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Enterprise risk management: Breaking down barriers for real-life application

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Healthcare risk managers have the opportunity to engage leaders from across their organizations to think more broadly about maximizing value protection and managing risk that comes with uncertainty through the application of an enterprise risk management (ERM) framework. While the implementation of an ERM program might seem daunting to some, moving from a traditional risk management framework to an ERM framework may seem more achievable by using real life risk scenarios to engage leadership. By demonstrating the myriad risks one event can present across the organization and placing those risks into a domain context that addresses the issues, a "bigger picture" evolves. Risk managers can be leaders in the ERM journey by guiding stakeholders to move out of silos for problem solving and into an organization wide, collaborative decision making process.

All entities face uncertainty. With uncertainty comes risk as well as the opportunity to create value by taking advantage of the synergies between all of the risk domains in an organization. To do so, risk managers must guide leadership to identify risk domains appropriate for the organization. The American Society for Healthcare Risk Management (ASHRM) has identified the most common risk domains used by risk management professionals in healthcare.[1] The domains identified by ASHRM are:

- Operational
- Clinical/Patient Safety
- Strategic
- Financial
- Human Capital
- Legal/Regulatory
- Technology
- Hazard

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Implementing a comprehensive ERM program may take years. Each organization must develop its own timeline and plan, recognizing changes may be necessary to move toward a more risk-aware culture. Defining a risk appetite, articulating strategy and objectives, and conducting a risk inventory are some of the steps that will be taken along the way. As this work is started, demonstrating how a realistic risk event may impact the organization across domains is one strategy for introducing ERM concepts to leadership and key stakeholders.

Significant acts of workplace violence have been occurring with increasing frequency around the country. Using an example such as a hospital shooting directed at a staff member or physician, one can work through the domains to explore where risks to the organization may exist and highlight the value of an ERM analysis.

Using the ASHRM risk domains, the following examples help illustrate how an active shooting event has the potential to impact the entire organization. The possible risks identified in each domain will require leaders from across the organization to collaborate and develop solutions.

- **Operational risks** – When an active shooting occurs, access to and egress from the hospital will likely be shut down. Communication pathways to employees and physicians should be previously established, and the message delivered will need to be clear, concise and timely. If staff members are unable to enter the hospital at shift change because the shooter hasn't been located, how will they be contacted? There should also be an established process for communicating with patients who may not be able to arrive for scheduled surgeries or other procedures. Other operational functions may also be interrupted, such as deliveries, parking and ambulance access.

- **Clinical risks** – These fall under one of two domains where there is a high risk of physical harm. Clinical risks may include the inability to care for an injured patient because staff members are injured or cannot access the hospital room, specific equipment or medication because the shooter's location is unknown. Other clinical risks can include issues such as the general fear and anxiety from patients or staff being pulled to answer calls from family members.

- **Financial risks** – Several potential causes of financial risks include possible litigation related to patient injuries or workers' compensation claims filed by staff members with physical or emotional injuries. In addition, there is a risk of lost revenue due to patients not being able to come in for surgeries and other treatment, or from the downstream effect of reduced patient volume resulting from decreased consumer confidence in the facility. Among the risks to consider, there may also be the potential for a ransom demand if the shooter takes hostages.

- **Human capital risks** – These risks are critical when considering the human capital needs in any healthcare facility. There is the potential for loss of life, short- and long-term disability, loss of confidence in leadership if emergency preparedness appears weak, and difficulty with recruitment and retention efforts due to the poor reputation for workplace safety.

- **Strategic risks** – This type of event is sure to be reported in the news and can have a significant effect on the reputation of the hospital, depending on the outcome and the facility's response. Loss of reputation, particularly in a competitive market, could be quite detrimental to the organization. Other risks may include inexperienced or unprepared media relations staff, the inability to manage the press that could descend on the facility and failure to respond to known threats in the community.

- **Technology risks** – These risks could come in various forms such as those involving social media. There is the potential for patients or visitors to tweet from inside their rooms, post videos on YouTube and more. Additionally, failure to use equipment such as security monitors and alarms may be raised as an issue during the debriefing.

- **Legal and regulatory risks** – After an event like this, regulatory agencies and accrediting organizations will likely appear quickly, and the hospital should be prepared to address both preparedness for and response to the event. These issues could further feed into loss of accreditation, loss of revenue and public reporting of facility deficiencies.

- **Hazard risks** – This domain gets to the core of preparedness for this type of event – from a community assessment of risk to development and testing of a response plan.

While not all-inclusive, the more expansive view outlined above highlights the importance of proactively developing risk responses across the enterprise. It is important to understand that input from each stakeholder – whether the contribution is major or minor – will help position the risk manager to elicit buy-in for the ERM process. Even if the organization is not ready to take a deep dive into the ERM pool, risk managers can still capitalize on the opportunity to bring a wide range of stakeholders into the decision-making process. By continually demonstrating the value of this work, healthcare risk managers can help organizations transition to this new ERM model.

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ENGAGING PHYSICIANS IN QUALITY AND SAFETY INITIATIVES

By John Webster M.D., MBA, MSEL, Sedgwick physician consultant

As healthcare delivery in the U.S. undergoes profound change from volume-based to value-based, patient-centered and more transparent care, there is increasing emphasis on quality and safety. In moving toward a culture of safety, leaders and policy makers have experienced both frustration and success while engaging physicians in this necessary transformation. The purpose of this article is to offer insights and potential success factors for healthcare leaders, risk managers, patient safety professionals and others who want to engage physicians in quality and safety initiatives.

Physician knowledge gaps

Many physicians tend to overemphasize the potential negative effects of change and are skeptical of the motivations for system changes. In addition, medical school and residency may not adequately prepare physicians for important aspects of healthcare delivery, such as systems thinking, the science of quality and patient safety, leadership and followership, teamwork science, non-technical skills and even key elements of professionalism. These knowledge gaps offer cognitive and experiential pathways to improving patient care quality and safety awareness through dialogue, presentations, reviews of root causes and near-misses, educational programs, coaching and mentoring. It is interesting to explore the drivers of physician perception and behavior change, particularly to assess whether they are focused more on "stories" or more on the data. Most physicians state that "it is all about the data," but on deeper analysis, there is great power in stories. For stories to be effective for individual change, they must be real (not contrived), believable, relevant to a physician's practice and encourage tenable solutions that may have prevented unfortunate outcomes. When physicians deeply understand that a story-based adverse event could have happened in their practice, there is often an openness to change.

The importance of physician values and change

Engaging physicians in organizational and personal change requires an understanding of their values and closely held beliefs. It is fair to state that many physicians emphasize efficiency, autonomy in practice and decision making, pride and excellence in individual clinical skills and knowledge, and concern for patient outcome. On the other hand, they are annoyed and resentful of (perceived) interference, inefficiency and bureaucracy, and "cookbook" approaches in medicine. There is an increasing paranoia about imposed changes, regulator interference, destruction of the doctor-patient relationship, and questionable motivations driving many quality and safety initiatives. However, just as with other complex negotiations, this analysis opens the door to necessary collaboration among nurses, physicians, administrators, patient safety professionals and patient advocates.

Safety culture:

What are the main DIMENSIONS of safety culture?[2]

1. Leadership commitment to safety
2. Open communication founded on trust
3. Organizational learning
4. A non-punitive approach to adverse event reporting and analysis
5. Teamwork
6. Shared belief in the importance of safety

Physicians need to have a clear, simplified understanding of a safety culture in healthcare. An excellent summary of the dimensions of safety culture was set forth by Halligan and Zecevic.[2] This starts with the premise that it is not possible to have quality care without safe care. Thus, one pathway to engagement has been to personalize "the case" for patient safety, and translate the principles of behaviors that physicians can use to improve their patients' outcomes and avoid errors that might tarnish their pride and reputation. Among these principles are educating physicians to be better team leaders, creating and executing clinical plans, and improving communication with colleagues, nurses, patients, their families and technicians.

Effective teamwork skills and behaviors can be taught using simulation, during day-to-day care delivery with coaching, and in educational environments using practice and feedback. Since many physicians are skeptical about "training," and in spite of the strong engagement potential, it has been difficult to get physicians to come to workshops and training programs such as TeamSTEPPS®.

One of the most helpful approaches includes recruiting and creating physician champions who are clinically respected and influential, and can make the case to colleagues that enhanced teamwork will improve clinical outcomes, decrease preventable harm, increase satisfaction and create better days at work. These champions can answer the ever-present question, "what's in it for me?" When these answers align with physician values and strongly held beliefs, the early adopters can rapidly engage in patient safety culture and change initiatives. Many health systems are incentivizing physicians to attend these important learning activities and to participate in efforts to improve care with payment for time away from their practices. When training is respectful of adult learning principles, and there is a continued emphasis on shared values with goals to improve clinical outcomes, decrease harm, improve efficiency (if true) and reduce frustration, engagement and participation occur.

Successful approaches

A thoughtful hospital leadership team used a creative and effective approach to maximize physician participation in the TeamSTEPPS workshops. They announced that a full page advertisement was going to be published in the local paper in six months describing the benefits of effective teamwork for patients and the community. The planned ad would also list the names of all the physicians who attended the training and were committed to using evidence-based communication skills. The physician participation rate was outstanding!

The following items top the list of the potentially effective strategies to engage physicians in patient safety initiatives:

- Customize the message(s); segment the types of physicians you wish to include and don't expect that one size fits all
- Engage them early and often
  - Over-communicate for clarity and consistency of vision
  - Identify and develop effective clinical champions
  - Be sure to let them know *how* they can be successful
- Consider formal leadership training for key physicians before they assume leadership responsibilities; leadership academies are powerful pathways to success
- Make sure engagement methods are respectful of physicians' time constraints, and that workshops and educational approaches respect the principles of adult learning
  - Teamwork training (e.g. TeamSTEPPS) should be incentivized so physicians can fill known knowledge and skill gaps
  - Offer psychological safety to all participants, but encourage practice of skills and effective feedback in real time
- Use physician-nurse partnership teams at the unit level for quality and safety initiatives to enhance implementation and to assure sustainment; partnership teams should review data, support continuous improvement actions, provide peer coaching and demonstrate effective clinical leadership
- Frame the initiatives and engagement efforts relative to values and beliefs of physicians including efficiency, enhanced clinical outcomes, reduced patient harm, reduced work frustrations, professional reputation and personal accountability
- Draw on physicians' natural competitiveness as a motivator in data analysis, clinical leadership, public reputation and patient outcomes
- Consider that carrots and sticks may motivate physicians when properly used and customized
  - Carrots include improved communication and teamwork, appropriate incentives and the benefits in patient outcomes as described above
  - Sticks may include bylaw changes that mandate teamwork and patient safety training for initial or renewal of practice privileges, fines similar to those imposed for delayed chart management, and posting of transparent data about compliance and outcomes
  - Set expectations and consistently hold professionals accountable for behaviors and actions; include an effective professional behavior policy
- Emphasize the opportunity for front-line physicians to develop and refine effective clinical leadership, teamwork and communication skills that improve patient outcomes
- Often, having a respected physician or nurse colleague simply ask them to participate is effective; this presumes a respectful relationship exists based on trust
  - Make clear exactly what is being requested
  - Remember the "what's in it for me?" aspect must be part of the expectation

As our healthcare system continues to experience unprecedented change to improve population health and maximize limited resources, the engagement of physicians as leaders in quality and safety is imperative. With pressure to decrease cost, increase efficiency and demonstrate value in the care provided across the continuum of health delivery systems, physicians are critical team members that must be engaged to achieve new levels of success in quality and safety.

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Retail clinics at big-box stores: Risks and strategies for mitigation

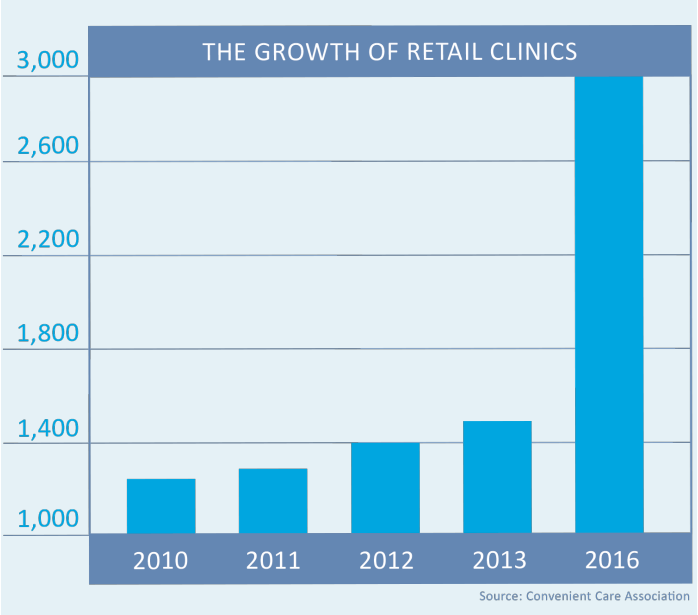
By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS, Vice President, Healthcare Risk Management

The "one stop shop" of convenience care offered by walk-in retail medical clinics has become popular with consumers and health insurers alike. This new model of care has been embraced by discount superstores like Walmart and Target, also known as big-box stores, and chain pharmacies such as CVS. While big-box retailers own and operate the majority of retail clinics nationwide, hospitals and health networks increasingly operate them, too, and some are operated jointly between retailers and traditional healthcare providers.[1] Healthcare risk managers need to keep abreast of new delivery models like convenience care, be prepared to manage the risks and potential liabilities they present, and also be able to support the community service and business opportunities they offer.

Background

Convenient care began as an industry in 2000 with the opening of the first walk-in clinics in Minneapolis-St. Paul. Since then, several companies formed through acquisition of these and similar clinics by retailers and healthcare organizations. While initially the clinics accepted only cash for very basic health services, most now have contracts with health insurers and/or employers.

The Convenience Care Association (CCA) uses the term "convenience care clinics" and notes that its membership includes more than 1,900 clinics throughout the U.S. According to CCA, its members' clinics are located in convenient locations such as drugstores, food stores and other retail settings...making it easier and more convenient for patients to get the right level of care, in the right place, at the right time.[2] According to critics of this care model however, this amounts to "commercialized" healthcare provided by for-profits as a marketing strategy for their other high-margin products.[3] Some state legislators have enacted or proposed regulations to increase control over retail clinic operations. While there may be regulations promulgated that could reduce the number of new retail clinics, there is no evidence that this sector is shrinking; rather, it is projected to grow exponentially. For a summary of state legislation and laws for retail clinics, see the National Conference of State Legislatures website http://www.ncsl.org/.



What are convenient care (aka walk-in) clinics and what are the risks?

The most common conditions treated at walk-in retail clinics are low-acuity problems like cold symptoms and flu, sinus infections, minor injuries (cuts and sprains) and illnesses (strep throat, allergies, poison ivy, etc.). Health services typically include immunizations, sports and driver physicals, health screenings, laboratory testing and blood pressure monitoring. However, some big-box retailers' clinics are moving into more chronic care management[4] – a concern for primary care providers who cite the

potential for ineffective communication and care coordination issues that arise among multiple care providers. For example, in a March 2014 policy statement, The American Academy of Pediatrics noted that they view "retail-based clinics as an inappropriate source of primary care for pediatric patients, as they fragment medical care and are detrimental to the medical home concept of longitudinal and coordinated care."[5]

Most retail clinics are staffed by nurse practitioners or physician assistants. Risk managers whose organizations provide retail clinics should ensure that the mid-level providers' scope of practice, which is governed by state regulations, fits the range of services provided by the clinic and that careful due diligence is carried out for provider credentialing/re-credentialing and/or employment contracting.[6] If the clinics are providing primary care or chronic care management, it is especially important that risk, quality and safety monitoring encompass the effectiveness of care coordination and communication among providers, along with standard monitoring, evaluation and improvement processes.

Liability risks and mitigation strategies

Top liability risks for retail walk-in clinics include:

- Failure or delay in diagnosis, or misdiagnosis
- Communication, care management/coordination of care
- General liability (e.g. retail traffic hazards, falls, equipment-related issues)

Strategies to mitigate these risks and reap the benefits of a retail walk-in clinic as a service to the community and a new business opportunity for the healthcare enterprise include the following:

- As noted above, careful provider selection, credentialing and monitoring of clinical practice to avoid errors in diagnosis are key loss prevention strategies; use of clinical decision-making systems and algorithmic software may also assist with prevention of diagnostic errors

- Use of electronic health records and information systems is a must, not only for billing and payment, but for communicating with primary care providers, reporting laboratory and other diagnostic tests and referrals, and coordinating patient care and follow up; failure to track and follow up on diagnostic tests are major contributors to liability in any ambulatory setting

- Standard loss prevention strategies for any walk-in clinic should include assessing the physical environment, implementing infection prevention and emergency response plans, and developing general safety procedures to avoid injuries from falls or equipment

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CASE STUDY: STROKE IN THE EMERGENCY DEPARTMENT – AN INDECISIVE JURY AND AN ATYPICAL PATIENT

Jayme T. Vaccaro, Vice President, Specialty Claims Operations

Background on emergency department (ED) strokes

As we see in real-life cases, and studies on professional liability claims in emergency medicine confirm, the top five conditions in terms of frequency and severity of claims related to treatment in the ED are:

1. Myocardial infarction (MI)
2. Infections
3. Lacerations and fractures
4. Airway/breathing complications
5. Brain/strokes[1]

> *Stroke is a top condition for claims in terms of injury and damages in ED professional liability cases.*

Some of the most severe injuries in these claims occur in the stroke category and involve atypical patients or presentations. For example, the patient's age can be an atypical factor. Clinicians don't generally expect to see a person near the age of 40 with a stroke or MI. A theme that

arises in atypical presentations is the fundamentals of what was diagnosed may not add up. Some providers will defend their diagnosis in an atypical presentation by claiming the very fact that it is atypical relieves them of "getting it right." In retrospect, had the provider taken a step back and rethought their conclusions, they may have continued their evaluation and made the correct diagnosis. Conferring with other providers when certain elements of the diagnosis don't quite fit can also prove to be the best course.

EDs throughout the U.S. are seeing more claims involving the failure to timely diagnose and treat stroke.[2] Atypical presentations as well as patient expectations for using technology, testing or treatments like tissue plasminogen activator (tPA) that break up blood clots come into play. This case study is an example of the challenges of stroke care in the ED setting.

Case facts

A 39-year-old woman was seen in an ED for dizziness, pressure behind her left eye, double vision, nausea and headache. Her symptoms began approximately 90 minutes prior to arriving at the ED. The ED physician examined the patient, ordered laboratory studies, a lumbar puncture (bloody tap) and a CT scan (which showed old ischemia). All findings were considered normal by the ED physician. Given that the patient reported a history of migraine headaches (ten years prior) and her symptoms resolved except for the headache, she was diagnosed with a migraine headache and discharged six hours after arrival. An outpatient MRI was recommended.

The next morning, the patient's family found her in a "comatose" state. When she was returned to the ED, a stroke was diagnosed and her permanent condition included the inability to speak, walk or see.

The family sued the physician and the ED group for medical malpractice, arguing that her symptoms on the first ED visit warranted an MRI. Plaintiffs argued an MRI could have led to the administration of tPA and she could have potentially avoided the stroke.

tPA is the use of thrombolytics for acute ischemic stroke. However, administration of tPA increases the risk of intracranial hemorrhage. Administering it beyond the appropriate treatment window can also put the patient at risk. Ironically, in professional liability claims, plaintiff cases are brought for both reasons: not administering tPA timely and administering it timely but with the hemorrhage complication.[3]

This case was tried in front of a jury. The defense argued that the tests ordered (labs, CT, lumbar puncture) were done timely and the three-hour window of time for effective tPA use elapsed. The defendants also argued that the episode prompting the first ED visit was a transient ischemic event, not an acute ischemic stroke, and tPA was therefore not indicated.

At the time this case was tried, studies were being published regarding a longer, 4½-hour window of opportunity for tPA.[4] Given that the labs, CT and lumbar puncture were completed within this timeframe, the plaintiff argued that tPA should have been administered. The defense argued that even if the standard of care was changing, the jury must not apply the new standard retrospectively. There was also growing public awareness that tPA was a lifesaving treatment to prevent stroke.

Jury trial outcome

The jury was hung after three days of deliberation and could not reach a decision. The parties chose to settle the case rather than retry it. The jury struggled with the sympathy of this young woman's injuries, the timing of tPA, the changing standard of care regarding the window of opportunity to administer it and the atypical presentation leading to a diagnosis of a migraine headache when the patient had not had one in ten years.

Conclusion

Stroke is a top condition for claims in terms of injury and damages in ED professional liability cases. The atypical presentation and the ever-evolving standard of care created challenges for a stroke diagnosis in this case study. While the jury got hung up, ED providers need not if their minds remain open and their evaluation practices stay disciplined when treating younger patients or using evolving treatments like tPA.

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IMPROVING HAND-OFF COMMUNICATION IN STROKE CARE

By Claranne Mathiesen, MSN, RN, CNRN, SCRN
Sedgwick HCRM Nurse Consultant

Handoffs occur frequently in the management of acute stroke emergencies as patients are received quickly from the pre-hospital setting, begin care in the emergency department, and are then transferred to an endovascular suite and transitioned to a critical care setting. There are multiple handoffs in a very short time span, making it essential for hospital staff training to include effective hand-off procedures. Multiple sources have noted that communication breakdowns can be implicated in all types of sentinel events, are cited as a factor in clinical errors and contribute to clinical morbidity and mortality.[1]

> *Standardizing the hand-off process using both verbal and written communication tools can optimize care transitions and reduce communication breakdowns.*

Across the U.S., hospitals are implementing structured hand-off protocols and many include the use of mnemonics. Much of this effort follows the 2006 Joint Commission National Patient Safety Goal on hand-off communication. Mnemonics are commonly used to enhance memory of pertinent patient information and provide a structured process to follow. Standardizing the hand-off process using both verbal and written communication tools can optimize care transitions and reduce communication breakdowns. Here are four widely used hand-off communication systems:

- I PASS the BATON (Introduction, Patient, Assessment, Situation, Safety concerns, Background, Actions, Timing, Ownership, Next)
- SBAR (Situation, Background, Assessment, Recommendation)
- Five Ps (Patient, Plan, Purpose, Problem, Precautions, Physician)
- PACE (Patient/Problem, Assessment/Actions, Continuing treatment/changes, Evaluation)[3]

For effective handoffs, be concise and include essential information, be prepared to give a report and use the report to ask questions.[2]

In the Systematic Review of Handoff Mnemonics Literature[2], Riesenberg et al further summarized several effective standardization strategies that include establishing a defined process, formalizing transmission of information and evaluating the experience. Important aspects to consider when setting up the handoff include developing a consistent process, scripting communication with the use of a mnemonic, encouraging staff to ask clarifying questions and verifying that the information is complete. During face-to-face communication, use interactive questions to highlight clinical content, utilize walking rounds to check the environment and complete bedside neurological assessments at staff change. Whenever possible, include the patient and their family in the process, and use this time to discuss the plan of care. Routine validation of the hand-off process will provide an opportunity to monitor and evaluate the report content, offer direct feedback and focus attention on any system problems.

In the clinical setting, members of the professional care team are practicing in a fast-paced, dynamic environment that is prone to interruptions. This can lead to handoffs that lack complete clinical information. Tracing the path of the stroke patient in the first 24 hours of care illustrates how many handoffs occur, underscoring the need to have effective tools to capture and communicate information.

To improve handoffs during stroke care, it is important to begin with prehospital providers to standardize the radio report on stroke patients. This report should include:

- Last known well time
- Focused neurological findings using a prehospital stroke scale
- Vital signs and any pertinent medical history

The handoff between the emergency department physician and consultant neurologist should include:

- Time of onset
- Focused neurological findings using common severity scales such as the National Institutes of Health Stroke Scale (NIHSS), ICH score, and Hunt/Hess score and any pertinent medical history.

The handoff between the emergency department and radiology or intensive care unit should include:

- A review of vital signs
- Time of stroke onset
- Focused bedside neurological examination using of NIHSS
- Current interventions and hemodynamic parameters and goals

Many healthcare facilities have developed structured paper or electronic tools to prompt the discussion of key clinical information. Both written and verbal handoffs are important in transferring patient information and ensuring coordinated delivery of care. Written handoffs can provide a reference for the receiving providers. Verbal handoffs allow discussion and help to facilitate cross-checking with the care team to ensure that information is understood.

There has been a rapid expansion in effective interventions for stroke patients and efforts are underway to develop a more formalized system of care, which will increase the need for clear communication during transitions. Studies to date have focused predominantly on tools for intershift handoffs and interdepartmental communications.[4] Intrafacility transfers of patients for emergency stroke care can create additional communication challenges. Specific interventions will be needed to ensure critical information is shared in a timely manner so smooth transfers may occur.

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Ann Gaffey: ASHRM President-Elect

We extend special congratulations to our own Ann Gaffey, RN, MSN, CPHRM, DFASHRM, Sedgwick's SVP, Healthcare Risk Management and Patient Safety, for her election as ASHRM President-Elect and her upcoming role as president of the organization for 2016. This well-deserved honor reflect's Ann's true dedication to healthcare risk management and her commitment to moving the industry forward.

Ann is an industry-recognized career risk management, quality and patient safety professional with nearly 30 years of experience in healthcare. At Sedgwick, she has responsibility for overseeing and providing innovative consultative services to improve and enhance risk management and patient safety programs with emphasis on risk identification, assessment, analysis and prevention as well as risk management and patient safety education. Ann's experience includes managing self-insurance and captive insurance programs, insurance purchasing, claims management, and traditional risk assessment and mitigation activities.

Ann received her degree from the University of Virginia with a Bachelor of Science in Nursing. She also received her Master of Science in Nursing Leadership and Management from The George Washington University. Ann serves as Adjunct Faculty at The George Washington University in Washington, DC.

We are fortunate to share Ann's insight with you in this issue of *RiskResource*; find additional articles from Ann in our newsletter archive at http://www.sedgwick.com/news/Pages/newsletters.aspx.

Ann Gaffey will be presenting at ASHRM 2015; learn more from her on Tuesday, October 20 at 3:30 in her session "Hidden Treasures in Physician Offices: Findings of the Hunt Revealed!"

Click here to watch the video interview with Ann from the 2014 ASHRM Annual Conference: https://youtu.be/nhWyCmvFyDI.

Improvement collaboratives can ensure patient safety and reduce liability risks

Sedgwick's healthcare risk management (HCRM) team excels at helping clients improve patient safety and reduce liability risks in areas such as the emergency department, perioperative services and perinatal care. Often, that means leading improvement collaboratives for multiple hospitals or facilities within a healthcare system or network. Through engaging executive sponsors and clinical leaders, the collaboratives work to establish best practices by sharing resources, knowledge and the efforts of healthcare providers who are supported by national experts.

Our coordinated approach is multifaceted and includes risk assessments involving data collection, interviews and surveys, and real-time observations. By assessing clinical programs, practices and culture, we guide healthcare leaders in identifying risk management, quality and patient safety issues that can have a negative effect on patient care and outcomes – and lead to liability claims. This involves providing benchmark data, tools and solutions for identified risks. Sedgwick uses data analytics to support decision making and to drive the implementation of solutions that may be difficult for participants to develop and put in place individually. Following the risk assessments, participants receive reports with prioritized action plans and comparative data.

During one perioperative improvement collaborative, inconsistent practices for preventing retained surgical items were identified. Our experts worked alongside participating hospitals to establish best practices, standardize approaches, provide training and education to staff, and implement auditing processes and tools to monitor the effectiveness of the improvements.

The outcomes that Sedgwick's clients have demonstrated show that ongoing support is one of the keys to achieving sustainable improvements. When experts are involved in ensuring that opportunities exist for improvement initiatives, the effectiveness is greatly enhanced.

Some examples of the ongoing support provided by Sedgwick's HCRM team through our improvement collaboratives include:

- Developing perioperative toolkits focused on key areas of safe handling of specimens, preventing wrong side/site surgery and fires in the operating room
- Providing tools for assessing documentation quality in specialty areas
- Delivering educational programs for clinicians covering topics such as management of shoulder dystocia and communication/disclosure following an adverse event
- Providing training on teamwork and communication strategies using TeamSTEPPS® with follow-up coaching calls and support for sustainment

Our clients tell us that the benefits of participating in improvement collaboratives go beyond enhancing safety and reducing risk. They also include sharing best practices and forging relationships with other facilities at both the staff and management levels. Communities arise out of safety and risk reduction work. In addition, individuals and healthcare teams expand their professional knowledge, offering advantages for clients now and into the future.

more than a TPA
a world of resources

With Sedgwick's national reach and expert resources, we have set the industry standard for customized, performance-based professional liability claims and healthcare risk management solutions. Where you see medical malpractice liability risk, we see an opportunity to provide a highly innovative service to reduce costs, maximize resources and achieve a financially sound professional liability claims management program.

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Upcoming events

Visit the Sedgwick professional liability team at ASHRM:

- **American Society for Healthcare Risk Management Academy (ASHRM) 2015**
  October 18-21 | Indianapolis, IN
  - *Visit Sedgwick at booth #415*
  - *Hidden Treasures in Physician Offices: Findings of the Hunt Revealed! – faculty: Ann Gaffey & Julie Radford (Inova)*
  - *Healthcare Access at Your Big Box Store: One stop shopping takes on a whole new meaning and all-new risk – faculty: Jayme Vaccaro & Kathy Shostek*

About Sedgwick

Sedgwick is the leading global provider of technology-enabled claims and productivity management solutions. 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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