPPS training program includes:

- Pre-training phase
  - Pre-assessment readiness
  - Guidance in implementation planning
- Training phase
  - Two-day Champion training (attendees become certified as Master Trainers)
  - Four-hour fundamentals courses
- Post-training phase
  - Implementation support
  - Tools, tips, and resources to encourage success
  - Coaching calls and webinars

During our training sessions, the groups participating learn effective communication techniques and strategies, such as the importance of briefings, huddles, debriefs, feedback, the "two challenge" rule, and how to help people use the language the same way.

Continued on page 12

Raising safety awareness

St. Joseph and Redwood Memorial Hospitals in Humboldt County, CA recently recognized several hundred of their medical and clinical staff members who have completed TeamSTEPPS training. "Our front-line staff's awareness of Hospital Acquired Conditions is now at a level never before realized in our organization in my 21 years as a staff physician and physician leader," said Dr. Matthew Miller, Chief Medical Officer and Patient Safety Officer for the two hospitals.

Our goal is to ensure the strategies are hard-wired and safety is top-of-mind for all staff members. We strive to integrate core values to ensure long-term success. For many, the TeamSTEPPS training is literally a personal and professional life-changing experience.

Contact Sedgwick today to learn more about TeamSTEPPS and our unique training services.

866-225-9951
HealthcareRM@sedgwick.com
www.sedgwick.com

Upcoming events

Visit the Sedgwick professional liability and healthcare risk management team at these upcoming conferences:

- **Southern California Society for Healthcare Risk Management (SCAHRM) – February Webinar – *register at www.scahrm.org***
  February 18 | 12:00 – 1:00 pm (PST)
  Outsourcing and Telemedicine Risks and Rewards – Ann Gaffey, Kathleen Shostek, and Jayme Vaccaro
- **California Association for Healthcare Quality – February Webinar – *register at www.cahq.org/taking-patient-safety-to-the-next-level***
  February 20 | 11:30 am – 1:00 pm (PST)
  TeamSTEPPS®: Taking Patient Safety to the Next Level – Kathleen Shostek
- **California Society for Healthcare Risk Management (CSHRM) Annual Conference**
  February 26–28 | Napa, CA
  – *Culture Change with TeamSTEPPS®: Leading from the C-Suite – Ann Gaffey*
  – *Outsourcing and Telehealth: Risks and Rewards – Ann Gaffey and Jayme Vaccaro*
- **Crittenden Medical Insurance Conference**
  March 30–April 1 | San Diego, CA
  Hospital-Physician Integration: Steps for Successful Collaboration (Panel) – Cynthia Hartsfield and Ann Gaffey
- **Professional Liability Underwriting Society (PLUS) Medical PL Symposium**
  April 23 | Atlanta, GA
  Tackling the Top Claims Trends (Panel Moderator) – Jayme Vaccaro
- **SCAHRM Annual Educational Conference**
  May 7–9 | Rancho Mirage, CA
  Driving Down Claims: Tackling the Top Ten – Ann Gaffey and Jayme Vaccaro

About Sedgwick

Sedgwick is the nation's leading provider of technology-enabled claims and productivity management services. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

Are you concerned about a lack of teamwork in your perioperative area affecting patient care, possibly leading to retained foreign objects or wrong-site surgery? Our demonstrated success in reducing perioperative risk through assessments, team training, coaching, and ongoing education may be the solution for you. Please contact us today for a customized approach to your perioperative risk management and patient safety challenges.

Download a QR code reader from your mobile device's app store, then scan the code to the left to visit our **professional liability** page at www.sedgwick.com.

Or scan the QR code to the left to visit our **healthcare patient safety** page at www.sedgwick.com and learn more about our services and solutions.

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