Letter from the Chair

Welcome to our fourth-quarter issue, and thank you to our authors and reviewers, for their fine contributions. This newsletter would not be possible without the members of the Forum Newsletter Task Force.

As I write this I am reminded that at this time last year, I was tasked by my supervisor with leading an effort to revise our institution's written disclosure policy to include an early resolution provision. As often happens, we had been doing early resolution for some time, but needed to codify the process in writing. And as often happens when we start to put things in writing, things are not quite as clear as they seemed. I thought I would share a few of my observations for your consideration. There are many of you out there who have had processes in place for some time and came to terms with these issues long ago. I know you will forgive my rather naïve observations.

Renee G. Wenger
JD, RPLU, CPHRM

First, it is quite difficult to meld disclosure and early compensation. I discovered this when I asked the Committee I was leading what our guiding principles are and again when I asked what our policy should be called. No one wanted to use the phrase "early compensation" in the title or in conversation. Throughout our meetings, we were much more comfortable discussing the disclosure piece than we were discussing the resolution piece. This made sense in retrospect because the principles and agendas can be quite different. We could not ignore the fact that compensation inherently includes negotiation and all that term implies. Nor could we ignore that disclosure is the purview of an organization different from compensation.

It was not until we started talking in terms of "support" that we gained momentum. The word resonated with the providers as signifying the true need to be met after disclosure has been completed. It applies to all affected parties, and it applies to other things besides money since money is not always appropriate in every situation. That is how our policy came to be called "Disclosure, Apology and Support."

Second, it is quite difficult to capture in writing the dynamics of event reporting, event management and disclosure. I had done my research and created a lovely, detailed flow chart and draft policy. It seemed to cover all aspects of the process from occurrence to resolution. It lasted about 10 minutes! As soon as someone began challenging my definitions or order of steps, it all fell apart. I was reminded quickly that no two people think alike and no two highly-educated people subscribe to the same theories and substantive knowledge. It's no wonder managing an adverse event from beginning to end is so difficult. (I said this might seem obvious.) No two people even agree what the first priority is. Nor are any two people in charge of all aspects of the process. That is how we ended up revising three policies instead of one and beginning a fourth policy.

Member Profile
25 Years of Experience Guides Sherrill Peters' Leadership Style

By Renee Wenger

Sherrill Peters says she was thrilled to learn that an ASHRM member had anonymously nominated her to serve a second term as an ASHRM Board Member. After being vetted by the nominating committee and earning a spot on the ballot, she was re-elected for the 2014-2016 term. With experience on the 2002-2003 board, she says she feels even better prepared to serve. Since the board is focused on its strategic plan and plan stewardship, Sherrill's aim is to implement actions to facilitate these strategic goals

Sherrill Peters
BSN, CPHRM, ARM,
FASHRM and
ASHRM Board Member

A resident of Franklin, Tenn., Sherrill is the director of risk management for Community Health Systems. CHS is in 29 states with 206 hospitals and 3,500 employed physicians. A 13-year CHS veteran, Sherrill was with Humana for 18 years doing similar work. Trained as a nurse, Sherrill graduated from the University of Evansville in 1980, working in obstetrics for five years. In 1985, she was named head of Infection Control and Employee Health at the University of Louisville Hospital and soon added risk management to her responsibilities.

Sherrill has been on the ASHRM faculty for several years, teaching in the Barton Modules and, currently, for the CPHRM Preparation Course. She lectures extensively on risk management-related topics to promote a culture of patient safety. As the 56th ASHRM member to take and pass the certification exam, she enthusiastically advocates for risk managers to sit for the exam after they have qualified in healthcare risk management through education and experience. Certification is based on national standards and verifies that a risk manager has the requisite knowledge to perform all aspects of the role. While this is helpful in seeking and maintaining employment, she says, most of all, the exam gave her confidence in her knowledge and in herself.

The ability to become involved early in an adverse event to mitigate risk, to share information more immediately and to make the adjustments necessary to prevent similar future events is what drives her as a risk manager. She points out she became a much better change agent when she transitioned to clinical risk management from claims management. She appreciates the advantages of today's protections with patient safety organizations.

Overall, Sherrill finds risk management to be "very thrilling" work, especially when she sees the wins of event prevention. She recognizes attorney and experienced healthcare risk management consultant Fay Rozovsky as a professional role model.

"Fay is the brightest and most down to earth person I have ever met," she explains. "She has the unique ability to make someone stretch beyond their limits to be a better person and a better risk manager than they ever dreamed they could be."

Her advice to someone interested in becoming a risk manager is not to "jump from the bedside to risk management" without managerial experience. She notes that those risk managers who stick with it over time are those who have a managerial background.

Sherrill's enthusiasm about risk management as a profession is spurred by the impact it can have on patient care. She views technology as one of the newest challenges in risk management; and points out that although younger people may be technologically adept; they may be less able to identify risks because it is so familiar.

She cites one of her most rewarding experience as a risk manager as when she was working with a widower and his family after a sentinel event. She felt she was able to bring closure to the family through pre-litigation mediation. While unfortunate events occur because of the human element in healthcare, she believes the right thing must be done to make the patient and family as whole as can be expected afterwards, and healthcare must learn from medical error s.

Sherrill also assists her organization with disclosures. While disclosures are very difficult for caregivers, she believes the facts of medical errors must be communicated to the patient. She shared a recent touching experience she had with the family of a decedent who wanted to meet with the surgeon. She assisted in preparing the surgeon for the meeting. No one believed the patient's death was due to a medical error. The surgeon talked with the family, explained the events leading up to the patient's death and quickly learned the underlying reason why the family wanted to meet with the doctor. They wanted to understand why their loved one had died because they were unprepared for the death. Also, the family did not have a church affiliation

Book Review
The Cleveland Clinic Way: Lessons in Excellence from One of the World's Leading Healthcare Organizations

By Jennifer M. Groszek, RN, BSN, MJ, CPHRM, FASHRM

With the continuous evolution of the healthcare industry and its emphasis on value rather than volume, providers and leaders must remember that patient focus and a "putting-patients-first" philosophy are essential for surviving this transformational environment.

Toby Cosgrove, MD

Earlier this year, Chief Executive Officer and President of the Cleveland Clinic, Toby Cosgrove, wrote a book entitled, The Cleveland Clinic Way: Lessons in Excellence from One of the World's Leading Healthcare Organizations, to demonstrate how one organization may serve as a model for the nation.

The book's preface tells a patient story that demonstrates a model in which a group of healthcare professionals work as a team, physicians practice medicine and patients come first. Cosgrove acknowledges that as a surgeon, he knows the technical and clinical operations of healthcare. But he also says he doesn't consider himself a "medical insider." Through his own challenges and limitations, Cosgrove notes his detachment from the "herd mentality." Rather, he says he has forged his own learning methods.

The book skillfully presents Cosgrove's leadership style at the Cleveland Clinic as well as the organization's impact on the healthcare system.

The author addresses a question frequently asked by Americans, "How can the broken healthcare system be fixed and which model is best?"

At Cleveland Clinic the reorganization of physicians and other healthcare providers has been recognized as a way to enable more efficient teamwork. Cosgrove asserts that a reorientation of medical institutions – through collaboration, innovation, patient experience and wellness – can resolve many of the perplexing issues confronting the healthcare industry today. The Cleveland Clinic Way is the result of the national debate about healthcare reform, Cosgrove says. However, the book does not focus upon the complexities of health insurance, legislation, or how physicians should treat diseases. Rather, it highlights the positive aspects of U.S. healthcare and demonstrates how Cleveland Clinic and comparable organizations and healthcare systems are changing the future of medicine.

The book is divided into eight chapters, each representing a key trend that will define the future of medicine:

1. Why group practices provide not only better — but cheaper — care

2. Why collaborative medicine is more effective

3. How big data can be harnessed to improve the quality of care and lower costs

4. How cooperative practices can be the wellspring of innovation

5. Why empathy is crucial to better patient outcomes

6. Why wellness of both mind and body depends on healthcare, not sickcare

7. How care is best provided in different settings for greater comfort and value

8. How tailor-made care treats a person instead of a disease

As a physician and as a healthcare executive, Cosgrove uses his book to discuss quality, patient-centeredness, and cost from the various perspectives of provider, administrator, policymaker and consumer. He offers numerous examples of how the organization, its care-delivery models, leaders, researchers, providers and staff have impacted the lives of real people.

The Cleveland Clinic Way presents arguments for and against the group practice model through examples and success stories of other healthcare systems. In addition to developing enhanced teamwork and communication among healthcare providers and designated specialists, the Clinic expanded its model by eliminating departments as the primary organizing unit across the organization. Departments were replaced with 27 clinical, research, educational and support institutes. The conviction that patients would benefit from improved communication among personnel and billing, as well as access to – and geographic

clustering of – professional and administrative services spawned the change.

The book advocates for care that is monitored and recorded for quality. With new financial incentives associated with electronic medical records (EMR) and use of so-called big data, significant quality metrics are available to facilitate decision-making and promote wellness.

Care in the 21st century should be innovative; and Cosgrove distinguishes between innovation and idea. Unfortunately, the enemies of innovation are powerful, he asserts, while respectfully addressing barriers to innovation such as: reverence for tradition, success (or why fix what isn't broken?), and the traditional approach to medical education. However, he balances his premise with anecdotes that explain how the Cleveland Clinic and other institutions' support of a culture of innovation have led to considerable success.

Care should be a healing experience for body and mind. Culture change has redefined its "patient-first" model to include more than the patient's physical comfort by also focusing upon educational, emotional and spiritual needs. Various initiatives such as the "redcoats" program, "Communicate with HEART," and patient service navigators (PSNs) illustrate how change can significantly influence the patient experience.

Wellness depends upon healthcare, not sickcare, Cosgrove argues, beginning the discussion with a challenge confronted by Cleveland Clinic. The quality, experience and offerings provided in various healthcare settings (academic, community or specialty hospitals, rehabilitation facilities and hospice) can have a meaningful impact on patient outcome. Care should be tailor made for patients; and the book presents examples of personalized (precision) healthcare and genomics that have created individualized risk-prediction tools and precise management of disease.

With an eye on tomorrow, the book concludes with Cosgrove's declaration that he is "powerfully and enthusiastically optimistic" about the future of healthcare. Moreover, he observes that efficiency and affordability goals are within the power of all stakeholders – healthcare professionals, patients and policy makers. By making healthcare more accessible and efficient as well as personalized, it will serve Americans well and deliver value.

- Healthcare reform has brought new attention to wellness and prevention

- The digital revolution continues to have a profound impact on decision making and access to information

- Evidence-based medicine and the industrywide dissemination of best practices will facilitate value-based healthcare

- Through mergers and consolidation, medicine will become more efficient, effective and accessible.

The Cleveland Clinic Way takes readers on a journey through one of the country's most admired healthcare systems. The book, in its comprehensiveness, presents a thoughtful and stimulating discussion that addresses both the encouraging and challenging aspects of healthcare. Readers take away examples of lessons learned and best practices that began as small initiatives but, ultimately, led to major system changes.

About the Author: As president and CEO of Cleveland Clinic, Toby Cosgrove, MD, presides over a $6 billion system comprised of Cleveland Clinic, its eight community hospitals, 16 family health centers, and clinics in Florida, Nevada, Canada, and Abu Dhabi. A cardiac surgeon, he has published nearly 450 journal articles, book chapters, one book and 17 training and continuing medical education films. He has performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Dr. Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments. Cosgrove earned his medical degree from the University of Virginia School of Medicine. He served in the U.S. Air Force Casualty Staging Flight in Vietnam and was awarded the Bronze Star.
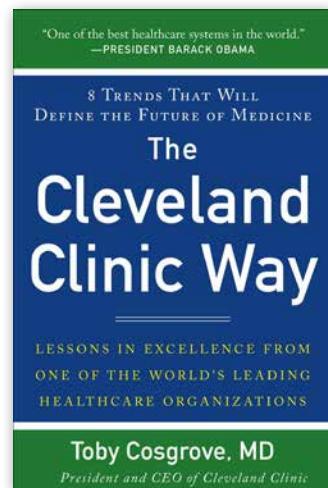
Clinical/Patient Safety
Caring for the Transgender Patient in a Behavioral Healthcare Hospital

By Fran Zucco, BSN, RN and Kathleen Barton, RN, MS

At Linden Oaks Hospital at Edward in Naperville, Ill., our mission is "Behavioral Healthcare with Compassion, Dignity and Excellence." We treat our patients, their families and friends, visitors and each other with respect. We appreciate that each patient is a unique individual with their own specific traits and attributes. It is our privilege to care for patients who have self-identified as lesbian, gay, bisexual or transgender. Our challenge is to become attuned to and then manage the clinical, legal, compliance and risk concerns that may occur when caring for these patients.

The National Transgender Discrimination Survey (NTDS) indicates that transgender patients experience injustice and discrimination in the workplace, school, housing accommodations, services and healthcare.

Data from the 2011 NTDS report illustrate:

- Survey participants reported that when they were sick or injured, they **postponed medical care** due to discrimination (28 percent) or were unable to afford care (48 percent.)

- Respondents faced **serious hurdles to accessing healthcare**, including:

- **Refusal of care:** 19 percent of our sample reported being refused care due to their transgender or to their gender non-conforming status, with even higher numbers among people of color in the survey.

   - **Harassment and violence in medical settings:** 28 percent of respondents were subjected to harassment in medical settings and 2 percent were victims of violence in a doctor's office.

   - **Lack of provider knowledge:** 50 percent of the sample reported having to teach their medical providers about transgender care.

Linden Oaks recruited a multidisciplinary task force to take a close look at how we care for our transgender patients and how our processes, unit rules and practices could be revised to increase sensitivity to the specific needs and requests of these patients and remove perceived hurdles to service access. Task force membership from within our facility included frontline staff (nurses, social workers, and counselors), unit managers, our risk manager, and members of the provider community. One of our members was from a community-based agency that advocates for the rights of the transgender population and develops housing options for transgender youths who are homeless. Task force goals were to review current processes, review current

literature, write guidelines for admission procedures, make recommendations for documentation in patient charts, and conduct ongoing education to increase staff awareness and sensitivity when caring for our transgender patients.

Here are some task force recommendations:

Identifying the Transgender Patient
You cannot assume a patient's gender or gender identity based upon their physical appearance. During the assessment process consider asking the following questions of all patients:

- What gender were you assigned at birth?

- Do you identify with the gender you were assigned at birth?

If the answer to the second question is "no" continue with these additional questions:

- What name do you prefer to be called?

- What pronouns do you prefer? (He/him/his, she/her/hers, they/them/theirs)

- What can we do to help meet your needs?

Inform patients you will do your best to accommodate their needs and preferences, but that there are instances in which you will need to use their legal name.

Admitting Patients: Safety Checks
Inpatient behavioral health facilities complete safety checks as part of the admission process. A safety check involves a check for contraband items on the person as well as an examination of the patient's body for wounds, bruises, embedded items, tattoos, scars and piercings. Patients, in general, can maintain greater dignity during the process when the safety check is done by a staff person whose gender is that with which the patient feels most trust and security.

Included in our specific practice guidelines for transgender patients is a requirement that safety checks be done by two staff members. One staff member is to be the gender the patient states he or she would prefer are present, and the other staff member is a nurse. If the patient's genitals are female, at least one of the two staff conducting the safety check is female; if the patient's genitals are male, at least one of the staff is male. The gender of the nurse does not need to match the patient's gender. Adolescent patients also have a parent/guardian present during the safety check. Prosthetics or binders worn by the patient are

removed during the safety check but may be worn during the treatment stay if no safety concerns are present.

Making Room Assignments

If your facility does not have all single patient rooms, privacy issues of the transgender patient make the assignment of a roommate very challenging, as assigning a roommate to a transgender patient can result in the unintentional disclosure of the patient's status. Personnel who see all transgender patients as the same may suggest putting two transgender patients together as roommates, but the risk of a privacy violation remains the same.

Recordkeeping and Verification

Everyone has part of their identity tied to what name they are called. For a transgender patient, those identity stakes are often higher. Therefore, a transgender patient may ask staff to call them by their preferred name rather than their legal name. While it is important to honor the patient's gender identification and new chosen name, the practice of using a preferred name increases the risk of misidentifying a patient. Additionally, documentation in the medical record must reflect the patient's legal name and gender to avoid misidentification and issues with third-party payors. All patients must wear a name band with their legal name.

Our task force enlisted the assistance of our information technology team to ensure that documentation in the electronic medical record (EMR) states that the patient prefers use of a name other than their legal name. Our EMR software also enables the preferred name to print on a patient list for each unit next to the legal name so the two names for the patient are associated with each other. We do not use preferred names for other patients, unless it is a shortened and commonly accepted version of the legal name, like "Jim" for "James."

Transgender patients at Linden Oaks can expect to be called by their preferred name with the following exceptions: (1) when an intervention requires two identifiers, as in the case of medication administration or a blood draw; (2) when being addressed by staff who work infrequently or have not recently worked on that unit and are conducting patient safety rounds (every 15 minutes) and are not familiar with the patient; and (3) during drills for fire or other emergencies when precisely and quickly accounting for every patient is essential.

Treating the Patient

- Adolescent transgender patients may self-identify with a different gender on different admissions/treatment episodes. This is due, in part, to the developmental age/stage they are experiencing. Do not assume that everything for this patient is as it was previously.

- Remember that transgender patients are seeking behavioral healthcare for a concern like suicidal ideation or depression, not for their transgender status itself.

Advancing Staff Competency

Staff competencies can be advanced by providing an arena for them to acknowledge their perceptions of transgender patients, receive accurate information, ask questions and practice new skills.

- Use an approach with staff that models the open and accepting attitudes and behaviors they are expected to have with transgender patients.

- Create an environment where staff feels comfortable asking questions.

- Help staff to understand that identifying as transgender means something different to each patient, but translates into consistent principled practices of care for your facility where respect and safety are concerned.

- Teach staff to maintain professional practices, regardless of personal beliefs.

Moving Forward

At Linden Oaks Hospital, our plan is for continuous process improvement through benchmarking with other behavioral health and acute care hospitals, for hardwiring considerations in the care of transgender patients into new employee orientation, and for offering continuing education for all staff. Our goal remains to provide a safe and healthy environment for all of our patients.

Forming Your Own Task force (Tips)

At Linden Oaks we value the knowledge and experience our staff have to offer when considering a change in practice. We recommend soliciting members from all patient care areas and disciplines to join a task force. Members, in turn, should request input and feedback from their respective departments.

We also networked in the community and engaged a social worker who advocates for transgender individuals for our task force. A diverse membership helps to create a rich environment for dialogue and goal setting. Using this process enabled us to develop practice guidelines that embrace our mission statement of "Behavioral Healthcare with Compassion, Dignity and Excellence."

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Enterprise Risk Management
Cybersecurity and Enterprise Risk Management (ERM)

By Jennifer M. Groszek, RN, BSN, MJ, CPHRM, FASHRM

Cyber-based threats continue to increase in frequency and severity across all markets: retail, financial/banking, government, and telecommunications[1]; and the healthcare industry is not immune. The SANS Institute says healthcare cybercrime is a reality and confirms how vulnerable the healthcare industry has become. Exploited medical devices, conferencing systems, web servers, printers, and edge-security technologies have the capacity to transmit malicious electronic information from healthcare organizations. In some instances, devices and applications were openly exploited for many months before the organization recognized or intervened with respect to the breach.[2] Cybersecurity and risk management strategies have been identified as one of the major challenges in the healthcare industry. The Ponemon Institute Fourth Annual Benchmark Study on Patient Privacy and Data Security[3] revealed the following research data, further demonstrating the significance of the issue:

- 90 percent of healthcare organizations in the study (hospitals or clinics that are part of a healthcare network (49 percent), integrated delivery systems (34 percent) and standalone hospitals or clinics (17 percent); have had at least one data breach in the past two years.

- Criminal attacks on healthcare systems have increased exponentially to 100 percent since the first Ponemon study was released in 2010. Healthcare employees are fueling breach risks through increased use of personal unsecured devices such as smart phones, laptops and tablets.

- Data breaches continue to cost some healthcare organizations millions of dollars every year. Based upon the experience of the healthcare organizations in the Ponemon study, the potential cost to the healthcare industry could be as much as $5.6 billion annually.

The proliferation of mergers, acquisitions and partnerships within the healthcare industry – as well as continued reliance on information generated, transmitted and stored electronically – not to mention goals associated with the electronic health record incentive program driven by the Health Information Technology for Economic and Clinical Health (HITECH) Act, have spurred additional exposure to cyber attacks and data breaches. Personally identifiable information (PII) and/or protected health information (PHI) may be breached through external sources, including cyber attacks, malware, viruses. Internal sources of data breaches may result from loss/theft of data, system failure or breakdowns, or by employees (intentional or negligent.) In early 2014, the FBI warned healthcare providers that their cybersecurity systems were lax compared with other sectors, making them vulnerable to attacks by hackers searching for Americans' personal medical records and health insurance data.[4] Healthcare data is valuable to hackers for a variety of reasons.[5-7] For example, the data may be used for an extended period of time prior to recognition of the breach. In addition, it may be used to obtain prescriptions/controlled substances; to submit fake insurance claims resulting in financial fraud; and to engage in identify theft providing access to bank accounts and social security numbers.

Applying an ERM perspective facilitates identification of some of the risks[8] and implications of cybersecurity events:

- Clinical: Medical identity theft may result in inaccurate medical records resulting in misdiagnosis or mistreatments.

- Operational: Business interruption will occur. Systems may be inaccessible or temporarily unavailable due to investigation, audit, notification, and repair. Routine operations and procedures may require a temporary work around.

- Legal: Liability claims and class action lawsuits will require legal representation and advice.

- Regulatory: Compromised PII and/or PHI may result in fines, penalties, and/or potential criminal sanctions under applicable laws and regulations.

- Strategic: Brand and reputation are critical components to the success of any healthcare organization. Significant marketing efforts may be employed to help restore consumer confidence.

- Financial: Financial implications, resulting from a loss in revenue during the interruption, compensation/settlement of claims resulting from a breach of privacy, external audits and investigations, and information technology support to assist with the recovery and restoration of services will have implications.

Although the healthcare industry confronts numerous competing priorities, developing and implementing a cybersecurity plan is critical. The following proactive risk management strategies can assist with the deterrence, prevention, detection and response to cybersecurity incidents:

- Incorporate security into your organization's culture. Emphasize security and integrate security processes into the culture and workflow.[9]

- Devote adequate resources to cybersecurity, such as appropriate information technology (IT) budget, leadership and staff.[10]

- Implement basic cybersecurity measures: encrypt and choose secure passwords for PHI, web-based applications and portals; audit tools, and log management.[9]

- Limit network access and control physical access to information technology systems. [12-13]

- Perform electronic health record (EHR) audits.[12-13]

- Develop and take precautions regarding "bring your own device" ("BYOD") policies.[9]

- Establish a procedure for the storage, disposal and archiving of data (both paper and electronic).[12-13]

- Create an IT security plan that defines roles and responsibilities for incident response and documentation procedures of the response team, specifically dedicated to cybersecurity. This differs from your organization's compliance program.[12-13]

- Inventory data and tools to determine what information you collect and how you use it. Create an itemized list of IT functions, network infrastructure, data, and medical devices and equipment.[9]

- Develop automated procedures that ensure devices are updated and maintained, new products saved, and former employees no longer have access.[9]

- Train and educate your workforce regarding the required cybersecurity procedures and awareness program. Perform employee background checks.

- Address third-party contractors, supplier, and vendors within your security program. Ensure that business associate agreements are in place.[11]

- Perform drills and/or consult with an IT security firm to assess your data system integrity and weaknesses, including response procedures.[12-13]

- Look to other industries for best practices and lessons learned.[9]

Minimizing and preventing cybersecurity threats remain challenging. Moreover, such vulnerabilities and threats will continue to evolve. Risk managers are well positioned to take a lead role in assisting their organizations reduce this risk. By incorporating cybersecurity within your ERM program, providers and systems can ensure compliance, maintain security of PII/PHI, facilitate patient safety, avoid financial loss, and minimize the potential for legal and regulatory exposure.

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2. SANS Analyst Whitepaper: Health Care Cyberthreat Report: Widespread compromises detected, compliance nightmare on horizon. February 2014. www.sans.org

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Additional Resources:

▪ The U.S. Department of Health and Human Services (HHS) Office for Civil Rights

Omnibus HIPAA Rulemaking. www.hhs.gov/news/press/2013pres/01/20130117b.html

▪ HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414

www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/index.html

▪ American Hospital Association (AHA) Cybersecurity Resources:

– Cybersecurity and Hospitals: What hospital trustees need to know about managing cybersecurity risk and response (August 2014)

– Cybersecurity and Hospitals: Four questions every hospital leader should ask in order to prepare for and manage cybersecurity risks

▪ www.aha.org/advocacy-issues/cybersecurity.shtml

▪ Health IT.gov. CyberSecurity. 10 Best Practices for the Small Health Care Environment. (Includes multiple checklists) http://www.healthit.gov/providers-professionals/cybersecurity

▪ U. S. Department of Health and Human Service (HHS). The Office of the National Coordinator for Health Information Technology (ONC) Security Risk Assessment (SRA) Tool. http://www.healthit.gov/sites/default/files/risk_assessment_user_guide_final_3_26_2014.pdf

▪ U.S. Department of Health and Human Services (HHS). Food and Drug Administration (FDA). Medical devices and cybersecurity. www.fda.gov/medicaldevices/productsandmedicalprocedures/connectedhealth/ucm373213.htm

▪ National Institute of Standards and Technology (NIST) Framework for Improving Critical Infrastructure Cybersecurity Version 1.0, Feb. 12, 2014. www.nist.gov/cyberframework/upload/cybersecurity-framework-021214.pdf

▪ U.S. Government Accountability Office (GAO) Report to Congressional Addressees, Cybsersecurity: National Strategy, Roles, and Responsibilities Need to Be Better Defined and More Effectively Implemented. February 2013. http://www.gao.gov/assets/660/652170.pdf

We now have separate policies on event reporting; event management; and disclosure, apology and support, and we plan to develop a fourth policy on just culture. I thought it could be done simpler. And maybe it can in other places. I just know that we struggled with the conflicting goals and requirements when we tried putting everything in one place. This is not to say that we did not "crosswalk" the policies, because we did. But I know that we have not covered very eventuality, and I am painfully aware of the various interpretations still possible in implementation.

Third, and finally, there is a daunting level of trust needed to create and implement a process for disclosure, apology and early resolution. The more expedited the process, the greater the level of trust necessary. What if this happens to me? Who is going to be explaining what happened? Who should apologize? How is the decision about compensation going to be made? How do we avoid breaking the bank? What if I object to early compensation? How can we make the process fair? When you overlay these questions on top of the complexities described in the previous paragraph, you can wind up with a system that is either so unwieldy that it collapses under its own weight, or you can wind up with a system that puts too much power in the hands of too few people. I do not think there is a perfect way. I think there is only a way that is balanced according to your own facility's values.

In conclusion, I will note that we are now working on socializing our disclosure, apology and support policy. It was an exhilarating year discussing disclosure. I feel very fortunate to have been part of that process. I now have some idea of what it takes to make a healthcare policy, which I do not think I could have learned nearly as effectively without doing this.

Please share your own stories with me. Perhaps you would even like to write a story for the newsletter to share with others?

Best regards.

Renee G. Wenger
Forum Newsletter Chair

Claims & Litigation
A Working Relationship Among Risk Managers, Defense Attorneys and Claims Professionals

By Peter Chidichimo, MS PT

How this collaborative effort can help to improve care and save costs

In the paradigm of assessing and defending medical malpractice claims, it is common for various professionals, engaged from different vantage points, to find themselves working collaboratively in a strategic and value-oriented relationship.

Defense attorneys defend healthcare professionals and facilities against allegations of medical malpractice. Professional liability claims specialists typically work with these defense attorneys, on behalf of an insurance carrier or third-party administrator, managing the claims file, making timely recommendations, preparing reports, approving requests and performing many other litigation-related functions. Risk managers are highly-regarded professionals, often with healthcare or legal backgrounds, employed by hospitals and nursing homes, and dedicated to the daunting task of evaluating the inherent risks associated with healthcare delivery:

- Litigation
- Maintenance of professional standards
- Hiring and credentialing staff
- State and federal compliance
- HIPAA
- Financing and budgeting
- And many other potential hazards and risks

This article examines how claim specialists, defense attorneys and risk managers work together, and how this collaborative relationship can result in improved care, including better training of healthcare workers, identification and prevention of hazardous conditions, clearer documentation, reduced litigation costs, reduced healthcare costs, and better adherence to quality standards.

Any effort to reduce the frequency of adverse outcomes in healthcare, and possible litigation, is of value to society. According to a study published in the New England Journal of Medicine, defense costs constitute an important expense for insurers, and these costs raise malpractice premiums, and medical care costs, respectively. These findings further show that, although the cost of resolving complaints is higher for claims that result in indemnity payments, there are still meaningful costs to addressing claims that do not result in a payment. Therefore, it is good strategy to be proactive and avoid errors and adverse outcomes to the extent possible.

Professional liability claims specialists, who often have a healthcare or legal background, are in the unique position of being able to review complaints from patients and families at the pre-litigation stage, when issues are identified as adverse events or claims rather than a full-blown lawsuit. Investigation usually includes: medical records review, relevant research, staff interviews, and possibly the rendering of an opinion on the care in dispute.

Issues identified may include possible liability, patient communication, staff training, documentation, and follow-up care. Once these issues are identified, the risk manager can use this information to take the appropriate corrective measures. Corrective action may result in improved care, as well as reduced risk, improved efficiency and lower costs.

Professional liability claims specialists work with defense attorneys to assess the quality, availability and specialties of numerous medical experts who are retained to review a particular case or incident and render a professional opinion. Professional claims specialists and defense attorneys communicate regularly to discuss the strengths and weaknesses of the care provided, based on these expert reviews. This dialogue provides a valuable service to risk managers charged with updating policies and procedures, evaluating physician performance and other risk-mitigating functions.

Other personnel who may be retained to help defend a medical malpractice claim include professional investigators, witness preparation specialists, trial preparation firms, and life care/economics professionals.

In preparing to defend a malpractice claim or suit, defense attorneys rely on the facility risk manager to secure cooperation of defendant providers, such as physicians and nurses, so they may be interviewed and questioned regarding the care that was rendered. Risk managers can help identify any and all key personnel associated with specific care, or a specific case. As the litigation process may be intimidating, risk managers can help explain the process to these employees, and arrange meeting times

as well as answer questions. Defense attorneys may then meet with these staff members and review the pertinent care. Often times, in the course of these interviews, weaknesses with care, training, supervision or documentation, are identified, and can be reported back to the facility for appropriate discussion and intervention.

Defense attorneys also are well positioned to inform administrators, healthcare professionals, risk managers and other staff as to what is discoverable in court, particularly pertaining to the electronic chart, applications on private cell phones, personal email and documents, and various types of social media.

Metadata, or the "who, what and when" of the way records are maintained and modified in the facility (audit trail), is also vulnerable to discovery. Physicians may be completely unaware that an audit trail, if produced in court, can be damaging to the defense if modifications were made to a record. In addition, claims professionals and defense attorneys can alert a facility early when a litigation hold might be appropriate. A litigation hold is the preservation of medical records and other data, when litigation is reasonably anticipated. In such a case, clients need to be notified as soon as possible, to avoid problems in court, should a suit be filed.

Risk managers and their staff perform an invaluable function for their facilities, by addressing the numerous and inherent risks associated with the delivery of healthcare. When working with defense attorneys and claims professionals, risk managers have the responsibility of enlisting the cooperation of physicians and other staff who have provided care and may need to be defended in a malpractice suit. Physicians who are named in lawsuits, or who may be important witnesses, must understand the importance of cooperating with the defense team, which could include making themselves available for interviews and offering insight into the care provided, including identifying supporting documentation or pertinent research. Risk managers may be asked to produce written policies in support of the care provided. Nurse consultants and defense attorneys, who interview defendants, can assess these individuals on the basis of their strengths and weaknesses as witnesses. Further preparations may be needed – prior to a deposition or trial – to prepare witnesses who have little experience with the litigation process, who are particularly anxious, or who simply require additional preparation and a confidence boost.

One critical area of concern for risk managers with adverse or poor outcomes is patient compliance. Poor patient compliance, whether due to poor health literacy or other reason, may lead to poor medical outcomes and unwanted litigation. Legal nurse consultants, who review medical records for insurance companies and third-party administrators, often identify patient compliance as a factor where an adverse outcome is the end result. Poor

patient compliance can include failure to follow discharge instructions, failure to obtain medication and to maintain a medication schedule, failure to complete recommended testing or even failure to schedule regular dental check-ups. Once this early investigation is communicated to the facility, risk managers can implement measures in an attempt to improve patient compliance. There are many sources available to help identify and improve health literacy, which is especially a problem among the elderly and less-educated population.

Defense attorneys provide an invaluable service by staying current on public health law in a particular jurisdiction. As new cases are decided, particularly at the appellate level, and this information is shared, hospital administrators and risk managers can assume the responsibility of adopting and revising their standards of care, including updating all written protocols and procedures. Having clear, current and measurable written protocols is important when defending claims of malpractice.

Claims professionals and claims managers are valuable to client healthcare facilities and medical centers for their ability to produce enterprise reports. These reports provide a helpful service by capturing specific data, such as:

- Noting trending data in claims and suits as to departments, specialties, types of injuries, etc.

- Identifying providers who are frequently named in lawsuits

- Tracking litigation costs

- Other statistical analysis

This information is then shared with Risk Departments, facility administrators and other stakeholders, who share a vested interest in identifying risk, implementing corrective measures and improving care.

Claims professionals also assist with identifying potential liens, especially where Medicare is involved, since federal law mandates a right of recovery as to lawsuit settlements, where Medicare payments were made on behalf of the injured party.

In working together to assess and defend malpractice litigation, conferences are frequently held to discuss specific claims or suits. By meeting face to face, risk managers, defense attorneys, department directors, administrators and claims professionals can discuss the specifics of a case and identify strengths and weaknesses. Such discussion might include the opinions of the experts retained to evaluate the care, whether it might be necessary to have a trial, or whether settlement is a viable option. Risk managers may use this opportunity to re-evaluate their systems and procedures. Additionally, if a trial is necessary, then a claims professional or risk manager may plan to attend to observe the proceedings.

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!

SHARING IN THE CARING

ASHRM
ANNUAL CONFERENCE & EXHIBITION
October 26-29, 2014 ▪ Anaheim, CA
E ▪ R ▪ M

2014 ASHRM Annual Conference & Exhibition
At a time when Ebola focused the nation on hospitals and healthcare, more than 2,600 engaged attendees and exhibitors converged on Anaheim, California for ASHRM 2014, Oct. 26-29. As the exclusive healthcare risk management industry conference of the year, ASHRM 2014 continued to deliver optimal learning, networking, inspiring and career-building opportunities. This year's theme, "Sharing in the Caring through Enterprise Risk Management," emphasizes the vital role that all healthcare workers play in furthering patient safety. ASHRM hosted a "What's Your Why" wall at this year's annual conference where attendees wrote statements about why they do such challenging yet meaningful work. Click here to see what they wrote. To learn more about how to share your Why story, Click Here…

The Annual Business Meeting and Opening Keynote featuring American Hospital Association President and CEO Rich Umbdenstock kicked off the conference. With more than 70 educational sessions over six tracks, a wealth of events and countless professional development opportunities, ASHRM 2014 again proved to be an exciting and exceptional professional as well as personal experience. The conference closed on a final inspirational note by renowned entrepreneur and NBA Hall of Famer Magic Johnson. Click Here for highlights, photos and more…

Rich Umbdenstock

Magic Johnson

ASHRM Academy 2015 Registration is Open!
The Early Bird deadline is March 20, 2015 for ASHRM Academy 2015 being held April 13-16

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

in Tampa, Florida. ASHRM Academy attendees build their expertise in risk management and patient safety while relaxing in a rejuvenating, retreat setting. Offering a balanced approach to learning, ASHRM Academy combines days of stimulating programs with healthful activities such as yoga classes and nature walks. This exceptional educational experience is a chance to learn from industry leaders, upgrade credentials and establish valuable career connections. Click Here to find out more about enriching your mind and invigorating your spirit at ASHRM Academy 2015.

**This Holiday Season, Share Your Passion for Your Profession. Give the Gift of ASHRM Membership.**
Valuable member benefits at ASHRM help professionals like you make informed business decisions and prepare for the demands and regulations of managing risk in the ever-changing healthcare environment. When you give the gift of ASHRM membership to a friend or colleague, you build and strengthen your community dedicated to furthering patient safety. For more information, Click Here.

ASHRM/Aon 2014-2015 Hospital and Physician Professional Liability Benchmark Report (add thumb of Report Cover) Each year, ASHRM and Aon partner to deliver a benchmarking analysis of medical professional liability costs. This year's study marks the 15th annual report and incorporates data from more than 100 participating healthcare systems. The goal of our study is to provide a business intelligence tool for better estimating and understanding self-insured medical malpractice costs. Our analysis examines trends in two dimensions - the number of claims (frequency) and the average value of claims (severity). We show historical claim trends and forecast cost levels for the upcoming year. For more information, Click Here.
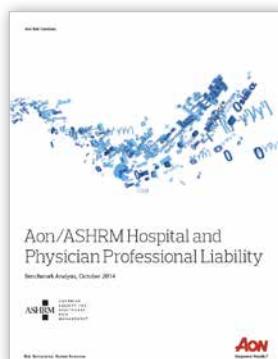
ASHRM's Updated Risk Management Pearls for Physician Offices, 3rd edition Launched
Today's physician faces legal and regulatory issues that could not have been imagined during medical school. As physicians' practices become part of hospitals, new challenges arise for the risk manager. The paradigm shift from inpatient care to ambulatory care, from caring for the sick to preventive medicine and population health is creating new risks to both the practitioner and to the organization. These updated Pearls share a range of strategies aimed at reducing malpractice and business risk that were assembled from risk management professionals with a keen interest in, and understanding of, physician office practices. View the ASHRM bookstore Click Here.
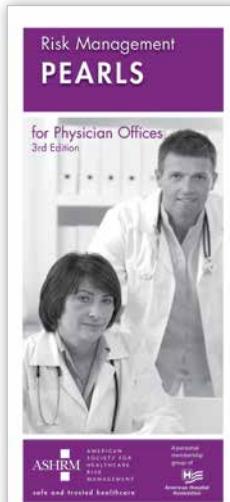
Two New ASHRM White Papers Published:

Serious Safety Events: A Focus on Harm Classification - Deviation in Care as Link
*Getting to Zero™ White Paper, Edition No. 2*
ASHRM published this white paper to provide healthcare professionals with a deeper understanding of how serious safety events are defined, classified and analyzed for harm prevention. Members can download the ASHRM's SSE II White Paper, Click Here...

Enterprise Risk Management: A Framework for Success
Healthcare organizations have made significant strides in developing Enterprise Risk Management (ERM) programs, but there is still much work to be done. To facilitate this process, ASHRM has defined ERM and created an ERM Framework for use in healthcare around which an ERM program can be formed. This white paper graphically displays the Framework and describes key structural components necessary in any healthcare setting. Use this Framework to help build consistency in your efforts to move ERM forward. To download the ERM Framework white paper, Click Here...
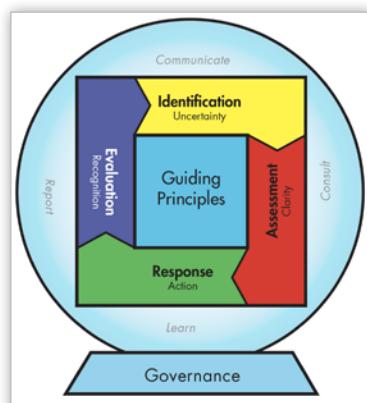
Healthcare Facility Workplace Violence Risk Assessment Tool Created
With more than half of all nonfatal workplace assaults occurring in healthcare services, according to the Bureau of Labor Statistics, the healthcare industry has become a focal point for security. ASHRM's Workplace Violence Toolkit demonstrates how to build a step-by-step program to prevent and de-escalate violent events at work. ASHRM members can download the Toolkit, Click Here...

New CPHRMs

Congratulations to these NEW CPHRM Recipients!

July
Cynthia Line
Sheryl Lee Sullivan
Julie Gadow
Sonjia Lee
Christie Young
Vicky Shull
Laure Lisk
Linda Navarre
Danielle Foster
Kevin Rider

August
Denise Shope
Enid Wade
Christina Bourgeois
Mariella Selvenis
Robin Maley
Stacey Lunetta
Emily Clegg
Michael Levine
Jennifer Carmichael
Patti Chambers
Amanda McGee
Joanne Phillips
Mary Page
Judy Fox

September
Betsey Jeffery
LaDia Broughman
Sandra Barbery-Drafts
Jose Guzman
April Klasko
Victoria Pruitt
Mirasol Fernandez
Jo Ann Davis
Haifa alnaimi
Constance Michael
Gayle Deaver
Christopher Cauch
Kim Nappier
Nawal Khattabi
Vivian Gallo
Teri More
Mary Powell

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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and could not afford a service. In their presence, the physician arranged for his church to hold the service and personally paid for the flowers. Sherrill asserts that the anxiety of meeting with families about their concerns should not stand in the way of such true compassion.

As to her personal life, Sherrill is married to a retired nurse practitioner and has a daughter who is a social worker and a stepson in the Army. Her two granddaughters are ages 6 and 3. Reading and traveling are Sherrill's hobbies. She loves major league baseball and her goal is to visit every stadium in the country. So far, she's been to half of them, with her favorite being Wrigley Field in Chicago, home of the Cubs.

Finally, if a physician or facility should be found liable in a medical malpractice proceeding, then the assigned claims specialist, defense counsel and client will often discuss the case, in an effort to apportion the liability, as federal and state laws mandate that this information be reported and accessible to the public.

In conclusion, risk managers, claims professionals and defense attorneys have the unique experience of working together in a collaborative relationship. Although malpractice litigation is often a common link within this relationship, there is an added benefit whereby weaknesses in care can be identified, corrective measures can be implemented, both litigation and healthcare costs can be reduced, and efficiency and quality of care can be improved at the point of delivery.

Meet Your ASHRM Staff

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