forum
news of the american society for healthcare risk management

Letter from the Chair

Renee G. Wenger
JD, RPLU, CPHRM

Thank you to those who contributed their time and knowledge for the articles in this issue of the Forum. I had planned to have message done earlier, but I was preoccupied with the sudden illness of a family member for nearly a month.

This was my first experience being at the bedside of a seriously ill family member. It was a new perspective on healthcare for me. Many of you already have been through this and know it is challenging. Being in a hospital two states away from home (as my ill family member was) creates an additional level of complexity. As we lived through the long days and nights, I tried to make mental notes for when I returned to my job in claims and risk management. Here's what I learned as a member of the patient's family:

1. You are uncomfortably dependent on the kindness of strangers. Every smile, every pause for directions, every kind word or helpful suggestion becomes a life raft in a sea of anxiety. The impact of the most ordinary manners, much less expressions of empathy or warmth, becomes magnified many times over.
2. You rarely will have previous experience with the level of physical and emotional fatigue that comes with being in a hospital room with a loved one for hours on end. We were lucky; there were five of us to split the day and night shifts and the facility welcomed us in the room with the patient 24/7. I tried to imagine what it would be like for someone with a small family or just a spouse. I could not envision it. It took more than one of us for each shift.
3. You will come to hate the sight of that hospital room, which you will have minutely observed over the course of the admission. Every square inch of floor, every knob, every drawer and every product will have been stared at, tried, evaluated, and remembered for its availability, usefulness, efficiency, comfort or cleanliness.
4. You will test your communication skills. The patient is at the center, but is not always in the know because family and the illness can get in the way. The patient only knows for sure what he or she can gather through the five senses from that hospital bed. What is important, what it means, how it fits into the larger picture, who is directing the process are all things that may or may not be explained depending on the demands on the providers, the level of consciousness of the patient and the knowledge level of the family. My family member's most pressing questions were never expressed directly and had to be intuited by those who knew him best. My family began its own huddles at every shift change to try to ensure continuity of information.

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ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT
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155 N. Wacker Drive | Suite 400 | Chicago, Illinois 60606
TEL (312) 422-3980 | FAX (312) 422-4580 | e-mail ashrm@aha.org | www.ashrm.org

Member Profile
Medicine and Patient Safety Calls ASHRM Board Member Victor Klein

By Joan Westlake

Victor Klein
MD, MBA, CPHRM, FASHRM

Victor R. Klein, MD, MBA, a Perinatalogist in the Department of Obstetrics and Gynecology at North Shore University Hospital, says a microscope first captured his interest in how things work in biology. By the time he was 7 years old, he knew medicine was his calling.

There are many reasons why Dr. Klein might be a familiar face to those in the ASHRM community. He is the vice chairman of Quality & Patient Safety and the director of Patient Safety and Risk Reduction in Obstetrics and Gynecology for the North Shore-LIJ Health System, on the Board of Directors of the North Shore-LIJ RRG and chairman of its Claims Committee.

Dr. Klein received his medical degree from the State University of New York at Brooklyn/Downstate Medical School. He says it was during his internship at Kings County Hospital Center that he knew he wanted to deliver babies. He focused on high-risk pregnancies and medical genetics during his residency in Obstetrics and Gynecology at The Johns Hopkins Hospital, and fellowships in Maternal-Fetal Medicine and Medical Genetics at the University of Texas Health Science Center at Dallas.

In his role is a leading expert on high-risk and multiple-births pregnancies, he has been featured in professional and consumer publications from The Wall Street Journal to People magazine as well as on dozens of television shows including Oprah, CNN and PBS. Behind the scenes, he has been called on as the technical expert for various medical television shows and movies.

Involved in risk management and patient safety for more than three decades, he speaks on these topics throughout the country. It was a decade ago when Dr. Klein says he first heard about and joined ASHRM. He earned CPHRM and FASHRM certifications and has presented at the ASHRM annual meetings. Dr. Klein has also been a member of the editorial board of the Journal of Healthcare Risk Management for the past five years, and is the current editor.

"ASHRM is an important organization for anyone involved in patient safety," he says. "It allows you learn and network with more than 6,000 members. Patient safety is everyone's responsibility. It is all evolving to Enterprise Risk Management. It is not about different segments – regulations, claims or risk formulas. It's about how we can, as risk management, quality and safety professionals, achieve the very best outcomes. Today we look at the entire picture and educate across the healthcare continuum about risk management because it is also everyone's responsibility."

Reflecting the ERM approach, Dr. Klein recently completed his MBA in Quality Management at Hofstra University. As to what keeps him engaged in a field known for unexpected and long hours, he says he enjoys interacting with people and taking care of his patients. He describes going to work as "fun and rewarding."

With his high profile as a multiple-births specialist, it might surprise people when they find out he is an active member of the Jericho Fire Department, New York. A fire department medic since 2005, there are three Kleins who answer the fire house calls. He responds to hundreds of calls with his son, who is captain of the Trident Engine Co. No. 3, and his daughter who is also an EMT. Helping people, he says, "It's a family thing."

Dr. Victor Klein, right, in his role as a fire department medic with his son, engine Captain David Klein.

Book Review

Practical Plans for Difficult Conversations in Medicine: Strategies That Work in Breaking Bad News

By Steven Shama, M.D.

Any opportunity to expand and deepen our communication skills is an opportunity to make our lives, and the lives of those we serve, more meaningful. It also can help to lessen the significant conflicts that exist in our day-to-day dealings with others. This book does just that and brilliantly so. It was written for physicians by a well-respected and accomplished practicing oncologist, yet it has many messages for each one of us in dealing with the difficulties and stresses of everyday healthcare delivery.

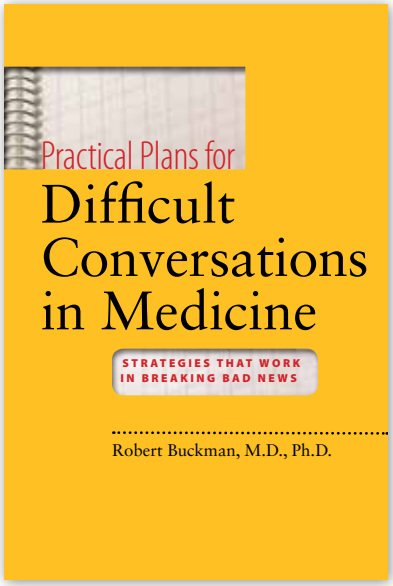
I found particular chapters uniquely relevant to risk managers such as the Breaking Bad News chapter and the one on Disclosing Error. However, Dr. Robert Buckman offers practical guidelines in dealing with difficult conversations in medicine throughout. Perhaps this book could have been titled, "What do you say when you don't know what to say?"

Not only can risk managers learn from reading this book but they could give the book to their physicians.

A valuable bonus DVD is included in which Buckman acts as the clinician with patients in eight challenging and difficult scenarios. They are powerful and realistic reenactments of a clinician disclosing a medical error, informing a relative of a patient's death, informing a patient that the surgeon did not "get it all" and a clinician discussing with a relative about the relative's strong wishes that if it is found that the mother has a cancer diagnosis the "mother is not to be told."

While Buckman readily admits that there is no one way of having a "better" difficult conversation and no one word or phrase can make all things better, he offers numerous strategies and approaches that can truly make the difficult situation not only less difficult but rewarding for both clinician and patient. He also points out that his approaches and teachings can work in everyday practice and in a reasonable period of time.

The entire book is filled with universals on how to make difficult, stressful conversations less difficult and ultimately more satisfying. He stresses that the most useful communication technique of all is the empathic response. However, while this is expressed in words, Buckman emphasizes that you ultimately have to show the person with whom you're speaking that you care. The universal phrase "I'm sorry" is used in so many different contexts that, as a reader, we begin to realize that it is not so much the words that we use to express this feeling…but our intentions to truly be empathetic that make the difference. The expression that came to my mind as I experienced Buckman's teachings is "People don't care how much you know until they know how much you care."



Chapters of direct applicability and relevance to risk management include Chapter 2 - Breaking Bad News: the SPIKES Protocol and Chapter 3 - Disclosing Error: The CONES Protocol. Richly worded text goes into great detail about the nuances of the various protocols and techniques that can be employed.

The acronym SPIKES, used for breaking bad news of any sort, stands for: S, the Start of the session and the Setting. Buckman talks about how to greet the patient, how to introduce yourself; shaking hands and sitting down; the appropriate distance between you and that person; adopting a neutral body posture; being ready to smile; and being ready for that critical step of true listening.

The P is the patient's Perceptions, what the patient understands or suspects of his or her situation. The I is the Invitation to share the up-to-date information. For example one might say," I have new information with regard to your blood tests. Would it be okay to share them with you now?"

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K stands for Knowledge, the sharing of the facts. Buckman reminds us to use simple vocabulary in small chunks and to check that the patient understands our words.

E deals with the Emotions that are elicited or expressed when the bad news is stated. If strong emotions experienced by the patient do not seem to be recognized by the person who is giving that news, the patient may regard that person as cold or insensitive. This rule of recognizing emotions applies to every stage of the communication process.

The final S reminds us that we need a Strategy to obtain a management plan to deal with information that was processed. This S also reminds us that there needs to be a Summary of what was discussed, an opportunity to ask the person whether he or she has any final questions and to make arrangements for the next meeting.

The acronym CONES is the protocol for dealing with a medical error. The C is for the physical Context within which the conversation takes place. Buckman stresses that this is extremely important and the approaches are similar to the S in SPIKES.

The O in CONES refers to the Opening remarks, also crucial. In words like," I'd like to discuss your mother's current condition and what has been going on. I'm sorry to say that something has happened," you are quickly establishing the agenda and suggesting with your tonality and words that you are focusing on recent serious events. The N in CONES stands for the Narrative of the facts. Be as truthful as possible; admit that you don't know something if you don't and make sure that the person knows that you'll do your best to find out the specific facts as soon as possible.

The E in CONES refers to the Emotions that are expressed. Identify at least one of the emotions and its probable cause, then connect the two with sensitivity. An example might be, "Clearly this information has been a major shock." This statement should be expressed in a nonjudgmental way, communicating that you are empathic and that you are doing your best to understand the person's emotional response.

The Final S in CONES is for the Strategy and Summary, similar to the final S in SPIKES. The persons to whom you are speaking must ultimately realize that you are taking the situation very seriously and that you have a plan to immediately notify them as soon as you have more information.

Additional protocols in the book include the HARD protocol for managing conflict and escalation and the SAFER protocol for giving information effectively. I found these chapters extremely helpful and very practical.

Buckman himself is the "star" of this book, using his many years of clinical care of patients to explore the world of healthcare delivery when the news you give people will negatively change their view of the future.

In the DVD, he uses his soft voice as well as compassionate body language. Empathy, kindness and humility are some of his greatest teachings. Not only do you see these qualities in his actions, you actually feel it.

Buckman states over and over again that the reader of his book and the viewer of the DVD may do things differently and that's okay, because it's one's intention and not one's specific words that are most important.

This book not only has great teachings for all of us, it is a truly humbling experience in how to BE with patients and their friends and family when we are faced with difficult conversations in medicine. It is an easy and relatively quick read and is inexpensive. It is unfortunately Buckman's "last chapter" because he passed away on Oct. 9, 2011. His spirit and teachings live on.

Risk Management
Issues in Telemedicine

By Sharon Harwood and Dave Murray

This is a guide to the many available resources surrounding the risk considerations within a telemedicine program. A simple Google search finds a number of papers, articles and presentations addressing telemedicine program risk management issues and assessment. References to just a few of these resources are listed within this article.

Definitions

The American Telemedicine Association reports that approximately half of United States hospitals employ some form of telemedicine. Telemedicine includes smart phones, patient portals, two-way webcams, image sharing, remote patient monitoring and more. The following are some basic definitions. The Centers for Medicare and Medicaid Services (CMS) defines telemedicine as a two-way, real-time interaction between a patient and a practitioner at a distant site through telecommunications equipment that includes at minimum, audio and visual equipment. The ATA definition is broader including the use of medical information exchanged from one site to another via electronic communication for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

Also, some states have their own definitions. The ATA website, americantelemed.org, offers a 50-state policy matrix. In addition to state definitions of telemedicine, there can be licensure requirements for physicians practicing medicine across state lines.

FDA

The Food and Drug Administration regulates equipment and software used in diagnosis or treatment of a disease or other condition as a medical device. The FDA issued Mobile Applications Guidance for the Industry and FDA Staff on Sept. 25, 2013. The FDA guidance concentrates on moderate and high risk applications used as an accessory to an FDA-regulated medical device or to transform a mobile platform into a regulated medical device. Consult www.fda.gov under the medical devices tab for more information.

CMS has issued two recent final rules of significance to telemedicine, the first on July 5, 2011 amending the Condition of Participation dealing with credentialing. Every state imposes a policy that makes practicing medicine across state lines a concern. Check to determine if there is no grant of cross state licensing or if the licensing is special or limited. In May of

2014, CMS issued a new rule eliminating the requirement that physicians travel to rural or federally qualified health clinics at least every two weeks when telemedicine is used.

From a risk management standpoint, there are multiple areas to consider -- privacy, security and encryption; physician credentialing (particularly if relying on the distant site); informed consent documentation; good documentation for handoff of care; reliable technology; correct use; prescribing laws; and overall encounter documentation. In addition, check insurance coverage adequacy, define the roles of non-physicians and define appropriate uses of telemedicine.

For reimbursement considerations, CMS has a 2014 Telehealth reimbursement publication at www.cms.gov/. Along with Medicare, there are state and private insurer considerations. Again the ATA website is a valuable resource in their State Telemedicine Gap Analysis, Coverage and Reimbursement, September 2014.

The American Health Lawyers Association provides recorded boot camp sessions on Telemedicine, which are available for purchase. Additionally, they have a number of scholarly and reference articles on the legal aspects of this topic.

One particularly comprehensive article that covers the legal aspects of telemedicine risk assessment is by Tara Kepler and Charlene L. McGinty titled Telemedicine: How to Assess

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Your Risks and Develop a Program that Works [http://keplerhealthlaw.com/uploads/3/4/1/4/3414608/kepler_mcginty_ahla_seminar_paper.pdf].

From the standpoint of medical negligence, all of the legal principles of duty, breach, causation and injury still apply, but there are variations which include the state where the physician is located; the state where the patient is located; equipment choice, training and appropriateness of use; licensing questions; choice of law; and specific state requirements.

The risk and compliance officer should consider the anti-kickback, stark and false claims act aspects of the arrangements. Always examine the Office of Inspector General advisory opinions, although they are limited to the question, fact pattern and parties reguarding the subjects of the opinion only. The opinions do provide guidance into the thinking of the OIG. Consider the equipment and services arrangements and reimbursement issues such as volume discount or per click arrangements in evaluating the anti-kickback statute. The determination of the application of safe harbors is very crucial to designing and maintaining a telemedicine program. Refer to the recent OIG advisory opinion 11-12. Two anti-kickback cases to consider are United States v. Greber, 760 F.2d 68, 69-70 (3rd Cir., 1985) and United States v. Polin, 194 F .3d. 863, 864 (7th Cir. 1999).

Prohibition Exceptions

Stark law prohibits physicians from referring Medicare beneficiaries to an entity in which the physician has a financial interest for designated health services reimbursable by Medicare. Here it is best to consult with the ability of your arrangement to fit within one of the Stark law exceptions such as the rural provider exception where an entity furnishes at least 75 percent of its designated health services to residents of a rural area. Stark law requires additional scrutiny as it is a strict liability offense that does not take into consideration the intent of the parties to the arrangement.

Finally there is the False Claims Act and Civil Monetary Penalties. FCA prohibits knowing submission or causing to submit false or fraudulent claims to the government. CMPs apply if a person knowingly presents or causes to be presented any false or improper claims to a state or federal government employee or agent.

Consider that states may also have complementary state fraud and abuse laws which may be more encompassing than the federal laws.

The Affordable Care Act promotes access to healthcare for a greater number of consumers. The goal of all carriers is to deliver this care in the most cost efficient means possible. This has led to a continuing growth in telemedicine applications with projects being trialed in the use of dedicated kiosks or at home consultation through devices associated with cable service.

Whether a large or small organization currently uses or is contemplating new uses for telemedicine, these programs change with the speed and availability of new technology and applications as well as growing provider shortage areas. Seek out information from organizations with established programs as well as the many other resources to assess program status. Auditing and monitoring of the program is fluid and necessary in this rapidly changing area of medicine and technology.

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Workers' Compensation
Issues to Watch

By Mark Walls, Vice President Communications & Strategic Analysis, Safety National

This list is going to be a little different than what you are hearing from others, as I want to emphasize things that may not be getting enough attention. With that in mind, here are my thoughts on the workers compensation issues to watch.

How Advances in Medical Treatment Can Increase Workers' Compensation Costs

There is one area in which advances in medicine are actually having an adverse impact on workers' compensation costs and that is in the area of catastrophic injury claims. Specifically, I'm referencing things such as brain injuries, spinal cord injuries and severe burns. Back in 1995, Christopher Reeve suffered a spinal cord injury which left him a quadriplegic. He received the best care money could buy from experts around the world. He died less than 10 years after his injury. But as medicine advances, we are now seeing that a quadriplegic can live close to normal life expectancy if they avoid complications. Injuries that used to be fatal are now survivable. That is great news. But surviving these injuries is very costly. The cost of catastrophic medical claims used to top off around $5 million, with a $10 million claim being a rarity. Now, that $10 million price tag is becoming more the norm.

The Need for Integrated Disability Management

More employers are realizing the importance of managing all disability, not just that associated with workers' compensation claims. Having an integrated disability management program is essential. Human resource issues such as the Americans with Disabilities Act and the Family Medical Leave Act cross over into the workers' compensation realm. The same interactive process required on non-occupational disability is required in workers' compensation. There is much confusion around this. Many employers feel that continuing to pay workers' compensation disability benefits when a worker is released to modified work eliminates the need for a reasonable accommodation under ADA. This is simply not true. Continuing to pay benefits is not considered a reasonable accommodation. There have been significant penalties against employers who have automatically terminated injured workers after a period of time where these employers did not offer modified work.

Marijuana

Marijuana legislation is a very hot topic these days. In national polls, the majority of Americans favors legalization of marijuana in some form. Twenty-five states have legalized medical marijuana. Four states (Colorado, Washington, Oregon and Alaska) now have legalized the recreational use of marijuana. Florida didn't pass their medical marijuana bill, but only because it required 60 percent approval. The majority of voters in Florida voted in favor of medical marijuana.

Employment policies around marijuana have been centered on the fact that it is illegal, so any trace in the system is unacceptable. Moving forward, that is going to change, although the Colorado Supreme Court ruled in June 2015 that employers' zero-tolerance drug policies trump Colorado's medical marijuana laws. However, I fully expect the federal government to reclassify marijuana from Schedule I to Schedule II in the next few years. When that happens, zero tolerance policies in the workplace will no longer be valid. Instead, the focus will have to be like it currently is with alcohol; whether the person is impaired.

Unfortunately, the science has not yet caught up with reality in this regard. We do not have years of research to determine impairment levels with marijuana like there is with alcohol. There is no breathalyzer for marijuana. Current testing is focused on detecting the presence of the drug, not a level of impairment.

Quite frankly, this is a dilemma that employers currently face with regard to opioid pain medications. Are these impairing workers? Possibly. To what degree? I don't think we know for certain.

This issue of determining "impairment" from marijuana and other legal drugs is going to have to be a significant focus of employment practices in the future. It's a new world; one that is going to take some getting used to.

The Next Pandemic

With workforces that travel around the globe, the threat of a global pandemic is very real. You know where you send your workers as part of their job, but do you know where they go on vacation? As an employer, are you allowed to ask about what employees do during their personal time? Are you allowed to quarantine an employee who traveled to an infected country during their vacation? These are very complex legal questions that I cannot answer, but these are discussions we need to be having. How do we protect our employees from the next pandemic? How do we continue our business operations if we had to close our offices for 30 days because of a disease outbreak? When is a disease such as this covered under workers' compensation? How will your insurance coverage respond? These are all questions that employers need to be asking before the next pandemic comes along.

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Rates and Market Cycles

You cannot have a discussion around issues to watch without talking about insurance premium rates in workers' compensation. After several years of increasing rates around the country, NCCI is projecting that, in 2014, workers' compensation combined ratios will be below 100 percent for the first time since 2006. This means that, as an industry, writing workers' compensation is profitable again.

So, what is the response to this? A call for rate reductions. Apparently, having an underwriting profit in a long-tail line of business is viewed as a sign that rates are too high. A strong, healthy carrier marketplace is good for businesses and carrier profitability is key to that long-term viability. However, the market cycles in workers' compensation have not often made much sense. They have been driven more by politics and competition than by the realities of claims costs. And the political influence is strong. States such as Florida recommended rate reductions beyond what NCCI suggested, even though there are cases pending in the Florida courts that will likely change the laws retroactively and increase the costs on the existing claims tail.

So what are buyers finding in 2015? Well, it depends. California continues to be a very challenging state for workers' compensation costs. New York is challenging as well. Given the percentage of the workforce in those two states, they have significant influence on the entire industry. Some employers will see rate reductions this year and some will not. In the end, your individual loss experiences will determine what happens with your premiums. That seems to be the one constant when it comes to pricing. Employers with favorable loss experiences get lower rates, so it pays to stay diligent in the areas of loss prevention and claims management.

Mobile Workforce

Finally, one of the biggest issues I see impacting workers' compensation in 2015 and beyond is the mobile workforce. Where is the line between work and personal life when you are using a company cell phone, tablet or computer to check emails any place, any time? Where do you draw the line for someone who works from home regularly? When are traveling nurses considered to be "on the clock" and subject to workers' compensation? There have been numerous court cases around the nation trying to determine where that line is. This is a very complex and evolving issue.

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5. You will feel like you have taken a financial log flume ride. It is taking everything you have just to make the daily decisions for yourselves and the patient, and the long-term financial implications are impossible to project. We had no idea what the healthcare costs would be or what kind of follow-up care would be needed. The financial implications of every decision were put on hold because there was no time to find out, and it is never a priority when your family member is at risk. The consequences hit later and sometimes all at once.
6. You may only remember the people that stand out. After a few days and nights, there will be a blur of hospital employees and providers. You will not be able to remember them all, and even the ones you remember are unlikely to be linked to a particular day or time in your mind. You mostly will come away with subjective impressions. The people who might stand out are the exceptions, and they are likely to be exceptions for the oddest reasons. For example, he is the one who brought you the good news or the bad news. She is the one who came in just after you had a fight with your sibling. They are the ones who were not successful in treating your loved one's pain. He is the one who helped you get discharged an hour sooner than planned. I think this was the most surprising thing about my experience to me. I know my family member received good care, but I doubt I will ever be able to thank a particular person or explain why I believe that. Yet it is a dearly held belief.

I could go on, but I am doubtless preaching to the choir. It was professionally and, of course, personally impactful to have this family experience. I am chagrined over any easy platitudes I may have offered families in the past. I may have future insight into why a witness recalls something the way he or she does. I will better appreciate the financial temptation of litigation. While I may not have any better answers, nothing surpasses having walked a mile in someone else's shoes. And when life takes me into the inpatient experience, as I am sure it will at some point, then I may add something valuable again to what I offer as a claims and risk manager.

ASHRM Update

Here are a few highlights of some of ASHRM's third quarter accomplishments and a list of upcoming activities you won't want to miss!

ASHRM ACADEMY
April 13-16, 2015 • Tampa, Florida

ASHRM Academy a Success April 13 - 16, 2015

This past April, nearly 200 ASHRM Academy attendees build their expertise in risk management and patient safety while relaxing in a spectacular retreat-like setting at the luxurious Saddlebrook Resort in Tampa, Florida. This third annual educational opportunity delivered a balanced approach to learning by combining days of stimulating programs with healthful activities such as yoga classes and nature walks.

New at the 2015 ASHRM Academy Program:

- Risk Financing Boot Camp - Marrying Financial Impact to Clinical Effort
- Enterprise Risk Management Concepts and Strategies
- ASHRM Leadership Series: TeamSTEPPS for Risk Managers

As is traditional, attendees had the opportunity to earn the Healthcare Risk Management or Patient Safety certificate; take the CPHRM Exam; and attend Partner Programs to earn up to 13 ASHRM credit hours that could be applied toward FASHRM, DFASHRM or CPHRM status. Watch for news on ASHRM Academy 2016!

Patient Safety Portal launched for National Patient Safety Awareness Week

March 8-14, ASHRM launched a Patient Safety Portal at www.ashrm.org/resources/patient-safety-portal. Featuring valuable tools and resources that are aligned with the American Hospital Association/Health Research & Educational Trust's Hospital Engagement Network, it continues to be updated, making it a go-to resource to be used all year. In addition to patient safety tips, 10 Core Topics are presented to assist healthcare professionals in reducing serious safety events. An interactive Patient Safety Quiz was also available to celebrate the special week.

ASHRM UNIVERSITY
ONLINE LEARNING CENTER

Online learning is now easier, faster and more convenient. ASHRM University helps make earning CEs more convenient than ever before. New features include:

- Easy-to-find CE credit information at-a-glance
- Guided interest-selection search feature
- Simplified 1-click selection menu
- Revamped site design for faster reading and easier navigation

New courses are continually added with a special, money-saving rate on a **Course of the Month**. Upcoming discounted classes are June - Neuroeconomics and Communication Science is Your "Secret Sauce" for Success with the C-Suite; July - Changing the Paradigm: Improving Patient Safety through Patient & Family-Centered Care; and August - Pain Management and Opioid Prescribing, Managing the Risks.

ASHRM presents a **live webinar** each month. April's webinar was Ounce of Prevention: Hospitalist Risk Reduction & Quality Improvement Strategies; May's was The Affordable Care Act: Mitigating Exposures through Focused Risk Management; and June's was a special HRM Week Webinar: Preparing for Complex Situations in Patient Care. Upcoming webinars:

- July 17 When EHRs Cause Patient Harm
- Aug. 13 Emergency Medical Treatment and Active Labor Act (EMTALA) Update 2015
- Sept. 11 Dealing with Difficult People
- Oct. 8 The Art of Consent Communication
- Nov. 19 The Clinician and Staff Support Toolkit: Navigating your way to developing a Clinician and Staff Support Program
- Dec. 11 Moral Issues with Risk Management Implications

For more information and to purchase a course of study or sign up for a webinar, go to learning.ashrm.org.

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New CPHRMs

Congratulations to these NEW CPHRM Recipients!

April
Melissa McGough
Kim Wittenberg
Mohamed Mousa
Anna Green
Santos Smith
Sandra Jones
Cheryl Love
Pamela Mullen
Frances Milanes
Susan Wante
Ann Hollyday
Phoebe Thriffiley
Paula McInerney-Hall
Elton Richardson
Richard Murphy
Christy Bourne
Rachel Thompson
Denise Olson
Mahmoud Seksaka
Robin Cooke
Nicholas Leute
Becky Winterer
Curtis Solomon
Aliza Foster
Clinton Spedding

May
Sarah Foss
Michael Smith
Tawana Shaffer
Tammye Hood
Itzel Harriott
Fred Ervin
Claire Owens
Versie Malveaux
Amy Meyer
Martha Ackman
Karin Calimano
Crystal McWhirter
Cynthia Gomez
Tina Luque
Therese Filley
Catherstine Jones

June
Karla Hannibal
Deborah Shanley
Tonia Teumer
Teresa Briggs
Alicia Cardinale
Mandy Lara
Mariea Urubek
Mario Woods
Nancy Marcum
Meghan Hatfield Yanacek
Janet Zicarelli
Gretchen Ratzlaff

The Certified Professional in Healthcare Risk Management (CPHRM)

The CPHRM is the premier credential for the risk management profession. Stand out from the crowd with this credential! For more information about the CPHRM exam or a complete list of recent CPHRM recipients, visit www.ashrm.org/cphrm.

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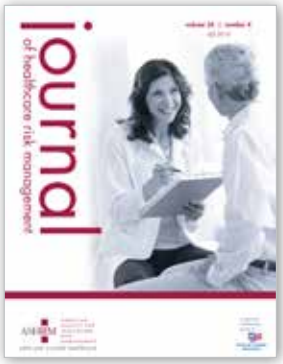
PUBLICATIONS

Journal of Healthcare Risk Management 2015 Q2 Edition Published



Volume 34: Issue 4 of the award-winning, quarterly Journal again presented industry's latest in-depth studies, important trends and upcoming developments in healthcare risk management.

Included in this edition are insightful, peer-reviewed articles and surveys such as:

- "*Designing highly reliable adverse-event detection systems to predict subsequent claims*" by Lorens A. Helmchen, PhD; Maureen E. Burke, RN, MSN, CPHRM; and Janusz Wojtusiak, PhD
- "*Decreasing intrapartum malpractice: Targeting the most injurious neonatal adverse events,*" by Palmira Santos, PhD; Grant A. Ritter, PhD; Jennifer L. Hefele, PhD; Ann Hendrich, PhD, and Christine Kocot McCoy, JD
- "*Risk managers' descriptions of programs to support second victims after adverse events,*" by Andrew A. White, MD; Douglas M. Brock, PhD; Patricia I. McCotter, RN, JD, CPHRM, CPC; Ron Hofeldt, MD; Hanan H. Edrees, MHSA; Albert W. Wu, MD, MPH; Sarah Shannon, PhD; and Thomas H. Gallagher, MD
- "*Hospital did nothing illegal in providing one-way bus ticket to mentally ill patient,*" by John C. West, JD, MHA, DFASHRM, CPHRM

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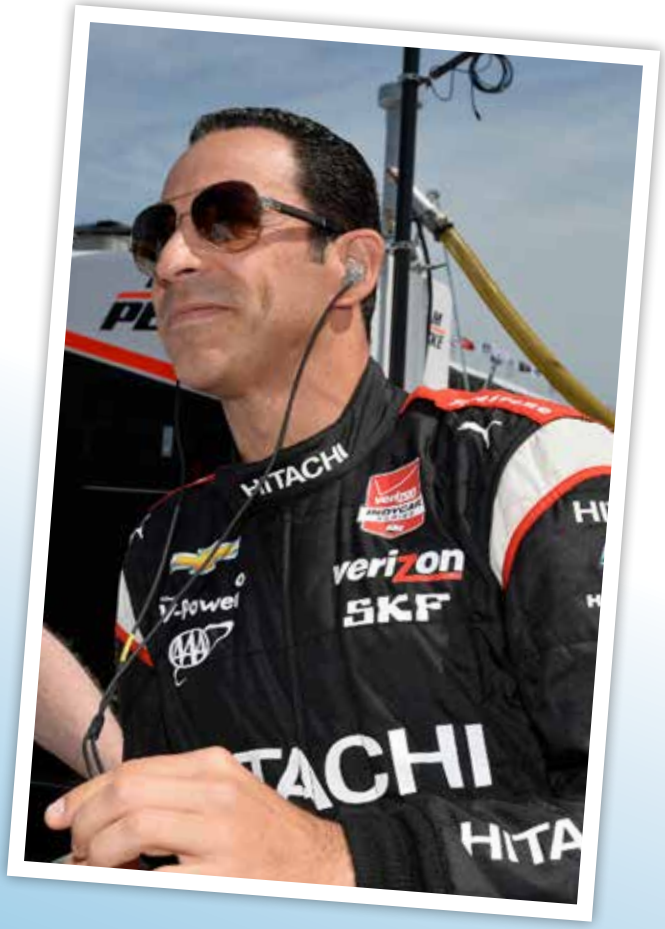

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