forum
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Letter from the Chair
Medical Scribes Increasing

By Renee G. Wenger, JD, RPLU, CPHRM

Renee G. Wenger
JD, RPLU, CPHRM

I've heard that the fastest growing medical profession is medical scribes because they have become a work-around in response to physicians' reactions to Electronic Health Record frustration and administrative overload. A few studies found that medical scribes improve the quality of clinical documentation and patient satisfaction, and allow doctors to see more patients.

The Joint Commission first released guidelines for the use of medical scribes July 2012. The Joint Commission's definition is *"a scribe is an unlicensed person hired to enter information into the electronic medical record (EMR) or chart at the direction of a physician or practitioner (Licensed Independent Practitioner, Advanced Practice Registered Nurse or Physician Assistant)."*[1] The Joint Commission neither endorses nor prohibits the use of scribes. However, if your organization uses scribes, the surveyors will expect to see compliance with all of the Human Resources, Medical Scribe Journal and Responsibilities of the Individual standards.[2] The Joint Commission does not support scribes being utilized to enter orders for physicians or practitioners *"due to the additional risk added to the process."*[3] The CMS agrees. And, the Joint Commission's stated position is that scribes may not act alone when documenting dictation or other activities determined by a physician.

The American College of Emergency Physicians, *"Focus On: The Use of Scribes in the Emergency Department,* S. Patel, MD, MPH; A. Rais, MS and Al Kumar MD, 2012, report that medical scribes come from a variety of backgrounds and education tracks including online courses, vocational schools, community colleges, undergraduate degrees programs and medical labor companies.[4] At least 22 companies provide scribe services across 44 states. Organizations, mostly scribe service vendors, train and certify scribes. The American College of Medical Scribe Specialists offers certification and publishes the Medical Scribe Journal.[5]

The American Health Information Management Association also published guidance in its November 2012 edition of Journal of AHIMA explaining that *"a scribe can be found in multiple settings including physician practices, hospitals, emergency departments, long-term care facilities, long-term acute care hospitals, public health clinics and ambulatory care centers. They can be employed by a healthcare organization, physician, licensed independent practitioner, or work as a contracted service."*[6]

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Legal & Regulatory
Root Cause Analysis

By Renee G. Wenger, JD, RPLU, CPHRM

Overview

The Agency for Healthcare Research and Quality defines a root cause analysis (RCA) as "*a structured method used to analyze serious adverse events.*" The philosophy is to focus on the processes that increase the likelihood of an error happening rather than to focus on individual blame. This systems approach is used to identify both active and latent errors. The ultimate goal is to prevent future harm by eliminating latent errors. The Joint Commission has mandated use of RCAs to analyze sentinel events since 1997. AHRQ , Patient Safety Primer, "Root Cause Analysis."

RCAs generally follow a specific protocol involving data collection, causal factor charting, root cause identification and recommendation generation. The Joint Commission has a Root Cause Analysis and Action Plan tool with 24 analysis questions that can help organize the steps for collecting data and reconstructing the event. The elements of the inquiry include: (1) the flow process; (2) human factors; (3) human resource issues; (4) communication issues; (5) equipment issues; (6) environmental issues; and (7) policies and procedures. T. Chen, O. Schein, J. Miller. Sentinel Events, Serious Reportable Events, and Root Cause Analysis. JAMA Ophthalmology. March 5, 2015. Online. The analysis helps identify what happened, how it happened and why it happened.

After using a systems approach to identify root causes, the focus is on creating a set of recommendations to prevent recurrence of the serious adverse event and to monitor adherence to the new processes.

Organization of an RCA

An RCA is essentially a formal, privileged meeting. It should be held any time there is a sentinel event, as defined by The Joint Commission. It should also be held any time there is a serious adverse event causing significant patient harm or death. Ideally, an RCA should be held even when there is minor patient harm, a near miss or an unsafe condition, as this is risk prevention in its truest sense. For purposes of this article, however, I will just use the phrase "serious adverse event" to stand for all possible categories.

The facilitator of the RCA is usually a quality or risk manager who is responsible for assembling and managing the team, guiding the analysis, documenting the findings and reporting to the appropriate persons. The title "facilitator" can be misleading as to the level of effective skills and amount of preparation and leadership needed for the job. The facilitator should begin by identifying the event to be investigated and gathering preliminary information under the auspices of the appropriate legal privilege.

An RCA should be performed by the facilitator as soon as possible after a serious adverse event so that important details and participants are not lost. Timing is one of the significant challenges to conducting an effective root cause analysis. It can be essential to have someone in a respected leadership role available to support the facilitator when it comes to scheduling conflicts, reluctant participants or other obstacles. Consideration should also be given to having established written policies or protocols with set deadlines for completing the process. Of course, some work, such as a final autopsy, an equipment investigation or stabilization of the patient's condition may need to be completed before the RCA can be held. But again, leadership may be helpful in expediting the completion of these tasks. It is important for the facilitator to anticipate what will be needed for an effective discussion and to help move all tasks forward as efficiently as possible to a reasonably promptly scheduled meeting.

Anyone with actual knowledge of the serious adverse event at issue must attend the RCA meeting. In addition to the direct patient care team, it may also include schedulers, OR staff, pharmacy technicians or others in the delivery of care stream. The facilitator may ask for recommendations of who should attend from the personnel involved in the direct patient care, but it is important for the facilitator to give individual thought to who will be needed to address the categories to be discussed. For example, if you use The Joint Commission analysis questions as an outline, there should be someone who is knowledgeable about the intended work flow process, as well as someone who can address the variance in process that occurred with this specific event. This may be the same person, or it may not. Also, it may be common for participants involved in the event to identify inadequate staffing as a contributing factor so someone from management is needed to analyze that issue. If the serious adverse event has been emotionally devastating for

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the patient care team, then consideration should be given to inviting a support resource. As you can see, RCAs can involve a fair number of people. The preliminary information is useful for deciding who should be invited. The facilitator's responsibility is to have enough basic information about the serious adverse event to be able to skillfully choose the minimal number of people without excluding anyone essential. It is also important to be realistic about the amount of time needed for the meeting without being inefficient. Preparation is the key to an effective RCA.

Conducting the Meeting

It is important for the person conducting the RCA to begin by stresses that the purpose of the meeting is to focus on the underlying processes rather than individual blame. The facilitator may even present a short list of rules of etiquette, if the meeting is anticipated to be highly emotional. The facilitator should remind everyone in attendance that the meeting is privileged, that the matters discussed are to be kept confidential and that the only one to be taking notes is the person conducting the meeting.

Begin by creating a timeline to be distributed at the meeting. The timeline should be labeled as privileged under the appropriate law and should be gathered back from the participants at the end of the meeting. Begin the meeting by describing what happened. Elicit other details from the direct patient care team and people who were not part of the care team. Then, revise the time line as necessary. Now is the time to add missing steps or clarify factual inconsistencies about the event. Be sure everyone agrees that the timeline represents what actually happened. In other words, does the timeline adequately tell the story (does each step derive directly from the step before)?

Once the timeline or case summary is completed, then the causal factors should be identified. Tools often used to help identify causal factors include: (1) Appreciation (use the facts and ask "so what?"); (2) the Five Whys; (3) Drill Down; or (4) Cause and Effect Diagrams. Define the end of the event sequence and the start point. Typically, the diagrams start at the end point and work backwards, identifying the most immediate contributing events first. Identify as many causal factors as possible. The group should consider all the possible causal factors, deciding if they were relevant to the event being investigated. The diagram should be started as soon as facts about the event begin to be collected. The diagram will need to be updated as more information is gathered, so it is important to choose a format that can easily be modified.

After all of the causal factors have been identified, the next step is to begin root cause identification. This helps answer questions about why particular causal factors existed. The definition of a root cause varies between authors and root cause methodologies. According to The Joint Commission, a "root cause" is the "fundamental reason(s) for the failure or inefficiency of one or more processes." The majority of events have multiple root causes, and each finding that is identified as a root cause should be considered for an action and addressed in the action plan. The most frequently identified root causes of sentinel events reviewed by The Joint Commission in 2014 were human factors, leadership, communication, assessment, physical environment, information management, care planning, health information technology, operative care and continuum of care.

Root cause methodologies need to be practical and easily applied. A number of root cause procedures or systems have adopted a battery of techniques that can be applied at particular stages of the investigation. At a minimum, a method of schematically representing information concerning the event will be used prior to applying the root cause methodologies to significant causal factors. The majority of methodologies are essentially checklists of potential root cause factors to stimulate thought.

In summary, there are three key components that need to be applied to ensure effective RCAs: (1) a method of describing and schematically representing the event sequence and its contributing factors; (2) a method of identifying the critical events and conditions in the event sequence; and (3) a method for systematically investigating the management and organizational factors that allowed the active failures to occur, i.e. a method for root cause analysis.

Having completed an effective RCA, identify corrective action(s) that will, with certainty, prevent recurrence of each harmful effect and related outcomes or factors. Check that each corrective action would, if pre-implemented before the event, have reduced or prevented specific root causes. If the investigators arrive at vague recommendations for action, then they have probably not found a basic enough cause and need to expend more effort in the investigation process. Implement the recommended root cause connections.

Enterprise Risk Management
Worlds Collide Creating a Safer Universe

By C. Rosalia Flora, MBA, CPHRM, CPPS, CHDA

Over the past decade, I am proud to say that ASHRM membership took the lead in accelerating the collision of and successful merging of the Risk Prevention world with the Patient Safety world. Allow me to offer a look-back at some of the catalysts that led to this groundbreaking universe. My first job in healthcare began 43 years ago. That's not a long time relative to the history of medicine yet, in that short time, so much has changed. Here are a few of the astonishing changes in healthcare over the past 50 years.

It was 49 years ago that the first heart transplant in the nation was performed. Today, there are more than 2,000 heart transplants performed annually in the United States. Forty-one years ago, I watched the first Sequential Multiple Analyzer with Computer (SMA-6) being installed in a Florida hospital laboratory. Forty years ago, Microsoft, personal computers, cell phones and the Internet were still science fiction. Thirty-five years ago, ASHRM was founded. In 1985, the first laparoscopic cholecystectomy was performed. The focus of early healthcare risk managers was primarily on reducing financial loss from medical malpractice claims.

It did not take long for the pioneers in healthcare risk management to realize that preventing financial loss went hand-in-hand with the creation of a safer patient care environment. With the lightning quick advancements of technology into all aspects of healthcare, it soon became clear to administrators and clinicians alike, that patient safety had to start advancing at the same rate as technology. Over the past decade, several drivers have pushed the merger between Risk Prevention and Patient Safety.

One such driver was the introduction of the culture of patient safety. I recently performed a simple correlation study for an acute care hospital involving the calculation of the correlation coefficient between the scores of their Culture of Patient Safety Survey (ARHQ model), and the rate of patient injuries. The test used data from the past eight years. The results very clearly showed that for each year that the survey scores were high, the rate of patient injury was lower. And when the scores went down, the rates of injury went up. It is compelling evidence of the impact of a Patient Safety culture.

Another important set of drivers is purely market driven. Patients today are more educated. This has driven the need for clinicians to become more educated. The market expectations are that healthcare providers demonstrate expert levels of competency. Hospital boards and medical staffs have swiftly moved to implement requirements that physicians be board certified and for nurses to have at least baccalaureate education levels. Publicly reported quality and safety indicators include these measures for the market to evaluate providers. The availability of this data allows the marketplace to choose providers based on quality and safety scores. This new transparency has also caught the attention of the clinicians and created many new converts to the heightened awareness state around patient safety. The implementation of value-based purchasing that includes the HCAHPS score is another key driver for this rapid collision between these two worlds.

Today, the culture of Patient Safety perception from the point of view of the healthcare provider can be compared to the perception of the patient. We now see acceptance by healthcare administrators and clinicians of new tools and methodologies such as TeamSTEPPS, Six-Sigma and Patient Centered Care. The "Cs" are even stepping outside of the C-suites. This new universe is what the ASHRM membership has been striving toward all along. Rapid changes have also happened in the fundamental structure of healthcare Risk Management. Many Risk Managers are evolving into Patient Safety Managers and, with that; qualifications for these positions are also changing. Some of us, myself included, who are without a clinical background as a physician or a nurse, have found ourselves misplaced. However, I am proud to have been a part of the ASHRM membership that never stopped pushing for this evolution in the healthcare universe, because that is what we worked so hard to achieve over the past four decades.

Member Profile
Margaret A. Curtin, MPA, HCA, DFASHRM, CPHRM, CPCU

By Renee G. Wenger, J.D., RPLU, CPHRM

Margaret Curtin
MPA, HCA, CPHRM, DFASHRM, CPCU
ASHRM Board Member

Margaret Curtin is a personable, smart and energetic professional who has been serving this past year as an interim ASHRM Board Member. Since she is running for election to the ASHRM Board next year, this is an ideal time to get to know her. Director of Risk Management, Education and Marketing and Business Development at Michigan Professional Insurance Exchange, she has been with this company for nearly a decade. MPIE insures physicians, hospitals, and mental health facilities primarily in western Michigan.

She began her career in the ambulatory care setting, working directly with providers and patients in the delivery of healthcare services. It was in this setting that she first became aware of the risks associated with patient care, specifically in communication failures and the effects of human factors on system design. Margaret has worked in the acute care and ambulatory care settings, managed care and medical malpractice insurance industries. She has held positions in customer service; provider relations and contracting; business development; marketing and client retention; education development; and risk management. She worked for the Sisters of Mercy Healthcare System, University of Michigan-MCARE, ProNational/ ProAssurance, MHA Insurance Company and the Risk Management and Patient Safety Institute. She has a Master's in Public Administration and a second degree in Healthcare Administration from Western Michigan University. Margaret's undergraduate degree is from Michigan State University.

With almost 30 years in risk management, Margaret says she has done most of the usual things a risk manager does, such as risk assessments, risk reduction tool development and high-risk clinical procedure assessment.

Since 1999, she has served ASHRM in many positions. She says she was advised as a young risk manager that by joining ASHRM, she could network and learn skills that can't be learned from books or coworkers. Currently, she is Chair and Board Liaison to the Practice Issues Task Force of ASHRM, whose main initiative this year is clinician wellness.

"Service as a board member has provided me with the advantage of direct experience and participation in the role and responsibility for strategic direction of ASHRM," she said. "I have learned that there is even stronger leadership in sitting back, being patient and allowing others to lead and encouraging those who may be reluctant to lead to do so or at a minimum to participate in order to come away with the best solutions and ensure all involved feel valued both in their ideas and self-worth."

Margaret says her objectives are to keep ASHRM focused on the member's needs and requests by identifying innovative and cost effective ways to provide educational support; to focus on identifying what is the next opportunity to elevate the role and enrich the member; and to tap the power in our membership diversity and leverage it to strengthen ASHRM as an organizational voice to impact legislative and governmental initiatives that may pose a potential threat to safe healthcare delivery. Margaret asserts that the following issues are on the minds of providers and hospitals: cyber liability, the Affordable Care Act (clinically integrated networks), hospital-acquired infections, litigation stress and disclosure skill sets/tools. She points out that government is going to become a larger player in healthcare in the near future.

On a personal level, Margaret is participating in 5K events raising funds for causes such as autism and cancer awareness. She says she finds energy from other participants as well as the commonality and inspiration in people's stories. She enjoys being able to stay healthy while helping such wonderful organizations.

Patient Safety/Clinical Care
Current Risks in Radiation Medicine

By Kelly J. Cameron, BSN, CPHRM, Clinical Risk Manager-Quality Management

Currently, in the United States, medical uses of radiation account for more than 95 percent of radiation exposure from human-made sources and about 50 percent of all radiation exposures (Hricak, 2011). Historically, radiation medicine-related injuries and errors have been low in the United States (patientsafetyauthority.org, 2009). However, when an event occurs it can be fatal.

A highly publicized case of radiation misadministration resulting in a fatality occurred in Scotland in 2005. A young patient, Lisa Norris, received a 58 percent higher dose than ordered to her craniospinal area. An autopsy revealed that her tumor was still present despite radiation therapy.

Another example is the Therac-25 incidents, which occurred between 1985 and 1987. Two different computer software errors in a computerized linear accelerator resulted in massive radiation overdoses that injured six patients and caused two fatalities" (patientsafetyauthority.org, 2009). In a summary of radiotherapy incidents that occurred in the past three decades in the United States, Latin American, Europe and Asia, 1.2 percent of 3,125 patients died of radiation overdose toxicity; 55 percent of these occurred during the planning stage; and 45 percent occurred during the introduction of new systems or equipment to include information transfers (World Health Organization, 2008). There are recent significant increases in both diagnostic and interventional medical procedures in the United States (Hricak, 2011).

"In the years 1976 to 2007, 3,125 patients were reported to be affected by radiotherapy incidents that led to adverse events. About 1 percent (N=38) of the affected patients died due to radiation overdose toxicity. Only two reports estimated the number of deaths from under-dosage. In the years 1992 to 2007, more than 4,500 near misses (N=4616) were reported in the literature and publically available Databases" (World Health Organization, 2008).

Dynamic and Complex

Radiation medicine is a dynamic and evolving discipline. It encompasses radiation treatments, implants and systemic radiation therapies. Each year brings new equipment that delivers radiotherapy using different modalities. While the benefits of medical radiation are well documented, there are known and unknown risks to the patient and to organizations. A recent literature review demonstrated that in the 1990s, operator error with new equipment was the basis of most events but now the greatest incidents occur with misinformation or errors in data transfer (World Health Organization, 2008). The risk manager can construct an effective mitigation plan through knowledge of the treatment process in combination with regular risk assessments

Radiation medicine is a complex treatment requiring a high level of accuracy to provide therapeutic levels of radiation without extensive collateral cellular genetic damage that could lead to death or second cancers arising at a later time in the patient's life (Freeman, 2015). There are a variety of treatment plan applications. They can be a primary cancer treatment, neoadjuvant therapy or for palliative measures when comfort is needed. The complexity of a treatment plan requires the multidisciplinary collaboration of medical physics, radiobiology, radiation safety and dosimetry. The healthcare professionals involved are the radiation oncologist, radiation therapists and medical physicists. Auxiliary support comes in the forms of a variety of technicians dependent on the modality involved (employed and vendor), clerical services, nursing and IT (software dependent).

Risks for a radiation treatment plan can be drilled down to specific buckets of contributing factors to manage. One of the most critical actions for the radiation medicine team is reliably identifying the correct patient. The incorrect identification of the patient increases the chances for error along the entire spectrum of the treatment plan from the primary assessment to treatment verification and monitoring. The next area of risk exposure is the failure to obtain a consent that provides understanding of specific risks and benefits to treatment as well as the documentation of this conversation. This gap can lead to the kind of miscommunication that leads to litigation. Another bucket is the finding of inadequate medical records. This deficit can increase the likelihood that communication of treatment outcomes, co-morbidities, prescribing errors and coordination of disciplines will occur. These kinds of events can involve untimely, inaccurate, illegible entries and/or missing documentation (World Health Organization, 2008). The occurrence of equipment failures is the final bucket. Although these can occur under diligent equipment management programs, they are important because the misuse or incorrect use of equipment and software has a higher risk of an adverse event with a poor outcome.

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Once all the numerous risks are identified, consider which risks present the most imminent danger; at what frequency could they occur; which risks could lead to a loss exposure; and what would that loss would be. This risk prioritization assists the risk manager in focusing where time is best spent. A risk assessment specific to radiation therapy helps to identify gaps in processes and efficiency in quality assurance controls. An on-site inspection of the premises, equipment and staff can help to validate findings from a standards-based risk assessment. Gleaning through incident reports, insurance and litigation claims provides trending data. Loss run reports are useful for determining fiscal impacts of radiological compensatory events or organizational write-offs. Successful risk mitigation in radiation medicine centers on synthesizing this information into a plan that maintains competent use of radiation technologies as well as protecting the stream of accurate information during patient care transitions.

Conclusion

Radiation medicine is a rapidly evolving discipline with complex algorithms for diagnosing, planning and implementing care. It is associated with few reported errors although these can have severe outcomes. There are many clinical risks in spite of the heavy regulation and quality controls standards that are in place. The most imminent and far-reaching risks are found in patient identification and the use of new technologies. Targeting these high risk areas with proactive risk activities leads to successful risk mitigation that provides increased patient safety and decreased organizational exposure to loss.

References

Patient Safety Authority. (2009, September 6). Errors in Radiation Therapy. Retrieved from patientsafetyauthority.org: http://patientsafetyauthority.org/advisories

Freeman, T. (2015, April 18). Medical Physics Web. Retrieved from http://medicalphysicsweb.org/cws/artcle/research/53113

Hricak, H. B. (2011, March). Managing radiation use in medical imaging: a multifaceted challenge. Radiology, pp. 889-905.

National Cancer Institute. (n.d.). Retrieved from National Institute of Health web site: http:// www.cancer.gov/about-cancer/treatment/types/radiation-therapy/radiation-fact-sheet.

World Health Organization. (2008). Retrieved from World Health Organization: http://www.who.int/patientsafety/activities/technical/radiotherapy_risk_profile.pdf

New CPHRMs

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ASHRM Update

Enjoy these highlights of ASHRM's accomplishments in the second quarter of 2014 and take note of some valuable upcoming activities, benefits and events.

★ CELEBRATING 35 YEARS ★

ASHRM HRM WEEK

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Celebrating HRM Week 2015: June 15 – 19
Healthcare Risk Management Week is when ASHRM raises awareness about our profession and helps members motivate their hard-working teams with **gifts featuring the HRM Week 2015 logo**. ASHRM made it easy for risk managers to spread the word about the importance of our profession by providing materials to customize and share with staff. From posting notes to posters and messenger bags to tech travel kits, the HRM week message is at hand throughout the year.

This year's **Healthcare Risk Management Week Toolkit** was packed with resources for members to download to communicate the value of healthcare risk managers and to educate others about the profession. Tip cards, PowerPoints, FAQs, key messages, talking points and sample articles and press releases are a few of the HRM Week items available to members.

Members tested themselves and colleagues with ASHRM's fun, interactive **Healthcare Risk Management Week Quiz**. It's an excellent educational tool for Lunch-and-Learn sessions, meetings or as an entertaining way to reinforce co-workers' healthcare risk management knowledge.

The June 17 HRM Week Webinar featured "Preparing for Complex Situations in Patient Care." Presenters Fay Rozovsky, JD MPH, DFASHRM, president The Rozovsky Group, Inc.; Hala Helm, JD, MBA, CPHRM, FASHRM, health risk officer Palo Alto Medical Foundation; and Susan C Boisvert, BSN, MHSA, CPHRM, FASHRM, senior risk specialist Coverys spoke about the fact that healthcare risk management professionals and healthcare providers face a growing set of challenges every day. The past few years have brought patient care issues with vaccinations, sexual orientation and electronic health care information systems. This webinar addressed the importance of preparedness and shed light on what RMs need to know not if but when complex situations occur.

ASHRM UNIVERSITY

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

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New courses are continually added with a special, money-saving rate on a **Course of the Month**. Recent classes with savings were June - Neuroeconomics and Communication Science is Your "Secret Sauce" for Success with the C-Suite and July - Changing the Paradigm: Improving Patient Safety through Patient & Family-Centered Care. You'll want to be certain to use your member discount for the August - Pain Management and Opioid Prescribing, Managing the Risks and September's Preparing for Complex Situations in Patient Care.

ASHRM presents a **live webinar** each month. June's was a special HRM Week Webinar: Preparing for Complex Situations in Patient Care and July's was When EHRs Cause Patient Harm. Upcoming webinars:

- 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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As you can see from all this information, the risk management issues are myriad. No state or federal agency currently monitors or regulates the growth or activities of this new industry. According to the ACMISS, the number of medical scribes has been doubling annually, with about 20,000 expected to be working by the end of 2014 and 100,000 by 2020.[7]

With regard to risk, I was told that medical scribes is the Wild West of medicine for a number of reasons having to do with scope of practice; training scribe and clinician behavior; assessing competency; and documentation quality. For example:

1. How is training to be standardized and competency to be assessed?
2. How is the role of the scribe to be clearly defined and communicated?
3. How does one prevent a scribe from making independent decisions or translations while entering information into the EHR? In other words, how does one prevent "use creep?"
4. Should one allow an employee to simultaneously fill the role of scribe and another clinical role?
5. What documentation guidelines will be needed?
6. How can documentation be audited? For example, how can it be monitored whether scribes are using CPOE?
7. What issues arise from giving scribes the same EHR security rights as a provider when most rights are role-based and only within the individual's scope of practice?
8. How will the presence of scribes in the room impact the honesty of patients?
9. Will the use of scribes adversely impact the motivation to generate technological fixes to EHRs?
10. The Joint Commission requires signing name and title; dating and timing of all scribed entries into the medical record. The role and signature of the scribe must be clearly identifiable and distinguishable from that of the physician. A physician or practitioner must then authenticate the entry by signing, dating and timing. A signature stamp is not permitted for use in the authentication of scribed entries, and the authentication must take place before the physician or practitioner and scribe have left the patient care area. Authentication cannot be delegated, and as noted above, no orders may be entered by scribes.

There are many more risk possibilities. Whether scribes are a good idea, whether they will solve the problems from which they have materialized, whether we've anticipated the risks and whether we've identified best practices are just some of the possible topics for discussion, ideally through ASHRM!

References

1. The Joint Commission, "Use of Unlicensed Persons Acting as Scribes," Revised 27 March, 2015.
2. Id.
3. Id.
4. Patel, Sachin. "The Use of Scribes in the Emergency Department," American College of Emergency Physicians, 2012.
5. Gellert, Ramierez, Webster, "The Rise of the Medical Scribe Industry: Implications for the Advancement of Electronic Health Records," JAMA 2015; 313(13):1315-1316.
6. AHIMA, "Using Medical Scribes in a Physicians Practice," Journal of AHIMA 83 (11), 2012.
7 JAMA

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ASHRM Exchange

The ASHRM Exchange continues to grow as an active and important private forum for members to ask questions, share policies, recommend procedures, build a professional network of contacts, connect with others who share their specialties and plug into an entire healthcare risk management community.

From policy queries to recommendations for products, what's on the minds and business agendas of risk managers is available in this web-based forum exclusively for ASHRM members to connect and share resources and expertise with other healthcare risk management professionals. To access the Exchange, you must be:

- An active member of ASHRM
- Registered for the ASHRM website
- Logged in with an account that includes your member ID.

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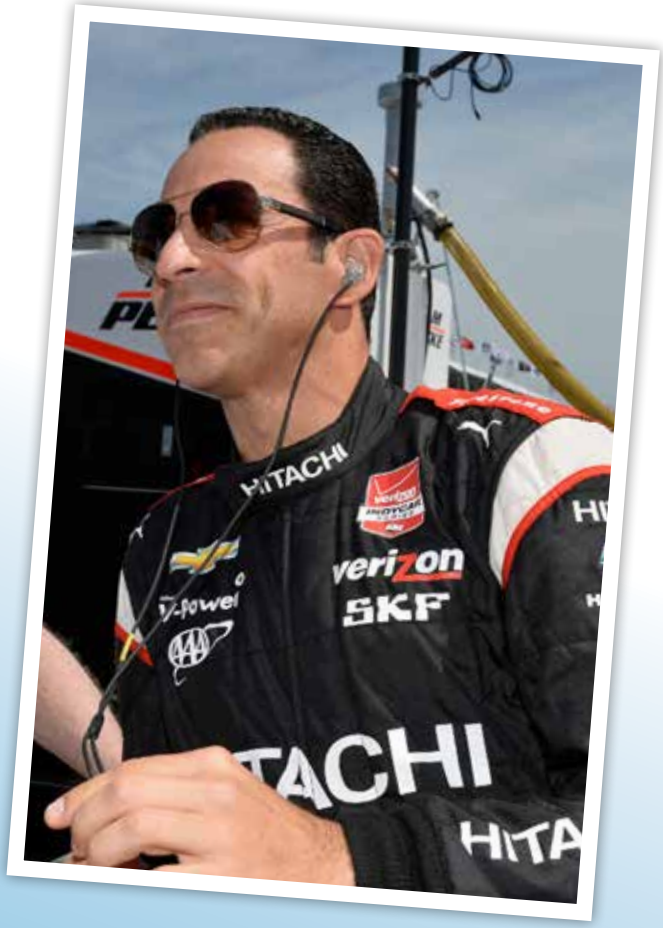

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Director, Risk Management

Katie Carlson
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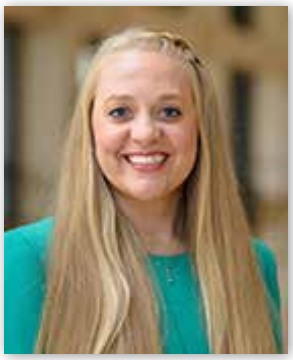
Education Manager

Laura Roberts
Senior Membership Specialist



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Senior Education Specialist

Shaun O'Brien
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Specialist, Governance and
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Cassandra Tulipano
Membership & Operations
Coordinator

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