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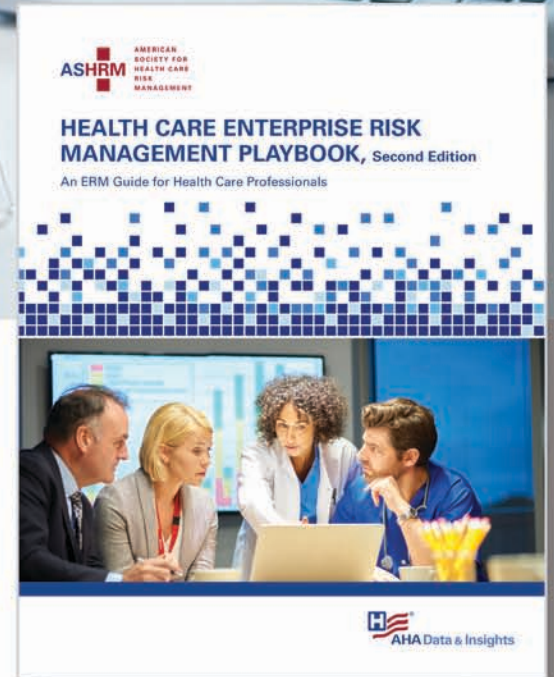
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Journal of healthcare risk management

volume 40 | number 3

5 Editor's Letter

Publishing in the time of covid

By Sue Boisvert, BSN, MHSA, CPPS, CPHRM, DFASHRM

7 President's Message

Goodbye 2020 happy new year—Challenges and change

By Meg Garrett

8 *Risk Financing

A description of medical malpractice claims involving advanced practice providers

By Laura C. Myers, MD MPH, Darlene Sawicki, RN MSN NP, Lisa Heard, MSN RN, Carlos A. Camargo Jr, MD DrPH, and Elizabeth Mort, MD MPH

18 Operations

Correlation between hospital rating agencies' data: An analysis and recommendation

By Samuel E. Sondheim, MD, MBA, Angela Mattie, JD (Esq), MPH, Julie Vigil, MS, CHC, CHRC, Christina McCulloch, RN, BSN, MBA, and Richard Feinn, PhD

25 Operations

The impact of clinical crisis management on trauma team outcomes following a prolonged strike by nursing, technical, and support staff

By John J. Leskovan, DO, FACS, FACOS, Jodi Pahl, MSN, RN-BC, Katy Stringfellow, MBA, BSN, RN, CENP, Nancy M. Buderer, MS, Aaron N. Moore, MD, FACS, Amer Afaneh, MD, Jay Raimonde, MD, FACS, Rachel L. Novakovic, MD, FACS, and Julie M. Stausmire, MSN, APRN, CNS-BC

35 Operations

Learning from others: A low-cost–high-impact risk/opportunity identification technique

By Brendan E. Williams, DBA, MBA, CPCU, CEBS, GBA, RPA, CMS, Anne S. Williams, DBA, MBA, CPCU, CEBS, GBA, RPA, CMS, and Katherine M. Williams, Ed.D., MS, CPLP, SHRM-SCP

43 Case Law Update

Case law update

By John C. West, JD, MHA

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The American Society for Health Care Risk Management (ASHRM) is a personal membership group of the American Hospital Association with members representing health care, insurance, law, and other related professions. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading health care organizations and government agencies.

ASHRM initiatives focus on developing and implementing safe and effective patient care practices, the preservation of financial resources, and the maintenance of safe working environments.

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The mission of the *Journal of Healthcare Risk Management* is to advance the field by publishing research and analysis that drives improvement in both the literature and practice of health care risk management.

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The purpose of the *Journal* is to publish research, trends, and new developments in the field of health care risk management. Articles also are archived for ASHRM members at www.ashrm.org.

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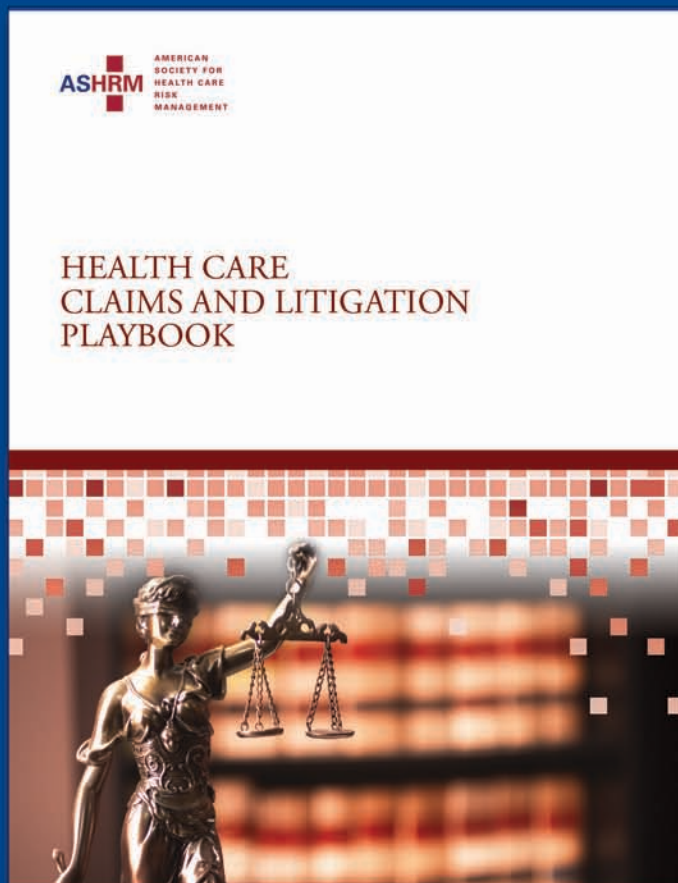
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Publishing in the time of covid



Sue Boisvert,
BSN, MHSA,
CPPS, CPHRM,
DFASHRM

By the time you read this piece, a full year will have passed since the first case of SARS-CoV-2 infection was identified in China. In the intervening months since that first case, so much in the world has changed irrevocably—journal publishing included. The global health care community also pulled together as the pandemic progressed. Physicians, researchers, and other scientists began collecting, analyzing, and sharing as much information about the novel coronavirus as possible. The day after the World Health Organization (WHO) announced that COVID-19 was an international public health emergency, more than 100 journals, societies, and research organizations signed an agreement¹ to make COVID-19 data and research openly available. Although journals had responded similarly to the 2015 Ebola and 2017 Zika outbreaks, this time the task was monumental. Almost immediately publications such as *JAMA*, the *New England Journal of Medicine (NEJM)*, and *The BMJ* pushed their COVID-19-related material out from behind the paywall, making nearly real-time information available to those who needed it.

Journals were faced with an influx of submissions. In a February 12 interview,² *NEJM*'s Edward Campion reported that the publication was receiving 20 coronavirus submissions *per day*. The sheer volume made peer review challenging. No matter how vital the content, scientific standards could not be relaxed as content validity was essential. In a bold and unusual move, journals agreed to permit authors to share their content on prepublication databases while stringent review, analysis, and evaluation proceeded. Concurrently, organizations—including the Centers for Disease Control and Prevention,³ Cochrane⁴ and WHO⁵—created libraries of COVID-19 research data and publications to further facilitate access and dissemination of COVID-19 information. To date, the WHO COVID-19 database contains over 88,000 free full-text articles.

Physicians, public health experts, and health care attorneys have created a huge body of literature to help us learn from the Great Pandemic of 2020. As risk managers, do we not have an obligation to contribute our risk management and patient safety expertise to this vast body of work? I encourage each of you to think about the challenges your organizations faced and how your teams rose to meet them. Please consider putting fingers to the keyboard and sharing your experiences. Every member of the *JHRM* Editorial Review Board is ready and willing to help you on your journey to authorship. Please share your stories with us.

Susan C. Boisvert

Editor, *Journal of Healthcare Risk Management*

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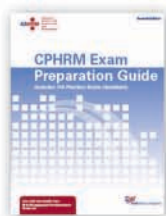


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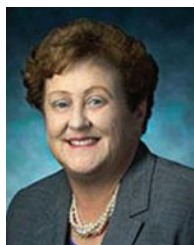


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Goodbye 2020 happy new year—Challenges and change



Meg Garrett

I am proud to be your new president of The American Society of Health Care Risk Management (ASHRM) at such a challenging and unpredictable time. In over 40 years in healthcare, I have never experienced a year that was so challenging both personally and professionally. As I welcomed 2020, never in my wildest dreams did I expect within 2 months our world would change so drastically.

I want to thank Hala Helm, our 2020 ASHRM President, for guiding us through some of the darkest days for Risk Managers. She led us through many challenges including the first virtual annual conference as well as many special webinars addressing the many changes in health care. It has been a challenge for risk managers, health care providers, our patients, our leaders, and our families. I want to thank all of you for your hard work during the past year through these unprecedented times. As the New Year begins, it is the time for all of us to reflect on the value we bring to our organization, patients, and our profession and ASHRM is ready to assist you in whatever way we can to meet whatever lies ahead.

Looking forward, we will experience a change in national leadership, health care delivery systems, economic challenges, risk management opportunities and challenges, and hopefully the eradication of COVID-19. We look forward to a year where we will all work together to continue to make health care safe and trusted.

In keeping with the opportunities, challenges and most certain changes for health care, the ASHRM board will be reviewing the 2019-2021 strategic plan that includes our core purpose to advance safe and trusted health care and our core values of leadership, integrity, and collaboration. Our goals under the plan are in three focus areas; risk management, patients, and the health care organization through enterprise risk management (ERM). ASHRM remains committed to the safety of our membership and our organization's mission "to provide health care risk managers with the resources, knowledge and support to strategically and broadly manage risk, reduce uncertainty, add value, and advance the safe practice of health care."

I wish each one of you and your families an incredibly happy 2021 filled with good health and some time off to enjoy LIFE! I look forward to meeting many of you this year.

A handwritten signature in black ink that reads "Meg Garrett".

Meg Garrett

A description of medical malpractice claims involving advanced practice providers

By Laura C. Myers, MD MPH , Darlene Sawicki, RN MSN NP, Lisa Heard, MSN RN, Carlos A. Camargo Jr, MD DrPH, and Elizabeth Mort, MD MPH

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[This article is updated on November 10, 2020, after first online publication, to identify it as a CE article.]

Background: The number of physician assistants (PAs) and advanced practice registered nurses (APRNs), together known as advanced practice providers (APPs), has risen dramatically. The goal is identifying characteristics of paid medical malpractice claims, in which APPs are defendants.

Methods: Retrospective cohort study using Harvard's malpractice insurer's national database. Closed claims (2007-2016) with PAs, APRNs, or physicians as defendants. The primary analysis compared claims by role group by patient-, provider-, and claim-level characteristics. Supplemental analyses compared claims naming APPs with and without physicians. Multivariable logistic regression identified variables associated with claim payment.

Results: Of 54,772 claims, PAs were defendants without APRNs or physicians in 26 claims; APRNs were defendants without PAs or physicians in 63; physicians were defendants without PAs or APRNs in 37,354. Approximately 75% of claims naming APPs co-named physicians. More claims naming PAs and APRNs were paid on behalf of the hospital/practice (38% and 32%, respectively) compared with physicians (8%, $P < 0.001$). Payment was less likely for inpatient care (OR 0.89, 95% CI 0.85-0.93, $P < 0.001$) but higher when APRNs were defendants (1.82, 1.09-3.03), when procedure-related (1.31, 1.25-1.38, $P < 0.001$) or patients died (1.09, 1.03-1.16, $P = 0.003$).

Conclusions: These results can inform patient safety initiatives to prevent future harms. The target is outpatient airway procedures performed by APRNs.

BACKGROUND

Advanced practice providers (APPs) are composed of two groups of clinicians: physician assistants (PAs) and advanced practice registered nurses (APRNs). The number of clinically active APPs in the United States has risen dramatically over the past decade.¹⁻³ Moreover, a report by the American Association of Medical Colleges projects that the number of APPs will double between 2018 and 2032.¹ The expanding roles of APPs across healthcare settings have raised concern about the quality of care being delivered.⁴

Work done by APPs is regulated at the department, hospital, state, and national levels.⁵⁻⁷ National boards of medicine and nursing are responsible for developing scope of practice guidelines for PAs and APRNs, respectively. Hospitals then develop local guidelines that further define the roles of APPs, as well as standards for appropriate supervision and interaction with physicians. Despite these guidelines, there may be areas in which APPs are at higher risk of being named in a medical malpractice claim, which results in claim payment.

Prior studies have described malpractice risk for APPs.⁸⁻¹⁴ However, none has used an insurer's database, which includes claims that closed with and without indemnity payment and spans the entire country. We used a unique, national data source to understand how claim characteristics differed depending on whether PAs, APRNs, or physicians were named, including when PAs and APRNs were and were not co-named with physicians. We sought to identify factors associated with claims resulting in indemnity payment. The rationale for identifying such factors is to inform how to prevent future events.

METHODS

Study design and data source

The study design is a retrospective cohort study. Medical malpractice claims were extracted from the Comparative Benchmarking Database, which is a national database maintained by Harvard's malpractice insurer called the Controlled Risk Insurance Company. The database contains >30% of all claims in the United States. Member institutions voluntarily contribute claims from all clinical departments. Trained nurse coders review all materials related to a claim. The Controlled Risk Insurance Company developed the original proprietary taxonomy and oversees it in an ongoing way via a governance committee. There is robust quality assurance, including biweekly coder conference calls, annual conferences, and auditing processes whereby 15% of the claims are reviewed quarterly. Several studies have been published using the database.¹⁵⁻¹⁸

The Institutional Review Board provided an exemption (2019P001490).

Major Findings: Claims naming advanced practice providers without physicians are different from claims naming physicians in terms of likelihood of (1) having a surgical allegation, (2) occurring in the outpatient versus inpatient setting, and (3) being paid on behalf of the hospital or practice. On multivariable regression, claim payment was less likely for inpatient care, but higher when there were advanced practice registered nurses involved, procedures, or severity of harm being death.

Pragmatic Applications: Claims naming advanced practice providers were rare overall. Outpatient airway procedures performed by advanced practice registered nurses may be a target for quality improvement. Although claims naming advanced practice providers were rare, the growing number of advanced practice providers as well as their expanding roles in health care makes this an important and timely topic.

Future Research: Future research should examine the likelihood of advanced practice providers being involved in claims in different states, given the variability in regulation of advanced practice providers by state. A database containing physician-coverage years is needed.

Malpractice claims

We analyzed claims closed between 2007 and 2016, in which a PA, APRN, or physician was named as a defendant. The APRN group was composed of nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives. Physicians included medical doctors and doctors of osteopathic medicine. Showing that claims differed depending on which role group was named as a defendant supports the hypothesis that patient safety efforts, such as targeted provider training, could be designed to prevent similar harm events. The dates were chosen because they contain the most recent data available with all claims closed by the end of the time period. Only closed claims were included to be able to report claim disposition and cost. Figure 1 is a Venn diagram showing the overlapping nature of claims that named these providers as defendants.

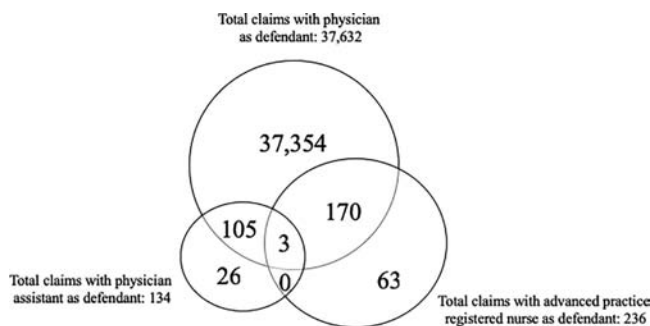
Groups for comparison

For the primary analysis, we restricted the control group to claims in which at least one physician was a defendant without a PA or APRN named as a codefendant. The two comparator groups were claims in which (1) at least one PA was named as a defendant without a physician or APRN named as a codefendant and (2) at least one APRN was named as a defendant without a physician or PA named as a co-defendant. Figure 1 of the Supplemental Digital Content depicts the control group in blue, the PA comparison group in orange, and the APRN comparison group in yellow. These groups are mutually exclusive.

Figure 1:

Venn diagram of claims with physician assistants, nurse practitioners, and physicians named as defendants

There is overlap of claims that name these three provider groups. The majority of claims naming physician assistants and nurse practitioners also name physicians.



We performed additional comparisons in the supplemental analysis. We compared claims in which PAs were named without physicians to claims in which they were co-named with physicians. We also compared claims in which APRNs were named without physicians to claims in which they were named with physicians. Figure 2 of the Supplemental Digital Content depicts the comparison of PA-involved claims in green and the comparison of APRN-involved claims in purple.

Variables

Variables in the database have been described in previous manuscripts but will be described briefly here.¹⁷ Region was classified according to US census regions.¹⁹ Loss date was the date on which the harm occurred, not the date on which it was discovered. Filing time was the difference between when the loss occurred, and the claim was filed. Open claim time was the difference between when a claim was filed and closed. A claim was considered paid if an indemnity payment was made via either settlement or plaintiff verdict. We examined claim payment when it was paid on behalf of any defendant, including people outside of the three aforementioned role groups, such as physical therapists or pharmacists. We also examined claim payment when it was paid specifically on behalf of one of the three aforementioned role groups. Costs were summed across defendants and expressed in 2016 valuation using the National Consumer Price Index.²⁰

Statistical methods

We did unadjusted comparisons of claim characteristics using Chi-squared tests for percentages and Kruskal-Wallis tests for medians.

We did multivariable logistic regression to identify factors associated with claims being paid on behalf of any defendant. Arguably, these claims should be targeted first for prevention because they demonstrated at least some merit to be awarded monetary compensation in the current legal system. We chose variables a priori that would be known about at the time of the harm events to include as predictors. Identifying significant variables that are known about at the time of the harm event would potentially allow us to anticipate whether the event would result in payment if it developed into a malpractice claim. Defendant role group (PA, APRN, physician) was treated as a categorical variable. Other variables included were patient factors, such as age and sex, outpatient versus inpatient care setting, whether the event was procedure-related and harm severity, which ranged from emotional harm to death. The reference group was the subgroup with the largest sample size.

Two-tailed threshold for significance was <0.05 . We used SAS 9.4 (Cary, NC).

RESULTS

Of 54,772 claims, we identified 37,721 claims with at least one PA, APRN, or physician named as a defendant. These claims originated from the Northeast (60%), West (32%), South (5%), and Midwest (3%). There were 134 claims naming PAs as defendants, 236 claims naming APRNs as defendants, and 37,632 claims naming physicians as defendants (Figure 1). The percentage of claims naming each role group was stable over time (Figure 3 of the Supplemental Digital Content).

Many claims had more than one role group named as a defendant. Of the 134 claims naming PAs as defendants, 81% had at least one physician co-named as a defendant. Of the 236 claims naming APRNs as defendants, 73% had at least one physician co-named as a defendant. Only three claims had all three role groups named as defendants.

For the primary analysis, we examined only claims naming PAs and APRNs that did not concurrently have physicians co-named as defendants. The characteristics are shown in Table 1 and compared across role groups. There was not a statistically significant difference in patient harm severity among claims naming PAs, APRNs, or physicians. Allegation relating to surgical treatment was more common in claims naming PAs (27%) and physicians (32%), compared with claims naming APRNs (17%, $P = 0.03$). Most claims involved a procedure (~65%), which did not differ by role group. Care setting differed by role group; claims from inpatient care were more common when PAs and APRNs were named (42% and 57%,

Table 1: Comparison of malpractice claim characteristics in which physicians, physician assistants, or advanced practice registered nurses were named as defendants, 2007–2016

Claim characteristics	Defendant role group			P value
	Physician assistant	Advanced practice registered nurse	Physician	
	<i>n</i> = 26	<i>n</i> = 63	<i>n</i> = 37,354	
Most common relevant patient co-morbidities				
Diabetes	5 (19%)	4 (6%)	2,161 (6%)	0.09
Obesity	3 (12%)	5 (8%)	2,752 (7%)	0.93
Hypertension	3 (12%)	5 (8%)	2,352 (6%)	0.71
Claimant age, median (IQR)	49 (33-60)	49 (37-60)	48 (35-61)	0.80
Claimant sex (% male)	14 (54%)	29 (46%)	15,152 (41%)	0.48
Filing time in months, median (IQR)	12 (4-24)	9 (2-24)	17 (10-6)	<0.001
Open claim time in months, median (IQR)	18 (10-28)	23 (10-43)	18 (9-32)	0.18
Severity				
Death	2 (8%)	15 (24%)	8,496 (23%)	0.18
Permanent	12 (46%)	20 (32%)	14,298 (38%)	0.40
Temporary	12 (46%)	22 (35%)	11,929 (32%)	0.26
Emotional or legal issue	0	6 (10%)	2,640 (7%)	0.28
Allegation category				
Surgical treatment	7 (27%)	11 (17%)	12,114 (32%)	0.03
Medical treatment	8 (31%)	12 (19%)	8,438 (23%)	0.49
Diagnosis-related	5 (19%)	7 (11%)	8,496 (23%)	0.08
Medication-related	2 (8%)	2 (3%)	2,630 (7%)	0.48
Obstetrics-related	1 (4%)	4 (6%)	1,805 (5%)	0.83
Procedure involved	18 (69%)	42 (66%)	23,051 (62%)	0.52
Care setting				
Inpatient	11 (42%)	36 (57%)	14,883 (40%)	0.03
Outpatient	12 (46%)	24 (38%)	19,985 (54%)	0.04
Emergency room	3 (12%)	3 (5%)	2,214 (6%)	0.44

n (%) is reported unless otherwise stated. An example of a claim with harm severity as “legal issue” is property damage, such as loss of dentures. IQR = interquartile range.

respectively) compared with when physicians were named (40%, $P = 0.03$).

We examined defendant and payment characteristics in detail (Table 2). Although claims naming PAs and APRNs were more likely to be paid on behalf of any defendant (50% and 46%, respectively), compared with claims naming physicians (33%, $P = 0.01$), they were more likely to be paid on behalf of the hospital or practice (38% and 32%), compared with physicians (8%, $P < 0.001$).

We also examined the amount of indemnity paid in claims naming PAs, APRNs, and physicians (Table 2, bottom panel). We did not detect a statistically significant difference in median indemnity paid on behalf of any defendant, on behalf of the specified role group (PA, APRN, or physician), or on behalf of the hospital or practice (Table 2, bottom panel). The confidence intervals for these estimates were wide with one confidence interval more than \$1,000,000.

Table 2: Defendant and payment characteristics of claims in which physicians, physician assistants, or advanced practice registered nurses were named as defendants, 2007–2016

Claim characteristics	Defendant role group			P value
	Physician assistant n = 26	Advanced practice registered nurse n = 63	Physician n = 37,354	
Number of defendants, median (IQR)	2 (1-3)	2 (1-3)	1 (1-2)	<0.001
Hospital or practice named as a co-defendant	15 (58%)	41 (65%)	14,026 (38%)	<0.001
Nurse named as a co-defendant	4 (15%)	8 (13%)	495 (1%)	<0.001
Paid on behalf of any defendant	13 (50%)	29 (46%)	12,259 (33%)	0.01
Paid on behalf of specified role group	4 (15%)	13 (21%)	10,064 (27%)	0.23
Paid on behalf of hospital/practice	10 (38%)	20 (32%)	3,071 (8%)	<0.001

	Defendant role group			P value
	Physician assistant n = 13	Advanced practice registered nurse n = 29	Physician n = 12,259	
Of paid claims, median indemnity paid on behalf of any defendant (IQR)	\$191,051 (\$75,000-514,950)	\$100,360 (\$30,897-325,000)	\$198,042 (\$55,207-514,950)	0.27
Of paid claims, median indemnity paid on behalf of specified role group (IQR)	\$353,000 (\$98,725-1,327,975)	\$57,674 (\$15,417-619,626)	\$192,334 (\$55,065-489,039)	0.52
Of paid claims, median indemnity paid on behalf of hospital/practice (IQR)	\$220,052 (\$75,000-633,181)	\$77,587 (\$19,463-265,707)	\$203,888 (\$54,878-517,806)	0.12

n (%) is reported unless otherwise stated. IQR = interquartile range. An example of indemnity paid on behalf of the “specified role group” refers to claims naming physician assistants that were paid on behalf of physician assistants.

The most common final diagnosis of claims overall was laceration during a procedure, which accounted for 2,910 claims. There was no statistically significant difference in the frequency of this final diagnosis by role group (Table 3). However, claims involving broken teeth were less common when PAs were named (0) and physicians were named (1%) than when APRNs were named (10%, $P < 0.001$). The vast majority of these tooth-related harm events involved certified registered nurse anesthetists and occurred in the operating room (90%).

The multivariable regression analysis revealed several factors significantly associated with claims being paid on behalf of any defendant (Table 4). When APRNs were named as defendants without physicians co-named, the odds ratio (OR) of claim payment was 1.82 (95% CI 1.09-3.03, $P = 0.02$). Likelihood of payment was lower when care was delivered in the inpatient care setting (OR 0.89, 95% CI 0.85-0.93, $P < 0.001$), but higher when claims were procedure-related (OR 1.31, 95% CI

1.25-1.38, $P < 0.001$) and when harm severity was death (OR 1.09, 95% CI 1.03-1.16, $P = 0.003$).

Lastly, we compared characteristics of claims in which PAs or APRNs were named without physicians versus claims in which they were co-named with physicians. There were few statistically significant findings, but a diagnosis-related allegation was less common when APRNs were named without physicians (11%) than when they were named with physicians (28%, $P = 0.005$, Table 1 of the Supplemental Digital Content). There was no difference in where events occurred (inpatient vs outpatient setting) depending on whether physicians were co-named. Of paid claims, the median indemnity paid on behalf of any defendant was significantly lower when nurse practitioners were named without physicians (\$100,360, 95% \$30,897-\$325,000) than when physicians were co-named (\$515,936, 95% CI \$193,295-\$1,051,605, $P < 0.001$; Table 2 of the Supplemental Digital Content). Finally, the final diagnosis of a broken tooth was more common when

Table 3: Final diagnosis of claims in which physicians, physician assistants, or advanced practice registered nurses were named as defendants, 2007–2016

Final diagnosis	Defendant role group			P value
	Physician assistant n = 26	Advanced practice registered nurse n = 63	Physician n = 37,354	
Laceration during a procedure	1 (4%)	7 (11%)	2,901 (8%)	0.46
Broken tooth	0	6 (10%)	250 (1%)	<0.001
Procedure-related hemorrhage	1 (4%)	4 (6%)	467 (1%)	<0.001

Table 4: Multivariable regression analysis of claim payment, 2007-2016

Variable	Odds ratio	95% confidence interval	P value
Patient age	0.98	0.97-0.99	<0.001
Patient male	0.96	0.91-1.00	0.07
Defendant role group			
Physician assistant	1.89	0.85-4.24	0.12
Advanced practice registered nurses	1.82	1.09-3.03	0.02
Physician		Reference group	
Care setting			
Inpatient	0.89	0.85-0.93	<0.001
Outpatient		Reference group	
Emergency room	1.04	0.95-1.15	0.38
Procedure related	1.31	1.25-1.38	<0.001
Severity			
Emotional or temporary	0.45	0.43-0.48	<0.001
Permanent		Reference group	
Death	1.09	1.03-1.16	0.003

The term *paid* refers to whether an indemnity payment was made on behalf of any defendant through either settlement or plaintiff verdict.

a nurse practitioner was named without a physician than with a physician (10% vs 2%, $P = 0.01$; Table 3 of the Supporting Information Digital Content).

DISCUSSION

We demonstrate that claims naming PAs and APRNs without physicians are different from claims naming physicians in terms of likelihood of (1) having a surgical allegation, (2) occurring in the outpatient versus inpatient setting, and (3) being paid on behalf of the hospital or

practice. Because of the unique data source that spans the entire country and contains chart review-level granularity, these findings are novel. We were able to differentiate characteristics at the defendant level for both paid and unpaid claims, whereas most previous studies using the National Practitioner Data Bank only contain claims paid on behalf of individuals. We were intentionally restrictive in presenting comparisons of claims in the main analysis that only named APPs without physicians in order to understand the differences in malpractice risk by individual role. Although the resulting sample size is small,

no other data set containing both paid and unpaid claims has been published to date.

Given that APPs are often working directly with physicians, we felt that it was also important to show the differences in claims depending on whether physicians were co-named with APPs. There appeared to be few overall differences between claims co-naming physicians with APPs, which could be due to low power. However, we did detect that APRNs named without physicians had a lower likelihood of having a diagnosis-related allegation and a lower median indemnity paid on behalf of any defendant. This could be attributed to the fact that APRNs see less complex, lower risk patients when working without physician supervision or consultation. These results could be used strategically to design patient safety initiatives that uniquely target care given by APPs.

Understanding why certain types of events are more likely to occur with physicians named or not named is difficult. For example, the final diagnosis of broken teeth occurred more frequently when APRNs were not co-named with physicians. This could reflect the fact that physicians were not directly involved in the care at the time of the event. Alternatively, however, there may not have been enough evidence to support a particular physician's negligence related to the harm event, that is, he/she being unavailable to supervise the certified registered nurse anesthetist when the expectation was that he/she be physically present in the operating room at the time of induction. Additionally, states' regulatory and/or legal milieu could also be playing a role. Claims naming APRNs without a physician could originate from states that view APRNs as independent (all states except Alabama, Delaware, and Massachusetts²¹) and thus prosecute APRNs as such. These claims could also come from states that require a higher burden of proof in the initial claim in order to pass initial screening processes, such as Massachusetts with state-appointed tribunals that screen claims for merit. The fact that the majority of claims originated from the Northeast should also be considered, because both the regulation of APPs and tort law are administered partly on the state level. All of these nuances should be considered when interpreting the data.

Several results related to claim payment are particularly interesting. When paid, claims naming either PAs or APRNs are more likely to result in payment on behalf of the hospital or practice compared with claims naming physicians. This makes sense given that APPs are typically hospital employees, rather than members of a provider organization, such as a physicians' organization. These claims paid on behalf of a hospital or practice, not an individual, would not be in the National Practitioner Data Bank, which distinguishes our study from previous studies. Additionally, because APRNs are considered independent practitioners in all but the three states mentioned above, we believe this is why the percentage of claims naming APRNs paid on behalf of the hospital or practice (32%) was slightly lower than the percentage of claims naming

PAs that were paid on behalf of the hospital or practice (38%). Further research is needed regarding the effect of state regulation on the practice of APPs, including whether a higher degree of regulation results in fewer adverse events and malpractice claims.

Our results with regard to the amount of indemnity paid on behalf of various providers build on previous work.^{9,14} Brock et al used the National Practitioner Data Bank to determine the rate over time that PAs, nurse practitioners, and physicians incurred: (1) claims that were paid on their behalf and (2) licensure adverse actions.⁹ Of paid claims, our median indemnity of ~\$192,000 that was paid on behalf of physicians was consistent with Brock et al's report of \$195,000, the latter of which was normalized to 2014 valuation and projected to decline based on the slope of previous years of data.⁹ However, our median indemnity of ~\$353,000 that was paid on behalf of PAs and ~\$57,000 that was paid on behalf of APRNs differed from Brock et al's report of \$125,000 and \$130,000, respectively.⁹ This discrepancy could be due to the fact that they had a larger sample size for the paid portion of claims (~800 for claims naming PAs and ~1,100 for claims naming nurse practitioners). Additionally, they did not include certified nurse midwives or certified registered nurse anesthetists, so their group called nurse practitioners was narrower than ours.

Our results differ from previous studies in terms of the most common allegation. We found only ~10-20% of claims naming PAs or APRNs had an allegation that was diagnosis-related. Brock et al reported that ~40-50% claims naming PAs and nurse practitioners had an allegation that was diagnosis-related.⁹ Two other studies by Sweeney et al¹⁰ and Leigh et al⁸ reported rates that were similar to Brock et al for diagnosis-related allegations when nurse practitioners were named (~40%). However, neither of the two latter studies examined claims naming PAs or claims naming certified nurse midwives or certified registered nurse anesthetists. Our study, which contained both paid and unpaid claims, likely captured more unpaid claims that were not diagnosis-related, such as claims involving childbirth and intubation.

The multivariable regression results indicate practical targets to potentially intervene upon to decrease the likelihood of harm events leading to paid malpractice claims in the future. The results suggest the following target: high-risk outpatient airway procedures, such as intubation, involving APRNs. Because the most common final diagnosis in claims naming APRNs were procedural complications, such as broken teeth, we would potentially recommend targeting technical competence of APRNs performing intubations. Because so many APP training programs in the United States are new, these results could be used to shape curricula across the country.²² Simulation may be an appropriate training mechanism to ensure procedural competence of airway procedures, as it has been shown to decrease actuarial risk for physician proceduralists (anesthesiologists and surgeons).^{23,24}

Claims naming PAs and APRNs were overall rare in a national database of claims spanning a 10-year time period. The fact that we found fewer claims naming PAs than APRNs is likely because there are fewer PAs than APRNs practicing in the United States.²⁵ Although these events are rare, it is important to consider that a single claim, even if unpaid, can have devastating consequences for patients, families, providers, and the healthcare system.²⁶ The literature demonstrates profound effects on providers that can last for years after a malpractice claim closes.²⁷ Providers can become underconfident in their procedural skills and refer more patients to interventionalists, who practice in expensive tertiary medical centers; they may develop a lower threshold for ordering expensive diagnostic imaging, especially when there is uncertainty in a patient's presentation. Claims in this study were open for ~1.5 years. Prolonged open claim times can worsen the anxiety felt by providers, since pending claims must be reported to state licensing agencies and credentialing committees.

The findings of the current study must be considered in the context of several key limitations. First, the role of APPs may vary between departments in the same hospital, so it is difficult to make broad suggestions that will apply uniformly across hospitals. No other data source of this size exists that contains both paid and unpaid claims, so these results add new information to the literature. Second, we could not perform multivariable regression on payment that was made specifically on behalf of APPs because of the small sample size. Nevertheless, the regression result that we did present provides a practical, interpretable result. Third, there was no way to identify the severity of acute illness that patients had leading up to the harm events when being treated by APPs or physicians. APPs may treat different patients, such as those with lower perceived periprocedural risks, for example, so the circumstances surrounding procedural laceration in claims naming APPs may be different from claims naming physicians. Despite this limitation, these data are highly granular and, again, constitute one of the best available data sources for this type of research. Fourth, the database cannot be used to assess malpractice risk in different states or regions. A count of physician-coverage years would be needed to make inferences about the legal milieu in different states or regions of the country.

In summary, the present study reflects a broad overview of the medical malpractice landscape for APPs in the United States. We utilize a unique data source that includes both paid and unpaid claims as well as granular defendant-level payment data. Designing patient safety initiatives and training programs according to the target areas identified in this study could prevent harm events from occurring in the future, which would benefit patients, providers, and the systems in which they work. Outpatient airway procedures performed by APRNs may be a target for quality improvement. Although claims naming APPs were rare, the growing number of APPs as well as their

expanding roles in health care makes this an important and timely topic.

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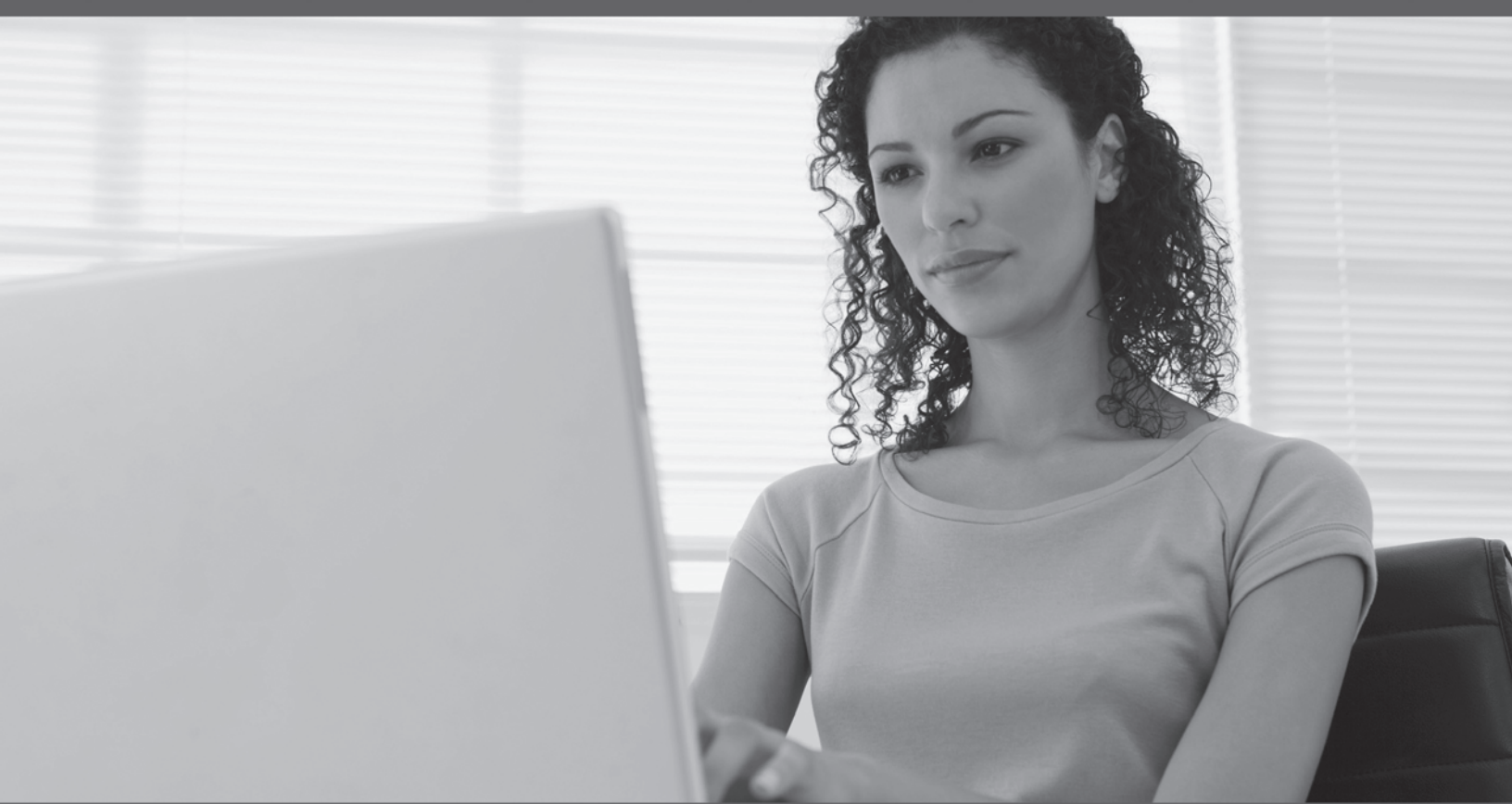
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Correlation between hospital rating agencies' data: An analysis and recommendation

By

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Hospital rating agencies exist to inform consumers through publicly available patient safety data. The large number of rating agencies, the variability in their methodologies and data presentations leave few consumers considering these data in making healthcare decisions. The objective of this study was to analyze the comparability of data from four different healthcare rating agencies to understand whether there exists a correlation among the rating agencies' published data. Four well-known rating agencies' data were gathered for 30 Connecticut hospitals and analyzed using correlation methods. The overall rating score was used for comparison accounting for patients' probability of referencing this score in determining a hospital's safety. The results indicate little or no correlation between ratings of Connecticut hospitals among the reviewed rating agencies. The only statistically significant correlation was between CMS and Leapfrog. The lack of correlation among rating agencies' publicly available data identified in this study leads to consumer confusion. This research provides support for the need for a valid, reliable, and transparent healthcare rating system to inform patient decision making. These findings can be used to advocate for a legislatively mandated national reporting system that focuses on user understanding of the data.

INTRODUCTION

Public disclosure of health care quality data has rapidly expanded since the early 1990s. It is estimated that over \$15.4 billion is spent annually to report quality metrics in the United States.¹ Studies cite hundreds of different metrics used to analyze and quantify health care quality.^{2,3} These quality metrics were initially hypothesized to improve the information provided to consumers. By providing these metrics, it was thought to foster informed decision-making and to encourage quality improvement (QI) by holding physicians, practices, hospitals, and health care systems accountable for public disclosure of their respective metrics.^{4,5} Despite attempts at expanding metrics, simplifying language, and displaying quality report cards in various different presentations, consumers have yet to fully embrace and benefit from the available data.^{5,6}

Earlier research indicated only 14% of consumers used quality measures to choose insurance plans, hospitals, and individual providers.^{7,8} In a more recent 2015 update, a Kaiser Family Foundation report identified that less 10% of consumers reported using any source of health care quality data in making these same decisions.⁹⁻¹¹ Studies conclude that the initiative of publicly reporting health care quality data has not yet reached its potential.¹¹ A significant portion of the population is not using quality metrics to inform consumer decisions.¹⁰ A recent study published in *Health Affairs* found “public reporting to date has been disconnected from consumer decisions,” much of which may be attributed to poor report card content, presentation, and availability.¹²

Among the reasons frequently cited for minimal consumer engagement, two are consistently identified: tremendous variability and inconsistencies among different rating agencies, and notably poor presentations of report cards and quality ratings.^{2,5} Austin et al compared hospital ratings from four well-regarded national hospital rating agencies: Leapfrog, *U.S. News*, Healthgrades, and *Consumer Reports*. The authors categorized high- and low-performing facilities according to each rating.¹³ Of the hospitals rated as a high performer by one rating agency, only 10% were rated as a high performer by any second rating agency.¹³ This research demonstrated poor comparability between different rating agencies. Our research expands on the work of Austin et al, as our study period advances the data by nearly 5 years, and our methodology accounts for the overall published agency hospital rating rather than categorizing as a high or low performer.

The general mission of rating agencies is certainly well intended: to provide transparency in quality metrics to inform patients (also known as consumers) and other stakeholders in decision making.¹¹ Stakeholders for these data also include payers wanting to direct employees to centers of excellence, and hospital leaders and boards to prioritize areas for improvement and/or market “excellent” graded performance. However, the proliferation of

agencies and metrics and the lack of consistency among the data leave stakeholders in a state of confusion, with few patients considering these data in making health care decisions.^{6,10,13}

The purpose of this study was to analyze the comparability of four different health care rating agencies—Leapfrog, Centers for Medicare & Medicaid Services (CMS), Healthgrades, and Why Not the Best (WNTB)—using data from Connecticut hospitals. This research provides an analysis useful in determining the variability among each agencies’ overall hospital ratings and consideration as to how the variability among ratings may hamper the consumers’ ability to use these data in making informed health care decisions. Our study provides a foundation to consider possible legislative initiatives to encourage useful and congruent ratings for consumer health care decisions.

METHODS

Five well-known national hospital rating agencies were identified: The Leapfrog Group, CMS, Healthgrades, WNTB, and *U.S. News & World Report*. The leapfrog group’s goal is to improve the safety, quality, affordability, and transparency of U.S. health care. It releases hospital letter grades from A through F, updated twice a year.¹⁴ The leapfrog safety grades are calculated based on data from CMS Medicare-reported data, the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the leapfrog hospital survey, and the American Hospital Association’s Annual Survey and Health Information Technology Supplement.^{14,15} Leapfrog rating measures include hospital structures, processes and outcomes supported by the literature as known measures to improve patient safety.^{14,16}

CMS is a government agency that oversees the hospital compare website which includes the hospital star rating, rating hospitals from one to five stars, updated twice a year.^{17,18} Hospital compare provides U.S. hospital quality ratings from Medicare-reported data and the CDC.¹⁷ CMS hosts numerical grades for U.S. hospitals on its website¹⁸ based on hospital outcome measures for infection, mortality, readmission rates, and patient satisfaction surveys.¹⁷

Healthgrades uses CMS inpatient claims data to provide U.S. hospital quality ratings. Hospital performance is measured for the most common in-hospital procedures and conditions and adjusted for patients’ risk factors.¹⁹

WNTB publishes an “overall recommended care” metric²⁰ that includes data on process-of-care measures, patient satisfaction measures readmission rates, mortality rates, and average reimbursement rates. Data are obtained from CMS Medicare-reported data, Hospital Consumer of Healthcare Providers and Systems, and AHRQ indicators.

U.S. News & World Report is a well-recognized rating agency of universities as well as health care facilities and

providers.²¹ Its methodology focuses on rating the top five hospitals in CT rather than rating all hospitals. It also rates top hospitals for specific specialties and procedures. These data were not reasonably comparable to the other rating agencies that issued uniform ratings for nearly all hospital facilities in the state. As such, *U.S. News & World Report* ratings were excluded from this study.

Ratings available for all 30 Connecticut hospitals in summer 2017 were gathered from the publicly available websites of the respective rating agencies. Correlations were used to measure the association in hospital overall rating scores for the four grading systems. The Pearson correlation was used for ratings between two continuous scales. The polychoric correlation was used for ratings between two ordinal scales. Finally, for ratings between a continuous and an ordinal scale the polyserial correlation was used.

This study was approved by the Quinnipiac University's institutional review board (IRB) (#13517).

RESULTS

Of the 30 hospitals located in CT, ratings were retrieved for 27 (90%) of the hospitals. Table 1 shows the ratings for each of the 27 hospitals by each of the four rating systems. Leapfrog ratings were missing for four hospitals while the CMS, Healthgrades, and WNTB ratings were available for all 27.

Table 2 demonstrates the correlations between rating systems. Leapfrog was strongly and significantly related to CMS ($r = 0.72$) and moderately and significantly related to WNTB ($r = 0.53$). Healthgrades did not significantly relate to any of the other three rating systems. It was weakly related to CMS ($r = 0.30$) and very weakly related to Leapfrog ($r = 0.17$) and WNTB ($r = 0.16$).

Leapfrog letter grades for Connecticut hospitals ranged from A to D with an average rating of C+. CMS scores ranged from two to four stars with an average of 2.5 stars. Healthgrades ratings ranged from 57 to 84% with an average of 71.2%. WNTB ratings ranged from 93.19 to 99.53% with an average of 97.2%.

LIMITATIONS

This study was limited to Connecticut hospitals. The one exclusively pediatric based hospital was excluded from this study as it did not receive any ratings. As such, data cannot be extrapolated to the pediatric populations. Two additional hospitals were excluded due to limited sample size. Notably, the data analyzed is from the spring 2017 season. It is possible that the results and respective correlations may change for different periods, but it is reasonable to believe drastic changes are unlikely. A previous *Health Affairs* study found similar results.¹³

DISCUSSION

This study examined four national ratings agencies overall hospital score to determine whether there existed correlation among the different agencies' ratings of hospitals. The results indicate minimal correlation between the different ratings of Connecticut hospitals among the reviewed rating agencies. The only strong statistically significant correlation, between CMS and Leapfrog is likely a result of Leapfrog's use of CMS data in the Leapfrog algorithm.¹⁴ Given the overlap in raw data between these agencies, it is no surprise that these two agencies yielded similar results with a significant correlation. Aside from Leapfrog and CMS, the only other statistically significant correlation appeared between Leapfrog and WNTB, but it must be noted that it was only a moderate correlation ($r = 0.53$). Otherwise, no significant similarities are noted between the other rating agencies analyzed. Notably, Healthgrades demonstrated the poorest correlations with all other rating agencies.

This lack of agreement between rating agencies' data may be explained by each agencies' use of different measures, methods, and foci. However, the lack of strong correlations between the different ratings agencies overall ranking score for hospitals highlights a lack of meaningful data available for consumer health care decisions due to confusing and inconsistent overall rankings. Our results correspond to the findings of several other recent studies.^{12,13} The research by Austin et al. identified a lack of agreement among rating agencies using high and low performing hospitals for each rating agency.¹³ This comparison of several of the rating agencies represents a number of concerning features highlighting a lack of congruency among rating agencies which may mislead patients. Patients may choose a top-rated hospital based on a particular rating agency's data, while other agencies rate the same facility far poorer. Patients who examine multiple ratings for a particular hospital are often faced with contradictory data, causing confusion and leaving patients unsure where to turn.

Aside from the contradictory ratings, the variability of rating scales between the different rating agencies poses additional challenges to consumers. For example, while a Healthgrades rating of 92% would fall much higher than any current rating in a Connecticut hospital, the same 92% by WNTB would be the weakest hospital in the state. The variability in rating ranges and standard deviations challenges consumers to properly interpret the data, as previously discussed.¹³

Despite the lack of consumer engagement, health care report cards show promise for improving care. Previous studies found value in using publicly available patient safety data. In response to some disappointing report cards, some hospitals and health care systems have improved significantly in performance and patient outcome metrics.⁵ Studies found that public disclosure of hospital data motivated an increase in QI projects to improve the

Table 1: CT Hospital Scores by Rating Systems

Hospital	Leapfrog	CMS	Healthgrades (%)	Why Not (%)
Backus Hospital	A	4 Stars	69	97.7
Bridgeport	D	2 Stars	71	93.2
Bristol	A	3 Stars	73	97.1
Charlotte Hungerford	B	2 Stars	62	96.8
Danbury	C	2 Stars	77	96.5
Day Kimball	A	3 Stars	69	97.3
Greenwich	C	3 Stars	84	96.4
Griffin	B	2 Stars	78	99.5
Hartford Hospital	C	2 Stars	69	96.4
Hospital of Central Connecticut	C	2 Stars	71	98.2
Johnson Memorial	No score	3 Stars	68	94.9
Lawrence & Memorial	B	3 Stars	69	96.6
Manchester	No score	2 Stars	57	97.8
Middlesex	A	3 Stars	80	98.1
MidState Medical Center	C	3 Stars	69	97.1
Milford	B	3 Stars	78	97.3
Norwalk	C	3 Stars	75	98.3
Rockville	No score	3 Stars	62	95.7
Sharon Hospital	No score	3 Stars	72	97.5
St. Francis	A	3 Stars	80	97.1
St. Mary's	C	3 Stars	72	97.8
St. Vincent's	C	2 Stars	71	96.2
Stamford	A	3 Stars	76	98.1
UConn-John Dempsey	A	3 Stars	76	98.3
Waterbury	C	2 Stars	65	98.4
Windham Hospital	B	3 Stars	69	99.2
Yale New Haven	C	3 Stars	76	97.9

publicly reported metrics.^{4,6,22} Public reports on hospital quality and patient safety have assisted in focusing hospital leaderships' attention to improving quality. These studies noted an increased investment in QI projects and in people and systems to improve patient safety.²³ Others found hospital staff were more inclined to follow best practice guidelines and the care provided was better documented.⁶ The same study found that senior leadership showed a greater focus on health care quality and patient safety with the publication of results although this did not hold true for small non-JACHO-accredited hospitals.⁶ Additional research found that some health care leaders supported the concept of measuring quality; however, the majority of those surveyed criticized the validity and utility of current quality measures.²⁴ Similar

improvements were noted among individual providers and private groups that are subject to public disclosure of their respective quality metrics.¹²

One question fundamental for hospital report cards remains as to how much data to include and their proper presentation.²⁵ It is evident that some report cards present too much detail for consumer to effectively process and understand.^{13,25-27} While simplifying quality report cards to a mere letter or numerical grade may mitigate risk of data overload, it limits the transparency of how the metric is calculated. For example, a patient looking for an orthopedist may find a particular hospital to have a LeapFrog assigned B rating because the hospital does not have a closed ICU. The B rating may lead the patient away

Table 2: Correlations between Hospital Rating Systems

	Leapfrog	CMS	Healthgrades	Why Not
CMS	0.742 ^{**}			
Healthgrades	0.166	0.298		
Why Not	0.525 ^{**}	0.172	0.162	
Average Rating	C+	2.5 stars	71.2	97.2

Polychoric between ordinal measures. Polyserial between continuous and ordinal measures.

^aPearson between continuous measures.

^{**} $P < .01$.

from seeing an orthopedist at that hospital, but it is unlikely to affect care from the orthopedist on an outpatient basis. As health care report cards move forward it is important to find the balance between simplicity and transparency.

As our results indicate, there is a general lack of correlation in publicly available patient safety data resulting in consumers' inability to use these data to make informed decisions as to safe and quality health care. These findings support the need to improve the assessment, underlying data, validity, reliability, and presentation of publicly available data.^{2,5,8,11,25}

One potential solution is limiting the number of publicly available conflicting sets of patient safety and health care quality measures by creating a national clearinghouse for these measures. A clearinghouse would provide for a national set of research-proven quality and patient safety measures. Any proposal and implementation of a national clearinghouse for patient safety measures should take into account the need for timely and accurate data. These efforts should consider the primary audience for these data—namely the patient—and allow for a presentation that is user-friendly. A national clearing house would also allow for uniform rating scales, either all alphabetical or all numerical, with comparable ranges and standard deviations.

A legislative solution might encourage provider participation in data submission and editing to one national database. Currently, health care organizations in order to participate in and receive federal payment from Medicare or Medicaid programs must meet the government requirements for program participation, called conditions of participation (CoPs). CoPs mandate certification of compliance with the health and safety requirements.²⁸ Tying Medicare CoPs to the providers' participation in data submission, editing, and analysis would provide a nationally recognized data source. This national data base, directed by content experts, could provide a foundation for analysis, transparency, and a format supporting health care decisions for stakeholders.

As discussed, the rate of consumer engagement in health care report cards remains low, and the consideration of these metrics in health care decision making remains even lower.^{4-5,7-11} Publicly reported health care metrics remain vital to the future of consumer health care decisions about their care, but the current landscape of health care rating agencies must be tailored to assure consistent, valid, and comparable measures.

This paper explored the lack of correlation among four publicly available ratings. Future research is needed to understand how the consumer uses hospital ratings data in their decisions for care and whether they are currently misled by the available data. Additional research is also required to design an ideal ranking system as it pertains to format, readability, methods, and transparency. One recent study, took a step in this direction by undertaking a systematic review of several ranking systems' methodologies, strengths, and weaknesses.²⁹ Their analysis found a need for better underlying data, edits and audits of these data, meaningful measures, development of standards, and peer review of rating methodology.²⁹ Publicly available rating data should inform decisions and move the health care quality curve forward in this country. Consistency in ratings is required for this to occur.

CONCLUSIONS

Hospital rating agencies' data are used in methods to improve quality and patient safety. They are also intended for consumers to make health care decisions in terms of choosing a physician, hospital, insurance plan, and so on. Currently, we have a number of publicly available sources; however, as our research indicates, there is little or no correlation among these rating agencies' overall rating that may mislead and confuse patients. The variability of methodologies, metrics scales, and data presentation formats remains a significant barrier to consumer engagement with these publicly reported data. A legislative effort that requires a national clearinghouse for patient safety and quality data is one potential solution for providing transparent and accurate consumer data.

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The impact of clinical crisis management on trauma team outcomes following a prolonged strike by nursing, technical, and support staff

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Abstract: There is a paucity of literature describing the preparation of hospital institutions prior to a nursing strike and the quality outcomes during and after a prolonged nursing strike. No published study was found describing the effects of a prolonged strike on quality outcomes specific to trauma patients. The American College of Surgeons (ACS) suggests specific critiques and complications data that each trauma program may choose to track as quality indicators, and those metrics are submitted to regional, state and national databanks and closely examined during site accreditations. This research study analyzed data from three equal time periods following a multiservices strike involving both nurses and service/technical staff lasting 63 days. The purposes of this study were to (1) evaluate the effects of prestrike organizational leadership and crisis management planning on organizational staffing and emergency management to reduce health care risk during the strike, (2) describe outcomes data from three equal time periods: prestrike, strike, and poststrike, and (3) specifically compare the trauma program's selected ACS trauma metrics for critiques and complication rates for our high-risk/high-volume population as a level 1 trauma center.

INTRODUCTION

The Mercy Health St. Vincent Medical Center is a community-based level 1 trauma center with approximately 60,000 annual emergency room visits and 2400 trauma admissions per year. This institution has multiple residency and fellowship programs and is a long-established tertiary care center. In June 2018, union contracts expired for both nurses and service/technical staff. The Nursing Unit Leadership Team encompassed all registered nurses in acute care areas including Life Flight (the air ambulance service). The Technical and Service Unit Leadership Team was composed of other licensed health care professionals, including respiratory therapists, diagnostic testing technicians, aids, health unit coordinators, transportation services, dietary, environmental services, and patient registration staff.

ANTICIPATORY PLANNING

Administrators remained hopeful a workforce stoppage could be avoided, but proactively began planning for a strike in June 2018. The Regional Chief Nursing Officer (CNO) networked with other CNO's who had experienced nursing strikes and were willing to discuss best practices for organizational staffing issues. The institution contracted with a company specializing in nursing strike assistance to provide expert advice, planning, and arrangement of multiple intricate details that ensured a smooth transition. Key concepts included:

1. Institutional assessment of essential departments that needed to remain fully functional. The institution is a level 1 trauma center with multiple intensive care units (ICU), including a burn unit, regional heart and vascular center, a stroke center, and a level III neonatal intensive care unit (NICU). There are multiple specialty areas, including inpatient hemodialysis, palliative care, stepdown units, general medical surgical units, an observation unit, and unique surgical specialties. Administrators needed to decide which units were essential to keep open and the units that could be temporarily consolidated or closed.
2. Unit nursing managers identified the specific skill sets and types of expertise needed to contract for, including credentials and certifications with the intent each nurse coming into the system would have the ability to function in their specialty role on day 1. Highly experienced emergency/trauma and intensive care nurses were recruited by the contracted agency to staff the emergency /trauma department, and trauma surgery ICU, as well as cardiovascular, neuroendovascular, and pediatric ICUs.
3. Training was key to success. When the strike became imminent, the traveling nurses flew into an airport in a different state where they reported to a location unknown to hospital administrators. The contracted

strike agency arranged for all onboarding, including prehire paperwork, physicals, immunizations, licensing paperwork for Ohio, etc. Nurses were then bussed to Toledo for training specific to the institution the weekend before the strike, and continual sessions occurred every weekend after the strike began.

4. The CNO was repeatedly told that all nursing staff would walk out, including the educators. Nurses and managers from other areas such as the quality improvement department, risk management department, the simulation lab, and other mercy facilities across the state were recruited and/or offered to help. One weekend educational session specific to training stations and competencies for institutional equipment, electronic medical record documentation, policies and procedures was held before the strike and then occurred every weekend until the strike concluded. This was due to the constant influx of new team members to ensure staffing needs were met.

On April 26, 2019, a 10-day notice to strike was delivered to the hospital. The institution activated our Hospital Incident Command System on April 29 in preparation for a workforce stoppage. There was always at least one administrator in the hospital that was constantly updated to readjust resources. Twice daily conferences were held with section chiefs to brief the administration on operations and planning of staff, beds, and other resources. On May 6, 2019, the union commenced a strike with staff officially walking out at 4:30 pm. The work stoppage lasted 63 days and likely will have long-lasting financial, systemic, and staffing ramifications.

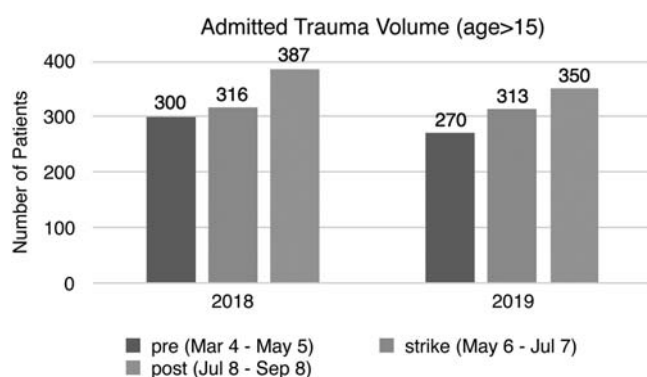
There is a paucity of medical literature describing the leadership preparation of hospitals for clinical crisis management and patient safety prior to a strike and the quality outcomes during and after a prolonged nursing strike. Most of the evidence-based literature regarding the effects of a nursing strike was published prior to the late 1990s. No study was found describing the effects of a prolonged nursing, technical and service unit strike on clinical outcomes specific to trauma patients. The American College of Surgeons has standardized recommendations for quality measures that trauma programs track and submit to regional, state and national databanks that get reported back to the facility for performance improvement, commonly known as complications and critiques. The purpose of this study was to describe our trauma team emergency management plans and organizational staffing experience during the strike and compare the effectiveness of our crisis management interventions on trauma outcomes as measured by quality measures before, during, and after the strike.

METHODS

This study received expedited Institutional Review Board approval for a retrospective observational study that

Figure 1:

Comparison of admitted trauma volume during same time periods, 2018 vs 2019



analyzed data from three equal periods of time: *prestrike*, *strike*, and *poststrike*. Each time period equals 63 calendar days or 9 weeks, which was the length of the strike. Data from the trauma registry were used to compare any changes in outcomes, quality indicators, and/or complications. The three 9-week intervals were: *prestrike* (March 4, 2019-May 5, 2019), *strike* (May 6, 2019-July 7, 2019), and *poststrike* (July 8, 2019-September 8, 2019).

Subjects included any patient aged 15 years old and greater who was admitted with a traumatic diagnosis from the subset of time from prestrike, strike, and poststrike. Research data were exported from the trauma registry into a deidentified Excel data set as outlined in the IRB-approved protocol. Descriptive statistics are reported by time period. Data were expressed as number of patients, number patients (% of total), or median (interquartile range 25th percentile to 75th percentile).

For critiques and complications, the number of patients with the critique or complication is reported. The rates of complications and critiques are expressed as the total number of events per 100 patients. The median ICU days are calculated using only patients with at least 1 ICU day recorded. Similarly, the median number of vent days is calculated using only patients with at least 1 day recorded on vent. Data were tabulated with SAS v9.4.

RESULTS

Trauma volume

The data set included admitted trauma patients age 15 or older who met the criteria for the trauma registry: 270 patients *prestrike*, 313 *during the strike*, and 350 *poststrike*.

Figure 1 demonstrates patienttrauma volumes in 2019 were comparable with trauma volumes in 2018.

Patient characteristics

Traumatic injuries are typically classified as blunt, penetrating, or other. Trauma types were similar across the time periods: *prestrike*, 86% of traumas were blunt, 4% penetrating, and 10% other; *during the strike*, 85% were blunt, 8% penetrating, and 7% other; *poststrike*, 86% were blunt, 5% penetrating, and 9% other. See Table 1.

Trauma patients transferred from another facility averaged 39% in all time periods. The mode of arrival across time periods was as follows: *prestrike*, 72% of patients arrived by ambulance (referring or scene), 13% by helicopter (referring or scene), 15% mode other than ambulance or helicopter; *during the strike*, 70% arrived by ambulance, 15% by helicopter, 15% by other mode; *poststrike*, 67% ambulance, 21% helicopter, 13% other. See Table 1.

Patient outcomes

The median ICU length of stay (LOS) was 2 days (*pre and strike*) to 1-day *poststrike*. The median total LOS was 2 days during the strike compared with 3 days poststrike. Median ventilator days were 3 days prestrike compared with 2 days during and poststrike. Regarding patient transfers, 2% of *prestrike* patients were transferred out to another acute care hospital, 1% of patients *during the strike* were transferred out, and fewer than 1% were transferred *poststrike*. See Table 2.

Trauma program selected metrics from the American College of Surgeons Suggested Reporting for Complications and Critiques

The occurrence of 23 different complications and 21 critiques was totaled over all patients in a time period and expressed as a rate per 100 patients.

Overall complication rates were 13 complications per 100 patients *prestrike*, 8 per 100 *during the strike*, and 12 per 100 *poststrike*. See Table 3.

Overall critique rates were 12 per 100 patients *prestrike*, 9 per 100 *during the strike*, and 10 per 100 patients *poststrike*. See Table 4.

Other important critiques were analyzed separately in Table 5.

The percentage of patients for whom a short clinical assessment tool designed to screen for substance-related risks and problems, SBIRT/CRAFFT (screening, brief interventions, referral to treatment and car, relax, alone, forget, friends, trouble), was not done but should have been: 48% *prestrike*, 41% *during the strike*, and 37% *poststrike*.

Rates for emergency department LOS greater than 2 hours for ICU admission were: 51% *prestrike*, 46% *during strike*, and 54% *poststrike*.

Table 1: Characteristics of Trauma Patients

	Pre	Strike	Post
No. patients	270	313	350
Age (years)	60 (45-74)	49 (32-68)	57 (34-69)
Race			
White	198 (73.3%)	228 (72.8%)	261 (74.6%)
Black	56 (20.7%)	58 (18.5%)	60 (17.1%)
Hispanic	1 (0.4%)	0	0
Other Hispanic	10 (3.7%)	22 (7.0%)	20 (5.7%)
Asian	1 (0.4%)	0	0
Native Hawaiian or Other Pacific Islander	0	2 (0.6%)	0
Not documented	4 (1.5%)	3 (1.0%)	9 (2.6%)
Sex			
Female	100 (37.0%)	110 (35.1%)	143 (40.9%)
Male	170 (63.0)	203 (64.9%)	207 (59.1%)
Cause code			
Bicycle	1 (0.4%)	6 (1.9%)	5 (1.4%)
Cut/pierce/stab	12 (4.4%)	15 (4.8%)	14 (4.0%)
Fall	138 (51.1%)	132 (42.2%)	148 (42.3%)
Fire/friction/steam/electrical burn	21 (7.8%)	8 (2.6%)	27 (7.7%)
Gun shot	1 (0.4%)	15 (4.8%)	10 (2.9%)
Hanging/suffocation	3 (1.1%)	1 (0.3%)	1 (0.3%)
Inhalation	1 (0.4%)	1 (0.3%)	1 (0.3%)
Machinery	4 (1.5%)	1 (0.3%)	4 (1.1%)
Motor vehicle auto	46 (17.0%)	56 (17.9%)	61 (17.4%)
Motorcycle	10 (3.7%)	18 (5.8%)	25 (7.1%)
Near drowning	0	1 (0.3%)	1 (0.3%)
Other (includes electrocution)	2 (0.7%)	14 (4.5%)	6 (1.7%)
Other vehicle	0	5 (1.6%)	4 (1.1%)
Pedestrian	4 (1.5%)	5 (1.6%)	4 (1.1%)
Struck (other than choices listed)	23 (8.5%)	33 (10.5%)	32 (9.1%)
Unknown	4 (1.5%)	2 (0.6%)	7 (2.0%)
Trauma type			
Asphyxia, drowning, inhalation, carbon mon ...	2 (0.7%)	10 (3.2%)	2 (0.6%)
Blunt	232 (85.9%)	265 (84.7%)	301 (86.0%)
Burns/cold	21 (7.8%)	8 (2.6%)	27 (7.7%)
Drowning ...	4 (1.5%)	4 (1.3%)	4 (1.1%)
Penetrating ...	11 (4.1%)	26 (8.3%)	16 (4.6%)
Transfer from another facility	107 (39.6%)	123 (39.3%)	137 (39.1%)

Continued

Table 1: Continued

	Pre	Strike	Post
Transfer mode from scene or referring			
Ambulance from referring	93 (34.4%)	101 (32.3%)	110 (31.4%)
Ambulance from scene	102 (37.8%)	118 (37.7%)	123 (35.1%)
Helicopter from referring	14 (5.2%)	23 (7.4%)	25 (7.7%)
Helicopter from scene	20 (7.4%)	24 (7.7%)	46 (13.1%)
Inhouse—when injured	2 (0.7%)	0	1 (0.3%)
Police vehicle	3 (1.1%)	0	5 (1.4%)
Private vehicle from referring facility	5 (1.9%)	3 (1.0%)	0
Private vehicle, also walked in	31 (11.5%)	43 (13.7%)	38 (10.9%)
Not documented/unspecified	0	1 (0.3%)	0
Trauma team			
Priority (MHW-alert)	75 (27.8%)	96 (30.7%)	112 (32.0%)
Alert (MHW-code)	39 (14.4%)	53 (16.9%)	60 (17.1%)
Consult	87 (32.2%)	85 (27.2%)	111 (31.7%)
No activation	69 (25.6%)	79 (25.2%)	67 (19.1%)
ISS	9 (4-12)	5.5 (4-10)	9 (4-14)

Median (interquartile range) is provided for age and ISS.

Under-triaged patients (urgency of condition was under estimated) prestrike were 6%, compared with 7% *during the strike* and 2% *poststrike*.

DISCUSSION

The specialty of trauma is a discipline of surgery in which the outcome of patients relies heavily on the team and the system functioning at a high level of efficiency. Even when a system is working well, there are still areas for improvement that are tracked, reviewed, and discussed among peers with the goal for improvement of the overall system. The system encompasses everything from prehospital emergency medical services to the discharge of the patient including the nursing, technicians, housekeeping staff, and dietary. During a strike, all of those factors can be affected.

As J. Cohen explains in his article “Strike!,” the keys to success during a strike include “thorough preparation, hard work and commitment to the organization and its patients.”¹ The preparation prior to the strike was a massive undertaking. Our risk management and quality performance departments, simulation lab, and advance practice nurses collaborated with department managers to prepare for training over 500 replacement workers in various specialties to be able to continue to provide health care services for the community. Prior to the strike,

replacement workers had completed all online hospital safety modules, had ID tags, hospital uniforms, and had completed hands-on competency assessments on vital hospital equipment in the simulation lab.

Despite the preparation, there was a mass influx of staff who were unfamiliar with institution-specific trauma processes, policies, guidelines, and physician preferences. There was a major concern that the transition from staff nursing to agency nursing would lead to a worsening of trauma quality data and outcomes. There was also a learning curve for the staff in the emergency department covering the trauma bays for both air ambulance and critical care ground transport arrivals.

During the strike, there were limited numbers of resources that likely impacted many aspects of care. For example, with respiratory therapists striking, managers anticipated a shortage of respiratory therapists, limiting overall critical care patient volume. Prior to the strike, one intubated infant in the NICU was transferred to another institution. Most of the adult ventilated patients were consolidated to our larger ICU (medical and surgical). This was a period where different practitioners involved in patient care had to take on tasks within their scope of practice but not normally done within their specialty, to make sure adequate care was being delivered. An unexpected advantage was many of the traveling nurses were from

Table 2: Patient Outcomes

	Pre	Strike	Post
No. patients	270	313	350
ICU LOS (among patients with at least 1 day)	2 (1-4) N = 104	2 (1-3) N = 102	1 (1-4) N = 134
Total LOS days	2.5 (1-5)	2 (1-4)	3 (1-5)
Ventilator days (among patients with at least 1 day)	3 (1-6) N = 39	2 (1-3.5) N = 36	2 (1-6) N = 49
Outcome			
Alive	260 (96.3%)	307 (98.1%)	339 (96.9%)
Dead	10 (3.7%)	6 (1.9%)	11 (3.1%)
Transfer out of Ohio to acute care hospital	3 (1.1%)	1 (0.3%)	1 (0.3%)
Transfer out to Ohio acute care hospital	3 (1.1%)	2 (0.6%)	1 (0.3%)

Median (interquartile range) is provided for ICU LOS, total LOS, and ventilator days.

California, a state with nurse/patient-mandated ratios. Those nurses routinely provide respiratory therapy treatments to patients at the bedside, expanding on this practice allowed available respiratory therapists to be assigned only to ventilated patients.

Interestingly, the study did not find a substantial difference in ICU LOS, total LOS, ventilator days, transfer out to another hospital, or clinical outcomes before, during, or after the strike. Also notable is that the rate of complications in trauma patients did not seem to be affected by the strike. Overall complications rates were 13 per 100 *prestrike* versus 8 per 100 *during the strike*. Overall critique rates went down to 9 per 100 *during the strike* versus 12 (*prestrike*) and 10 (*poststrike*). Rates of under triage were not affected by the strike but did go down poststrike. Unplanned transfer to ICU and unplanned intubation improved from the prestrike to strike period.

Data support proactive prestrike leadership planning for staffing, and emergency medicine helped to prevent a serious clinical crisis. This study demonstrated many outcome measures were not affected by the strike. The administration developed a plan with different department heads to prepare well in advance of the actual strike. Every hospital that has staff in collective bargaining units should have a “strike plan” in place that is regularly updated, similar to a disaster plan. If a strike becomes increasingly likely as the time for contract negotiations comes closer, leadership needs to be prepared for the many changes required in organization staffing and training of temporary workers to decrease health care risks. Without a crisis plan, hospitals run the risk of dealing with a significant drop in patient volume the institution can continue to safely

manage. This study did not look at overall hospital volume, but an older study reported a 33% drop in volume during a strike.² As a level 1 trauma center, trauma volume did not drop during or after the strike and was higher than before the strike. This indirectly demonstrated the community continued to have confidence in the ability of the level 1 trauma center to care for trauma patients during and after the strike.

Secondly, the integration and utilization of agency nurses or contingency staff was critical to the hospital being able to maintain institutional the volume and quality of care. Ramsey et al found that at their institution, decreased nursing staffing adversely affected ED metrics including door to discharge LOS and number of patients who left without being seen.³ The quality of the nursing traveling nurses hired during the strike who had extensive experience in critically ill patients was a key factor. In some cases, they provided more attention to detail and accuracy than the striking nursing staff and educated existing staff on new evidence-based practices in use at other facilities across the United States. By fully staffing the hospital with agency nurses and other staff, administrators were able to ensure that our trauma center functionality was maintained.

It is important to not only staff institutions but to have a plan on how to integrate new members to the processes and policies at the institution. Surveys conducted after the strike found traveling nurses felt welcomed and appreciated by the institution and were impressed by the degree of administrative involvement and presence on a 24/7 basis.

Lastly, the psychological effects of the strike time period must be considered. In the prestrike period, nurses and

Table 3: Trauma Program-Selected Metrics for Complications

	Pre	Strike	Post
No. patients	270	313	350
Complication—CLABSI (SV117)	0	0	0
Complication—pressure ulcer (stages II-IV) (SV138)	0	0	4
Complication—deep surgical site infection (SV6)	0	0	0
Complication—deep vein thrombosis (SV8)	2	1	2
Complication—fall (SV23)	0	1	5
Complication—pneumonia—aspiration (SV14B)	2	2	2
Complication—pneumonia—vent acquired (SV118)	0	0	0
Complication—pulmonary emboli (SV15)	1	1	0
Complication—severe sepsis (SV16)	0	0	1
Complication—cauti (SV116)	0	0	0
Complication—unplanned admission to ICU (SV20)	10	4	4
Complication—acute kidney injury (SV1)	3	3	4
Complication—acute respiratory distress syndrome (SV2)	1	0	1
Complication—cardiac arrest with CPR (SV3)	2	1	4
Complication—alcohol withdrawal syndrome (SV137)	8	6	6
Complication—extremity compartment syndrome (SV9)	0	1	0
Complication—myocardial infarction (SV11)	0	3	3
Complication—organ/ space surgical site infection (SV12)	0	0	0
Complication—osteomyelitis (SV13)	0	0	0
Complication—stroke/ CVA (SV17)	1	0	2
Complication—unplanned intubation (SV19)	6	1	1
Complication—superficial incisional surgical site infection (SV139)	0	0	2
Complication—unplanned return to the OR (SV21)	0	0	0
Total number of complications during this period and rate per 100 patients	36 13.3 per 100	24 7.7 per 100	41 11.7 per 100

*Note: Some patients may have had more than one complication.

support staff had been without a contract for a year. Failure of the bargaining units to resolve key issues such as mandatory on-call and mandatory overtime to address nursing shortages probably contributed to emotional stress and work performance prior to the upcoming strike. Stress, unhappiness, resentment, and burnout may have all been emotions felt by staff in the period immediately preceding the strike and for workers returning to the institution after the strike. This study was not designed to examine the functionality of the hospital before the strike.

A study utilizing a sample of California Nurse Leaders regarding self-perception during union negotiations, strike preparation, or the actual strike primarily reported negative effects on nurses personally, on their family life,

and professionally.⁴ Union activities caused negative relationships with peers, to leaders they reported to, and those who directly reported to them. Respondents reported negative effects on patient care work environments and negatively affected “current or future initiatives such as Magnet designation or redesignation, certifications, and awards or recognition for excellence. It took approximately 6 to 9 months for the organization to return to a normal state.”⁴ For this study, poststrike, approximately 180 nurses chose not to return to work or took early retirement. Trust issues and tension between striking nurses, nurses who crossed the picket line, and agency nurses was reported by nursing administrators poststrike and the institution continues to use agency staffing to fill open nursing positions a year later.

Table 4: Trauma Program-Selected Metrics for Critiques

	Pre	Strike	Post
No. patients	270	313	350
Critique—prehospital—transporting EMS issues (2004)	1	0	0
Critique—prehospital—scene EMS issues (2005)	11	5	3
Critique—prehospital—referring hospital issues (2006)	0	2	0
Critique—ED—delay to OR (9003)	0	1	2
Critique—ED—delay to OR—admitted to ICU (9018)	0	0	4
Critique—ED—trauma activation upgrade/ downgrade (9013)	2	0	0
Critique—ED—>3 L crystalloids w/ out PRBC (only of hypotension w/ out correction) (INS7)	0	0	0
Critique—response time—delay in trauma surgeon response for alerts > 15 minutes (9004TS)	0	0	1
Critique—response time—delay in ortho surgeon response > 30 minutes (9004ORT)	3	3	6
Critique—response time—delay in neurosurgeon response > 30 minutes (9004NSR)	0	2	1
Critique—airway—esophageal intubation (2501)	0	0	0
Critique—airway—extubation unintentional (2502)	1	0	0
Critique—airway—mainstem intubation (2503)	0	1	0
Critique—hospital—delay in diagnosis (9006)	2	4	2
Critique—hospital—sutures placed ≥ 24 hr after PT arrival (9010)	0	0	1
Critique—hospital—missed diagnosis (9015)	0	1	1
Critique—hospital—radiology discrepancy (9014)	3	1	3
Critique—hospital—failed procedure (FAILPRCD)	0	1	1
Critique—outcomes—transferred out of MHSVMC (FOCUS6)	6	3	2
Critique—outcomes—medical death (MEDDEATH)	0	1	2
Critique—outcomes—readmission to hospital after discharge for same traumatic injuries (8507)	2	3	7
Total number of critiques during this period and rate per 100 patients	31 11.5 per 100	28 8.9 per 100	36 10.3 per 100

During the strike period itself, one must also consider the role physicians and mid-level providers had in making sure patient care was delivered. The strike period was a time of heightened vigilance among team members because medical staff recognized many of the agency nursing staff were unfamiliar with institutional policies. Due to this hypervigilance, good communication between the trauma team and nursing staff was perceived as a key reason worse outcome was not seen during the strike.

Limitations of the study include those inherent to a retrospective study. As previously stated, prestrike data, which were used to represent normal functionality, may

not have been a good measure of normal functionality given the possible psychological impact of an impending strike on nursing staff. Trauma volume being unaffected by the strike could have been due to seasonality affects. The strike and poststrike period were during the summer months which historically for a level 1 trauma center tend to be busier than other seasons. Finally, although trauma volume and the average number of daily emergency department visits was not affected, this study did not look at overall hospital volume. Most elective surgeries were rescheduled for a later date or moved to another nonstriking hospital within the system, which decreased the need for specialists in the general inpatient volume of

Table 5: Other Critiques not Included in Table 4

	Pre	Strike	Post
Critique—hospital—radiology not assigned OIS grade (not started until 7/29/19) (9020)	0	0	0
Critique—hospital—SBIRT/CRAFFT not completed (not started until 6/6/19) (9016)	34 not done and should have been out of 71 applicable (47.9%)	28 not done and should have been out of 68 applicable (41.2%)	31 not done and should have been out of 84 applicable (36.9%)
Critique—hospital—ISS>9 not admitted to trauma service (not started until 7/24/19) (9019)	0	7	8
Critique—hospital—ED LOS >2 hr for ICU admission (ACS3.A)	54 of 104 ICU admits (51.2%)	47 of 102 ICU admits (46.1%)	72 of 134 ICU admits (53.7%)
Triage			
Appropriate	251 (93.7%)	284 (93.1%)	338 (98.0%)
Over triage	2 (0.7%)	1 (0.3%)	0
Under triage (not transferred in)	15 (5.6%)	20 (6.6%)	7 (2.0%)
Under triage (but were transferred in from another hospital)	2	8	5

*Patients in the “under-triage” group who were transferred in from another hospital are excluded from the denominator when calculating the percentage of appropriate, over and under triage.

the striking hospital, allowing leadership to better staff critical care areas.

CONCLUSION

There are no previous studies that examine the impact of a strike on the trauma team and the American College of Surgeons quality metrics. This article describes the planning, implementation, and evaluation of a clinical crisis management plan that was primarily dependent on an entirely new set of nursing team members (excluding physicians) and the influence those temporary workers had on the trauma system and trauma clinical outcomes. The expertise of the agency nurses was a contributing factor to no meaningful differences in trauma outcomes or complications between the prestrike, strike, or poststrike periods. An examination of trauma outcomes is only one piece of the puzzle. However, it is indicative of a successful leadership team effort in preparing for an extended strike.

A work stoppage affects the entire organization at every level with a negative impact on system functioning and productivity. Furthermore, a strike has a significant and untold impact on compassion, workplace morale, and well-being. It is important for trauma teams to be aware of the potential challenges they will face in the event of a strike. The establishment of guidelines for such an event may benefit trauma centers that are facing this challenge.

Hospitals must have a plan for such occurrences in order to maintain hospital functionality. Finally, any plan must be centered around delivering safe and excellent care to all patients as the primary goal.

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Learning from others: A low-cost–high-impact risk/opportunity identification technique

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Abstract: News for risk/opportunity identification (NfROI) is a tool for practitioners to leverage the journey from a risk management mindset to an enterprise risk management approach. NfROI unleashes the power of storytelling and provides a standardized format to enhance the existing practice of gleaning information from sources such as *JHRM*, news outlets, social media, and the ASHRM Exchange. A series of 3 examples highlight the advantages of learning from others as a complement to retrospective internal data. The stories have implications across the ASHRM's ERM Framework domains and thereby provide bridges across the pillars in the organizational chart. Learning from others can reduce costs and reveal emerging risks before the direct impact on the organization.

INTRODUCTION

While navigating the changing health care landscape of the coronavirus pandemic, reflection supports the identification of missed warning signs. As the crisis emerged was information too dispersed or too unrealistic to draw attention. When thinking about risk and opportunities, strategic thought leaders extol the importance of recognizing not only strong signals but of weak/faint signals as well.¹ Prompt detection of weak/faint signals may lead to improved environmental scanning and broader foresight.¹ The purpose of this paper is to provide a process to improve an organization's ability to identify risks and opportunities. The process may also help practitioners to evaluate and catalog risks and opportunities. Identifying risks and opportunities is a fundamental step in enterprise risk management (ERM). Two ERM Frameworks inform this paper. The Committee of Sponsoring Organizations of the Treadway Commission (COSO) maintains an ERM Framework applicable across industries.² Additionally, the ERM Framework developed by the American Society for Healthcare Risk Management views ERM using a health care lens.³

Individuals consider events retrospectively and prospectively. Retrospective analysis focuses on what happened while the prospective view contemplates

what might occur in the future. Reviewing losses and events at the organizational level is a time-tested model for predicting future losses and events. While considering the past informs multiple methods in the COSO ERM Framework of identifying risk, the COSO data tracking method is the embodiment of reviewing the past.² A common practice involves root cause analysis of incident reports and events within the organization to develop preventative policies and procedures. Learning from others is a cost-effective complement to the root cause analysis/failure mode and effects analysis conducted for the risks/opportunities observed within the organization.

The news for risk/opportunity identification (NfROI) model enhances the power of these sources of information and adds the daily news to the risk/opportunity identification process. Risk refers to an event with potentially negative impacts.^{2,3} In contrast, opportunity describes an event with a potentially positive impact.^{2,3} In a competitive market, a risk to one organization becomes an opportunity for a competing organization. NfROI is a tool for codifying existing news sources such as stories shared during educational programs, the ASHRM Exchange Digest, and the case-law updates published in the *Journal of Healthcare Risk Management*.

BENEFITS OF LEARNING FROM OTHERS

Learning from others transforms retrospective events elsewhere to prospective events for the organization. Three potential benefits arise by learning from the experience of others. The first benefit arises from reducing the cost of learning. The second advantage stems from a broader scope of risk/opportunity identification sources. Finally, learning from others provides a platform for highlighting the value of the ASHRM's ERM Framework's 8 domains of risk.³

Reduce the cost of learning

When learning occurs from an organization's adverse events, the costs associated with learning include recovery and prevention. Direct and indirect recovery costs can be substantial and long-lasting. Direct recovery costs include facility repairs, workers' compensation claims, medical malpractice settlements including defense costs, and similar charges. Indirect costs relate to investigation processes, preparation of claim information, lost productivity, and associated reputation risk. In the age of health care consumerism, the costs associated with reputation risk could result in lost patient revenue and increased turnover leading to increases in recruiting cost.

Generally, organizations track direct costs by following the payouts. It is often a significant challenge to accurately quantify indirect costs. Research results indicate that for workers' compensation claims, indirect costs are between 80% and 400% of the direct costs.⁴ After recovery, organizations incur prevention costs such as buying

alternative equipment, training staff, hiring more staff, monitoring compliance, and related expenses.

When learning from others, the organization does not incur the direct and indirect recovery costs associated with the loss. By not incurring the loss, the organization can move directly to the development and implementation of prevention strategies.

Consistent with the underlying distinction between traditional risk management and ERM,² learning from others allows practitioners to anticipate that an event could happen. Learning from others may help by avoiding the past failures of others. Learning from others also gives an alternative method to identify risks/opportunities as well as providing evidence to document risk severity estimates.

Broaden the scope of risk/opportunity identification sources

In the 21st century, information about events that interrupt services, reveal claim exposures, or expose opportunities for growth is readily available at low cost. The media for shared information include print news, electronic news feeds, radio, television, professional journals, blogs, academic journals, social media, and other sources. Together, these sources make up a rich source of timely information. News stories are emerging as an essential source of information to consultants and professional organizations regarding risks/opportunities.^{5,6} Monitoring external sources supports high reliability. Precisely, high-reliability organizations maintain vigilance to identify early warnings of developing threats.⁷ The intensity of the 24-hour news cycle is such that a news consumer prepared to glean actionable news can provide the organization with a competitive advantage. The pathway to a competitive advantage arises from reducing the cost of identifying risk, developing a more robust list of risks, and improving the timing/quality of risk responses.

Furthermore, archival information can spark meaningful conversations. The history of others shared in news articles might transform the thought process. Reviewing actual events helps to unlock the mindsets from *that could never happen here* to *it happened somewhere else*, *how to keep it from happening here*, or *this happened elsewhere*, *how can the information advance our mission*. As the event took place elsewhere, the practitioner can evaluate the urgency for sharing the story. Learning from others emphasizes the value of both ERM Frameworks.

Highlight the value of the ASHRM ERM Framework

A powerful piece of the ASHRM ERM Framework is the notion of risk domains. The 8 domains embrace risks as operational, clinical/patient safety, strategic, financial, human capital, legal/regulatory, technology, and hazard.³ The transformation from a risk management mindset to an ERM approach requires practitioners to recognize and

embrace the extent to which risks may impact multiple domains.

Application of NfROI builds ERM bridges across risk domains using the facts and circumstances from events that have directly impacted other entities. Highlighting each of the affected domains is a pathway to gaining the attention of managers outside of the traditional risk management network. Engaging leadership from multiple domains supports the multidisciplinary aims of ERM.^{2,3}

NEWS FOR RISK/OPPORTUNITY IDENTIFICATION

NfROI presented in this section arises from pending research.⁵ Using the NfROI model is a multistep process. Figure 1 provides a visual representation of the process.

NfROI begins by *reviewing the news* to find a story that grabs someone's attention. The news event may directly involve health care. The event might be outside of health care but, involve something necessary for providing care. The examples that follow summarize two stories involving incidents at health care providers and one interruption to a supply chain outside of health care.

The analysis of the news event begins with *developing a chain of events*. When practitioners visualize the chain of events as falling dominos, the second goal is to prevent one domino from striking the next domino. Interrupting the cascading dominos requires a barrier or isolating the falling dominos from the rest of the chain.⁹ Knowing the chain of events supports the determination of ways to stop the chain or to control the damage caused by the chain.

A chain of events that contains steps shared by an organization *confirms the applicability* of the story to that organization. In this step of the process, it is essential to take a broad view. As an example of the broad view, damage to the electrical service represents the loss of a mission critical utility. Having confirmed the applicability of a story, the next step is to *determine the impact*. Assessing the impact supports convincing others that the situation is worth examining. In the context of NfROI, the impact is the cumulative impact across the ASHRM's ERM Framework domains. Finally, *sharing the story* with others in the organization reinforces the value of an ERM mindset.

In the following section, 3 NfROI model scenarios demonstrate how to share stories with the organizations. Leveraging these elements creates a compelling narrative that provides openings for discussion, insights, and learning through storytelling. In addition to applying the first 4 elements of the NfROI model, the provided comments might promote the consideration of alternative ways of viewing the scenarios. In the scenarios that follow, bold font highlights alignment with specific ASHRM's ERM Framework domains.

By construction, every news story generates reputational risk/opportunity. Therefore, each scenario is a tool to

evaluate the organization's disaster recovery plan in the context of reputational risk. In the face of these scenarios, do all employees know to refer all questions to the designated spokesperson? Do all staff hold firm when asked for *off the record*, *just background*, *what is it like to work here*, and other prompts by reporters.

In each of the 3 scenarios, a standard template illustrates the first 4 elements of NfROI, which then anchors conversations around sharing the story. Many of these news items appear in subscriptions to various Becker's Healthcare news feeds.

THREE SCENARIOS THAT DEMONSTRATE NFROI AND HIGHLIGHT THE VALUE OF THE ASHRM ERM FRAMEWORK

Scenario 1: Supply Chain Failure

Review the news	Headline: Review of the news headline "Water main in downtown Lubbock fixed, crews working to repair road" ¹⁰ Date: October 9, 2017 Source: KXXV.com
Develop chain of events	Water main break→ No running water→ Italian restaurant closed for business due to lack of water
Confirm applicability	This scenario is an example of news that affected an organization with a shared process. Health care organizations rely on available clean water. Limited access to clean water may affect food preparation, dishwashing, general cleaning, potable water, handwashing, flushing toilets, and other uses. This confirms that a failed water main could be an event that interferes with the operations of the institution. However, to address the reservations of skeptics who question the frequency of water main breaks for hospitals, an internet search confirmed that hospitals and other health care institutions are subject to business closures due to water main breaks. The search results included an emergency water supply planning guide for hospitals issued by the Centers for Disease Control and Prevention (CDC), an article in <i>hfm</i> (published by the Healthcare Financial Management Association), and a water main break that led to a power outage and closure of the emergency department and stoppage of transfers to the hospital.

Determine impact (Domains)	Risks: Closing areas of clinical practice will affect operational, financial, and strategic domains. Staff reassignments and changes in hours worked will impact human capital. Opportunities: Temporary closure of a competitor is an opportunity to grow revenue.
Other comments	The internet search for water main breaks establishes at least two openings to build an ERM bridge. First, this issue is essential to some of the <i>hfm</i> readers. There is also a bridge with the users of the CDC planning guide. In particular, the story involved damage to the organization's single source of water resulting in the suspension of operations. The disruption caused by the water main break was a single point of failure.¹¹ Even if an organization has water from multiple lines, what about other mission-critical utilities? In addition to water, mission-critical utilities could include internet access, electricity, medical gases, and sewers. Please remember stakeholders on the other side of the bridge evaluate the world from the perspective of their silos. Using an ERM lens can help reveal the potential impact of the analysis to others across the organization. If this event occurs at a competitor, the risk manager reading the news could propose steps to fill the service void. This might grow the revenue stream long term by strengthening the organization's reputation.

Scenario 2: Contrary to No Smoking Policy Woman Fatally Ignites Gown

Review the news	Headline: Woman dies after gown catches fire in PA, Hospital¹² Date: July 29, 2017 Source: <i>Leighhighvalleylive</i>
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Develop chain of events	The patient was a known smoker→ Their smoking materials were in locked storage→ The patient obtained replacement material, smoked while receiving oxygen→ The gown ignited resulting in burns that ultimately led to the patient's death→ Two staff members suffered burns while attempting to extinguish the fire with bedsheets→ A third staff member put out the fire using a fire extinguisher
Confirm applicability	This chain of events applies to organizations that have one or more of the following elements: a smoke-free policy, oxygen, and/or a fire safety program
Determine impact (Domains)	This event triggered strategic reputational risk at the time of the fire, and when the patient died. The substantial smoke damage presented a hazard. Finally, human capital risk with the employees who sustained burns. Meanwhile, 3 employees saw a fatally burned patient. The operational definition of the second victim evolved from clinical events to include adverse events, medical error, and patient injuries.¹³ Each of these employees might benefit from support by a second victim rapid response team.¹³
Other comments	Is the organization challenged by the incomplete implementation of the smoke-free policy? Staff properly secured some smoking materials from the patient. It is unknown how the patient obtained other materials or hid materials from staff. However, this news event confirms that there are circumstances that arise from breaking the rules that result in severe pain and death. This chain of events also raises questions about the fire response plan. What if the first employee in the room carried a fire extinguisher with them as the employee entered the smoke-filled room? It is unknown if the patient would have survived. Using the extinguisher first alters the chain of events regarding staff burns from the initial attempt to control the fire.

The chain of events is also a reminder of the interconnections between patient safety and employee safety. Second victim syndrome (SVS) may produce subsequent impacts. Researchers linked SVS with **Human Capital** due to burnout and suicidal ideations.¹⁴ SVS is also associated with increased medical errors with **Clinical Patient Safety**.¹⁴ Finally, interest in staff members' wellbeing and mental health is increasing as millennials and generation Z join the workforce; the organization's response has an opportunity to reinforce the holistic wellbeing support offered by the organization.¹⁵

Determine impact (Domains)	Had the organization purchased this firm, the impact might include the following domains. Legal/regulatory arising from the fraud, financial from restitution and medical malpractice stemming from the 2 deaths, and strategic from acquiring a firm that devalued the organization's brand.
Other comments	Again, this story is purely a what-if scenario. However, this story could build a bridge with the senior leaders involved in M&A.

Scenario 3: Justification for Due Diligence with Mergers and Acquisitions (M&A)

Review the news	Headline: Healthcare CEO gets ten years for committing fraud that led to 2 patient deaths. ¹⁶ Date: June 16, 2016 Source: <i>Becker's Healthcare Review</i>
Develop chain of events	Nonphysician employees were interpreting tests → Two patients died due to diagnostic errors → Tests were submitted in a fraudulent manner related to reimbursement → The CEO (age 67) and co-owner of the diagnostic firm received a 10-year sentence for defrauding Medicare, Medicaid, and health insurers
Confirm applicability	This story reveals an M&A risk. There is nothing in the story that indicates this entity engaged in an M&A. However, this is a period of physician practice consolidations and integrations. A purchase based on financial statements without discussions with staff might result in acquiring a practice with a similar billing history. The CEO was 67, which increases the likelihood of an attempt to sell their operations. Therefore, there are indicators that this practice was or would soon be involved in the M&A process

RISK RESPONSES REVEALED BY STORIES

Although it may not be present in all news coverage, some stories may include descriptions of what the organization did to respond to their identified risks. Finding a risk response in a story can reduce the time needed to develop a risk-response plan. As noted in scenario 1, access to potable water is a critical element in the health care supply chain. Another news story regarding the interruption of the water supply for Middlesex Hospital included arranging for tanker truck delivery of potable water.¹⁷ Time is of the essence when a supply chain interruption stops the revenue stream or creates quality of care exposures. The risk responses by Middlesex could indicate the maturity of the ERM process at the organization. Early ERM adopters will recognize supply chain risks and consider steps to enhance supply chain resilience. Entities with mature ERM programs develop a pre-event response plan, including a ready-to-go alternative supplier.²

SHARING THE STORY PUTTING NfROI INTO ACTION

Sharing the news in this format might increase awareness of the importance of ERM strategies and the specific exposures in the scenario. Some news is more applicable than others, and while the scenarios illustrate the model, the specific content may or may not have value in every organization. Regularly using the news prompts reflection and discussion, supporting the growth of an organization wide ERM mindset.

Preparing an NfROI analysis helps to define the urgency to act. Reports with high applicability and weak risk controls might trigger a rapid response. A story with low applicability could justify a delayed response. A story with high applicability and strong risk controls might lead to a

Figure 1:
Five elements of NfROI⁸



thank you from the ERM practitioner who is doing the NfROI analysis to the staff member charged with managing this risk. An example of high applicability with a strong risk response is the fatal smoking story for a system with a high performing smoke-free policy. The thank you note could contain a recognition of the efforts to enforce the smoke-free policy, a summary of the tragic events, and a thank you for protecting the patients, fellow staff, and the organization's reputation. Storytelling is a well-grounded and powerful tool for changing organizational culture and sharing the lessons learned from negative events.¹⁸ By sharing scenarios from the news as stories, real-life examples eliminate potential resistance of made-up scenarios: the "you're just saying that to get my attention" reaction.

The mode of storytelling should align with the culture of the organization. Storytelling options include using the story to set the tone of a meeting, such as using the broken water main story for a meeting around disaster planning or continuity of operations. Storytelling is a powerful tool for overcoming a crisis.¹⁹ The water main story is a supply chain interruption and could be a realistic scenario for tabletop drills, which often include multiple scenarios. An organization could begin with the water main break. As the disaster team addresses the interruption in the water supply, the layer of the smoking fire will change the impact of risk. The M&A story might apply to a conversation with a senior leader on strategic planning. The fatal smoking story sheds light on the importance of integrating patient safety with employee safety.

Compelling scenarios grab attention. Also, forming a bond with the individuals in the story might increase the acceptance of the analysis. The smoking death supports efforts to mitigate the normalization of deviance from best practices. Imagine hearing the stories of the workers who saw the fatal scenarios. These are the types of stories that will connect to employees' hearts and minds and are likely to be remembered as they return to work. Stories can also provide risk responses. The Middlesex Hospital story concerning a backup water supply¹⁷ could support business continuity discussions.

In an organization with a mature ERM program, discussing a solution might identify supply chain risks. The city water main supplies water at pressure. The water

tankers supply water but require a pump to provide pressure. Discussing the story might reveal the sources of pump failures as well as the parts and technical skills required to maintain and repair a pump. As the conversation develops a robust concept map for supplying pressurized water, the discussion could branch into other mission-critical utilities.

The NfROI template provides a standardized process for analyzing and archiving nascent risks/opportunities. Archiving has value for the organization and the practitioner. The practitioner could change employers, resulting in a loss of institutional knowledge. The practitioner's new employer may have a different strategic focus from the original employer. For instance, the practitioners may move from an employer who is not open to M&A opportunities while new employer seeks M&A opportunities. Archiving stories with the NfROI template embeds ASHRM's ERM Framework domain names as the nomenclature for keyword searches. A searchable portfolio of NfROI templates improves the practitioner's response time when conditions change. Furthermore, a comprehensive NfROI electronic library could help a colleague. For instance, when a colleague makes a post regarding business continuity plans, a peer could share the water main NfROI template to reinforce the concept of single point of failure risk.

CONCLUSIONS

Using NfROI adds value to the ERM process on multiple dimensions. Applying NfROI can support risk identification and inform how risks cross the ASHRM's ERM Framework domains. Events that happened to others can be the driving force behind change and the motivation to reinforce existing processes. Learning from others is thought-provoking and cost-effective. As practitioners develop the skill of learning from others, it is easier to detect weak/faint signals. Reviewing these signals may reveal emergent risks/opportunities. Learning from others can be the impetus for starting the ERM journey or the justification for extending the level of maturity in an existing ERM program. NfROI supports organizational resilience through organizing and prioritizing emerging risks/opportunities.

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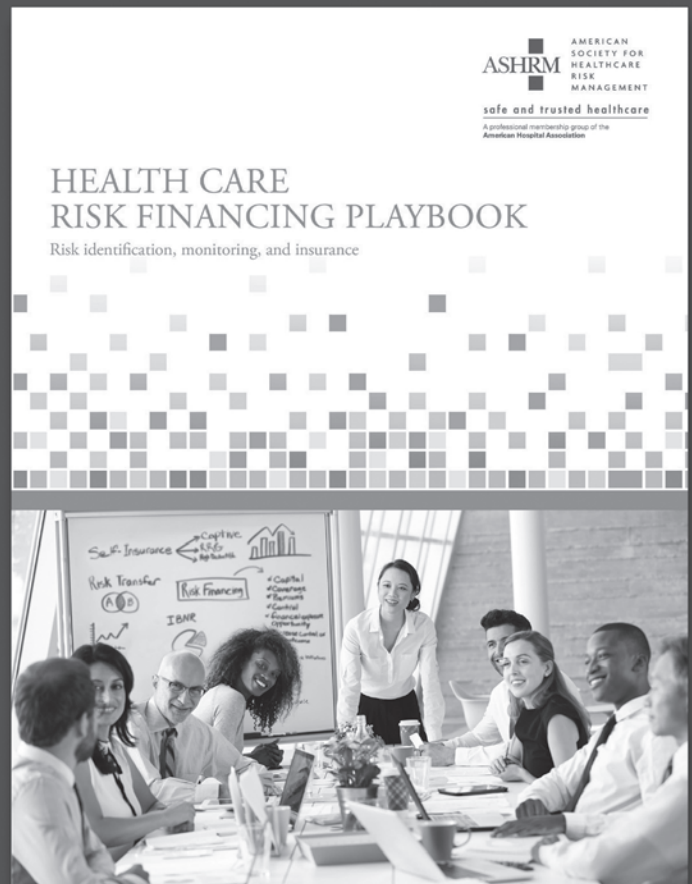
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Case law update

By John C. West, JD, MHA

MEDICAL INFORMATION

Error in medical record may give rise to an action in negligence

FACTS:

Betty Lou DeMarco is a 76-year-old woman who receives disability compensation from the U.S. Department of Labor's Office of Worker's Compensation Programs (OWCP). She is required to undergo an annual physical examination to remain covered by that program. She underwent an examination in 2011, by Dr Linda Bresnahan, an employee of the defendant Charlotte-Mecklenburg Hospital Authority. When Ms DeMarco requested her records in preparation for an examination 5 years later, she discovered an entry on her "Problem List" that stated that the plaintiff had been diagnosed with "gonococcal infection (acute) of lower genitourinary tract" and "gonorrhea" in 2011, which were "resolved" in January of 2016. Ms DeMarco has never been diagnosed with, or treated for, gonorrhea. When she requested a correction to her record, the defendant admitted that the entries were made in error and amended the erroneous entries by adding language reflecting that the diagnoses had been "canceled" and "entered in error." Ms DeMarco had wanted the entries removed entirely from her record.

Ms DeMarco filed suit for negligence, negligent infliction of emotional distress, and defamation. The trial court granted the defendant's motion to dismiss. This appeal to The Court of Appeals of North Carolina was taken.

ISSUES:

Did Ms DeMarco's complaint adequately allege a claim for negligence? Did Ms. DeMarco's complaint adequately allege a claim for negligent infliction of emotional distress? Did Ms. DeMarco's complaint adequately allege a claim for defamation?

ANALYSIS:

This case was dismissed on a motion to dismiss, which only tests the adequacy of the complaint's allegations. Whether the plaintiff can prove these allegations will come at a later time if the matter continues.

The court noted that there are four elements required for a claim of negligence in North Carolina. These are, as they are in most states, (1) a duty, or obligation, recognized by the law, requiring the actor to conform to a certain standard of conduct, for the protection of others against unreasonable risks; (2) a failure on his part to conform to the standard required; (3) a reasonably close causal connection between the conduct and the resulting injury; and (4) actual

loss or damage resulting due to the interests of another. The court noted that Health Insurance Portability and Accountability Act (HIPAA) and state law impose a duty on health care providers to keep and maintain accurate health information on behalf of the patient. The court noted that the complaint alleged a failure by the defendant to conform to this duty. The court noted that the complaint alleged a connection between the duty and the alleged injury. Finally, the court also noted that the complaint alleged Ms DeMarco suffered loss or damages. Consequently, the court held that the claim for negligence should not have been dismissed.

The court noted that “To state a claim for negligent infliction of emotional distress under North Carolina law, the plaintiff need only allege that (1) the defendant negligently engaged in its conduct, (2) it was reasonably foreseeable that such conduct would cause the plaintiff severe emotional distress, and (3) the conduct did in fact cause the plaintiff severe emotional distress.” The court noted that it had already found that the complaint stated a claim for negligence. The complaint also alleged that it was reasonably foreseeable that falsely being diagnosed with gonorrhea would cause someone distress. The court found that the complaint sufficiently alleged that Ms. DeMarco suffered emotional distress.

The law of North Carolina requires that “In order to recover for defamation, a plaintiff must allege that the defendant caused injury to the plaintiff by making false, defamatory statements of or concerning the plaintiff, which were published to a third person.” Additionally, “If a statement cannot reasonably be interpreted as stating actual facts about an individual, it cannot be the subject of a defamation suit.” *Craven v Cope*, 188 N.C. App. 814, 656 S.E.2d 729 (Ct. App. N.C. 2008). The court also rather succinctly noted that “A statement which acknowledges its own falsity is true, and thus immune from liability for defamation.” The court held that, since the Problem List specifically stated that an entry had been made in error, it could not be defamatory.

Accordingly, the court reversed the dismissal of the claims for negligence and negligent infliction of emotional distress, but affirmed the dismissal of the claim for defamation.

RISK MANAGEMENT ISSUES:

The amendment of medical records by patients has been controversial since the early days of the HIPAA, 45 C.F.R. Parts 160 and 164, if not before. There has always been hesitation about affording patients this right for fear that they will want something redacted or deleted, not because it is erroneous, but because it shows them in a poor light. Not everything in a medical record should be a positive reflection of the patient. The patient’s noncompliance, failure to keep appointments, or responses to inquiries need to be in the medical record. Erroneous entries, however, have no place in a medical record.

Health care providers need to be ever vigilant to keep erroneous entries out of a patient’s record. Unfortunately, vigilance is known to be a poor protector of patient safety. This is why providers need to rely on two identifiers, rather than memory, to properly identify patients and records to prevent errors. That is why this decision is a mixed bag for providers. On the one hand, all systems run by humans are prone to failure. However, this mistake could have had deleterious consequences had the entry guided future treatment.

Patient portals that allow patients to review their records whenever they wish to may be a partial solution to this issue. Patients should be encouraged to review their information regularly and report any errors to the provider immediately. The tort of defamation requires “publication,” which is another way of saying “telling someone.” If the provider does not tell anyone about the erroneous information, there may be no cause of action for defamation. However, this provider had told OWCP about the gonorrhea at least once, and possibly multiple times. The provider was fortunate that the court took a forward-looking and conservative approach on this issue.

Poor record-keeping has no place in health care. It is fortunate that no physical harm was done in this case.

Demarco v. Charlotte-Mecklenburg Hospital Authority,
No. COA19-350 (Ct. App. N.C. November 19,
2019)

VICARIOUS LIABILITY

Release of purported agent released potential principal

FACTS:

Margaret Rackerby Flint underwent surgery at Christiana Care Hospital (“Christiana Care”) that was performed by Dr Michael Principe, who was assisted by Dr Eric Johnson. The nature of the surgery was not disclosed in this opinion, but, apparently, it did not go well. Ms Flint died two days later, allegedly as the result of a negligent act that occurred during surgery. Beyond that, nothing related to the surgery was revealed.

Meeghan Carter, as administratrix of Ms Flint’s estate, filed suit for medical malpractice against Drs Principe and Johnson, as well as Christiana Care. The suit against Christiana Care alleged that it was vicariously liable for the negligence of Drs Principe and Johnson. The estate reached a settlement with Dr Principe. The plaintiff dismissed Dr Johnson and stipulated that its vicarious liability claim against Christiana Care for Dr Johnson’s alleged negligence was also dismissed. Christiana Care filed a motion for partial summary judgment on the grounds that it, too, was released from liability by the Release that the plaintiff had signed when releasing Dr Principe from further liability. The trial court denied the motion. This appeal to the Supreme Court of Delaware was taken by Christiana Care.

ISSUE:

Did the “Joint Tortfeasor Release” that released Dr Principe from further liability also release Christiana Care?

ANALYSIS:

The Release at issue reads as follows:

This release is intended to protect the Releasees from any further exposure or future liability from any claim relating in any way to the medical care described herein and in the Complaint filed in the above referenced lawsuit. This Release is executed in conformity with the provisions of 10 Del. C. §6301, et seq. the Uniform Contribution Among Tortfeasors Act, and shall be governed by Delaware law. Accordingly, should it be determined that any person or entity not released herein is jointly or severally liable with the Releasees, to the Releasers in tort or otherwise, the claims against and damages recoverable from such other person or entity shall be reduced by the greater of Releasees’ *pro rata* share of liability or responsibility for such damages or the sum of \$1,000,000, and this release shall operate as a satisfaction of those claims against such other parties to that extent.

The court reasoned that the Release is based on the premise that the party not released (here the hospital), but who is allegedly vicariously liable for the actions of its purported agent (Dr Principe), has a remedy against its agent for the full amount of its (the hospital’s) damages. This is based on the concept that the wrongdoer is liable for his damages and that the plaintiff should not be made whole twice. This meant that the Release, by extinguishing Dr Principe’s liability, also extinguished the hospital’s right of indemnification against Dr Principe.

Accordingly, the court held that the Release released Christiana Care from further liability. It reversed the ruling of the trial court and reversed the matter for further consideration.

RISK MANAGEMENT CONSIDERATIONS:

It is a difficult task for a plaintiff’s attorney to effectively release one party without releasing other parties. This is especially true when the nonreleased party is merely vicariously liable for the released party’s alleged negligence. Although it is rarely used, the principal always has the right to pursue an action for indemnification against its agent. For reasons that are more political than legal, hospitals are normally loath to bring an indemnification action against their agents (eg, emergency doctors, radiologists, anesthesiologists, and pathologists). This can set up a circular set of actions for indemnification against someone whose liability has been released by the plaintiff. However, regardless of the politics involved, hospitals may wish to reserve the right to bring an indemnification action

against an agent who “turns on” the principal and testifies against it at trial.

In any event, health care facilities and providers need to be sure to scrutinize a Release that extinguishes the liability of a co-defendant, joint tortfeasor, or an agent. A plaintiff may execute a covenant not to sue, which has basically the same effect as a Release, but does not release other parties. If the plaintiff does not execute such a covenant, the Release may have the unanticipated consequence of releasing the facility. It is worth the effort to carefully review all releases of co-defendants.

Christiana Care Health Services, Inc. v. Carter, No. 58, 2019 (Del. December 2, 2019)

DISCRIMINATION

Emotional distress damages not available under ACA or the Rehabilitation Act

FACTS:

Jane Cummings suffers from chronic back pain and sought physical therapy treatment from Premier Rehab Keller, PLLC (“Premier”). Ms Cummings has been deaf since birth and is legally blind. She communicates primarily through American Sign Language (ASL). She cannot communicate effectively through written notes and has difficulty speaking. She requested that the Premier provide her with an ASL interpreter, but the Premier refused to do so. Ms Cummings then sought care at another physical therapy center, but she claimed that that care was unsatisfactory. It does not appear that Ms Cummings suffered any physical injury or harm as a result of Premier’s refusal to provide an ASL interpreter.

Ms Cummings sued the Premier for disability discrimination, seeking injunctive relief, and damages. She alleged that the Premier violated Section 302 of the Americans with Disabilities Act of 1990 (“ADA”), 42 USC. § 12182; Section 504 of the Rehabilitation Act of 1973 (“RA”), 29 USC. § 794; Section 1557 of the Patient Protection and Affordable Care Act of 2010 (“ACA”), 42 USC. § 18116; and Section 121.003 of the Texas Human Resources Code, Tex. Hum. Res. Code § 121.003. The trial court granted Premier’s motion to dismiss and dismissed the suit. Ms Cummings dismissed the Texas state law claim and did not appeal the dismissal of her ADA claim. She did appeal the dismissal of her ACA and RA claims. What follows is a summary of the decision of the U.S. Court of Appeals for the Fifth Circuit.

ISSUES:

Did Ms Cummings state a cause of action for damages under the ACA and the RA if she did not suffer a physical injury?

ANALYSIS:

Congress is a body with powers that are limited by the U.S. Constitution, although it may not always appear that its powers are limited. Congress is not permitted to pass any law that it deems necessary. It may only act pursuant to powers granted to it by the Constitution. Many of its powers are sweeping, such as its power to regulate interstate commerce (Article I, Section 8) that allowed it to pass civil rights laws in the 1960s. The two statutes at issue here, the ACA and the RA, both arise under the Spending Clause (Article I, Section 8, Clause 1), which gives the Congress the power to tax and spend money for the general welfare of the country.

The enforcement of statutes enacted pursuant to the Spending Clause have been interpreted primarily by the common law of contracts. The entity that receives federal funds (the funded entity) agrees, as a condition of receiving funds, to abide by certain conditions set forth by the government. This means that the liability assumed by the funded entity is largely set according to contract law. The analogy to contract law is not perfect, but it serves in this context. Contract law allows pecuniary damages for injury or harm to a person or property, but it does not allow for the imposition of punitive damages. Damages for emotional distress are analogous to punitive damages in that they do not compensate for a pecuniary loss suffered by the plaintiff.

The court held that funded entities, by receiving funds, are “on notice” that they may be subject to claims for damages that arise under contract law. They are not on notice that they may be subject to unlimited damages. The court held that, because the ACA and the RA are Spending Clause statutes, funded entities are not subject to claims for emotional distress. Accordingly, the dismissal of the claims was affirmed.

RISK MANAGEMENT CONSIDERATIONS:

This decision is welcome for health care providers and entities that receive federal funding (such as Medicare and Medicaid). This is not to say that the ACA and RA do not have their place, and enforcement is certainly appropriate in situations in which a patient is injured through a violation of the statute. However, damages for emotional distress can be a thorny issue. It is virtually impossible to determine the just amount of compensation for a person who has suffered emotional distress. There is no quantifiable scale to even measure the amount of emotional distress a person has suffered, unless the person has been diagnosed with Post-Traumatic Stress Disorder (PTSD) or a similar condition. Emotional distress is a spectrum ranging from PTSD to being miffed about something. It is not always possible to determine where someone’s emotional reaction falls on the spectrum.

The foregoing considerations are important because both the ACA and the RA require that a provider or entity make

reasonable accommodations to ensure that the patient receives care and treatment in a respectful, dignified way. They do not require that *every* disabled patient be treated. Some accommodations are beyond the scope of a provider’s or an entity’s financial resources. Thus, reasonable accommodation is like beauty: it is in the eye of the beholder. What is reasonable to one beholder may be unreasonable to another. An accommodation for Ms Cummings’ disability would probably require an ASL interpreter to be physically present on-site during treatment, because she probably could not use any form of electronic communication, whether telephonic or video. While this certainly may be a reasonable accommodation for some facilities, it is probably not reasonable for all facilities. Consequently, it is important that not all denials of service for elective procedures be considered discrimination.

It is important, however, to remember that this is the law of the Fifth Circuit. It has set up a split with the Eleventh Circuit, which decided a similar case differently in *Sheely v. MRI Radiology Network, P.A.*, 505 F.3d 1173 (Eleventh Cir. 2007). In *Sheely*, a blind patient was not permitted to take her service dog with her into an MRI chamber. The Eleventh Circuit held that damages for emotional distress were recoverable. This was due to the “foreseeability” of harm, which can lead to recoverable damages under contract law. Whether this split is sufficiently significant to reach the Supreme Court is unknown at this time, but that may be unlikely.

This decision may also have an impact on the jurisprudence of other Spending Clause statutes. The one that comes to mind immediately is the Emergency Medical Treatment and Labor Act (EMTALA), 42 USC. § 1395dd. EMTALA is clearly a Spending Clause statute because it conditions federal funding on agreeing to screen and, if necessary, stabilize, any patient who comes to a hospital’s dedicated emergency department with what may be an emergency medical condition. However, at least one case has held that emotional distress damages are recoverable under EMTALA. *Henderson v. Medical Center Enterprise*, Case No. 1:05-cv-823-MEF (M.D. Ala. August 14, 2006). In *Henderson*, a 38-week pregnant woman who had been in an automobile accident was constructively turned away from an emergency department (ED) because her OB did not have privileges there. She went to another ED and was checked out. She subsequently delivered a normal full-term infant and sued for emotional distress under EMTALA (she received a jury verdict for \$2000). *Henderson*, however, was decided by the US District Court for the Middle District of Alabama, which is within the jurisdiction of the Eleventh Circuit.

Time will tell if the holding of this decision will be followed in EMTALA cases in which damages for emotional distress are sought or, by implication, punitive damages are sought. The provision in EMTALA that deals with damages in a civil action allows a plaintiff to “obtain those damages available for personal injury under the law

of the State in which the hospital is located, and such equitable relief as is appropriate” 42 USC.

§ 1395dd(d)(2)(A). This neither provides for, nor prohibits, damages for emotional distress or punitive damages. There have been cases in which state law prohibitions on punitive damages, as a feature of tort reform, have been upheld, but this case would entail a nation-wide ban. *Power v. Arlington Hospital Association*, 42 F. 3d 851 (Fourth Cir. 1994); *Barris v. County of Los Angeles*, 20 Cal. 4th 101, 83 Cal. Rptr. 2d 145, 972 P.2d 966 (Cal. 1999); *Jackson v. East Bay Hospital*, 980 F. Supp. 1341 (N.D. Cal. 1997).

It is not known whether a court in an EMTALA case would follow state law (that may allow damages for emotional distress and punitive damages) or follow federal law regarding Spending Clause statutes. Facilities that are embroiled in, or anticipating becoming embroiled in, EMTALA or disability discrimination cases in which noneconomic damages are sought would be well-advised to ensure that defense counsel is aware of this decision.

Cummings v. Premier Rehab Keller, PLLC, No. 19 – 10169 (Fifth Cir. January 24, 2020).

CONFIDENTIALITY OF MEDICAL INFORMATION

Photograph of resident posted on social media not an invasion of privacy

FACTS:

V.F. is a resident of Madonna Summit of Byron (Madonna) who suffers from Alzheimer’s disease. On June 17, 2017, a nurse’s aide (who was not identified in the decision) took a photograph of V.F. in a mirror. She posted the picture on her personal social media page with the caption: “This little sh-t just pulled the fire alarm and now I have to call 911!!! Woohoo.” Although V.F.’s features can be made out in the picture, she is not identified in the picture and there is no indication that it was taken at Madonna.

William Furlow, as the representative of V.F., learned of the posting and brought suit against Madonna and the aide under the Minnesota Health Records Act, Minn. Stat. §§ 144.291-.298 for wrongful release of health information. The trial court granted Madonna’s motion to dismiss (the aide had never responded to the suit) and dismissed the action. This appeal to the Minnesota Court of Appeals was taken.

ISSUE:

Did the posting of the photograph violate the Minnesota Health Records Act? Could Madonna be held vicariously liable for the acts of the aide?

ANALYSIS:

The Minnesota Health Records Act provides that:

A person who does any of the following is liable to the patient for compensatory damages caused by an unauthorized release or an intentional, unauthorized access, plus costs and reasonable attorney fees ... negligently or intentionally requests or releases a health record in violation of sections 144.291 to 144.297.

Minn. Stat. § 144.298, subd. 2(1).

The Act defines a “health record” as:

any information, whether oral or recorded in any form or medium, that relates to the past, present, or future physical or mental health or condition of a patient; the provision of health care to a patient; or the past, present, or future payment for the provision of health care to a patient.

Minn. Stat. § 144.298, subd. 2(c).

The court noted that the photograph did not name the resident, did not contain any details about her condition, her care or her treatment, and did not name the facility in which she was receiving treatment. Although the photograph did show her face, this did not necessarily reveal any details about her health status or care. Consequently, the photograph was not a health record for the purposes of the statute. The court affirmed the dismissal of the suit.

Since the court affirmed the dismissal of the suit on other grounds, it was unnecessary to reach a decision on whether Madonna could be vicariously liable for the actions of the aide.

RISK MANAGEMENT CONSIDERATIONS:

The decision in this case depends extensively on the unique facts presented in this scenario. The decision does not stand for the proposition that health care workers can post pictures of residents and patients on social media with impunity. Had any of these factors militated in favor of disclosing V.F.’s name, medical care or condition, the outcome could have certainly been different.

The court also overlooked a number of facts that would indicate that V.F.’s privacy had been breached. The picture was posted on the aide’s personal social media page, so the identity of the aide was known. The aide is pictured wearing scrubs, so the resident is clearly someone for whom the aide was providing care. If someone knows the aide, then they undoubtedly know she works at Madonna, which implies that the resident is receiving care from Madonna. Since it was disclosed in the caption that the resident pulled the fire alarm, one can surmise either (1) the resident has episodes of disruptive behavior, (2) the resident is a mischievous person, or (3) the resident suffers from some form of dementia. Certainly, anyone who

worked with, or formerly worked with, this aide and was friends with her on social media now knows who pulled the fire alarm that day, whether they needed to know or not. None of this shows the resident in a favorable light.

It may be true that there was nothing in the photograph itself that indicates where it was taken. However, as noted above, it could be deduced that it was taken at Madonna. While the mere fact that someone received care at a health care facility may not reveal much about the care provided, but, if there was something unique about the care provided at that location, it may reveal a great deal about a patient's condition. Just knowing that someone is a psychiatrist's patient says something about them. Just knowing that someone is being treated by a physician who specializes in gender dysphoria says something about them. Just knowing that someone is residing at a facility that has a memory care unit (which Madonna does: <https://www.madonnalivingcommunity.org/madonna-summit-of-byron/>) may say something about them. Additionally, some residents in secure memory care units figure out that pulling the fire alarm will make the doors automatically unlock, or may at least get them out of the building for a bit. Finally, Byron, Minnesota is a city of 5246 inhabitants, which indicates that a fair number of people who live there would recognize V. F. (<https://www.byronmn.com/>). All in all, there was more protected health information (PHI) in this fact pattern than the court was willing to recognize.

As a general rule, courts only hold employers liable for violations of patient privacy if the violation occurred within the course and scope of the employee's employment: *Bagent v. Blessing Care Corp.*, 862 NE 2d 985, 224 Ill. 2d 154, 308 Ill. Dec. 782 (Ill. 2007) (employee disclosed PHI to a friend in a bar—employer not liable); *Walgreen Co. v. Hinchey*, 21 N.E. 3d 99 (Ct. App. Ind. 2014) (pharmacist used company computer to access PHI, but she disclosed it outside of work—employer not liable); *Randi A. J. v. Long Island Surgi-Center*, 46 A.D.3d 74, 842 N.Y.S.2d 558 (S. Ct. App. Div. NY 2007) (nurse inadvertently disclosed PHI to patient's mother in a follow-up telephone call to check on patient's condition after abortion—employer liable). In this case, posting a picture with an unflattering caption on social media was probably not within the course and scope of the aide's employment, but the court did not reach this issue.

Additionally, courts often look to see if the employer was culpable in failing to train the employee properly. If the employer can show that (1) the employee was taught what information was confidential, (2) the employee understood that the information was not to be disclosed without the patient's consent, and (3) the employee understood the consequences of wrongfully disclosing the information, then the employer may not be held liable.

In short, employers must continuously train employees about the confidentiality of medical information. Everyone loves to tell a good story. Employees need to know which stories they can tell, and which they cannot.

Furlow v. Madonna Summit of Byron, No. A19-0987 (Ct. App. Minn. January 27, 2020)

MEDICAL STAFF

Credentials file may be discoverable in Pennsylvania

FACTS:

James Leadbitter apparently suffered from back pain and consulted with Dr Carmen Petraglio regarding surgery. Dr Petraglio recommended spinal surgery, which he performed on January 14, 2015, at St Clair Hospital. He performed a second surgery the next day, January 15, 2015, but the reason for the second surgery was not revealed in this decision. Following the surgeries, Mr Leadbitter suffered a series of strokes, resulting in permanent brain damage, cortical blindness, motor weakness, and impairment of his extremities, which appellees alleged was caused by the negligence of Dr Petraglio and the hospital.

Dr Petraglio had only recently received his privileges to perform surgery at the hospital at the time of this event. He had applied for privileges on July 28, 2014 and was granted privileges on September 8, 2014. As is typical in these situations, Dr Petraglio had a credentials file (containing his application, license verification, letters of recommendation, National Practitioner Data Bank (NPDB) report, etc.) and a peer review file (containing the results of peer review evaluations). It was undisputed that the credentials file contained peer review information, but not the peer review information generated by St. Clair Hospital.

Mr Leadbitter filed suit in January 2017 and sought discovery of Dr Petraglio's credentials file. The trial court held a hearing on the matter and, relying almost exclusively on *Riginelli v. Boggs*, 181 A.3d 293 (Pa. 2018), ruled that the credentials file was discoverable. This appeal to the Superior Court of Pennsylvania was taken.

ISSUE:

Are the contents of the credentials file protected by the Pennsylvania Peer Review Protection Act ("PRPA"), 63 P.S. § 425.1, *et seq.*, and/or the Health Care Quality Improvement Act ("HCQIA"), 42 USC. § 11101, *et seq.*?

ANALYSIS:

The Superior Court acknowledged that the credentials file contained peer review information. PRPA specifically protects peer review information in the possession of a peer review committee. 63 Penn. Stat. § 425.2. Additionally, the confidentiality of NPDB reports is protected by the HCQIA. 42 USC. § 11137(b)(1); 45 C.F.R. § 60.20(a).

However, the court relied on the distinction between a “review committee” and a “review organization,” which the court read to be the holding of *Reginelli*.

Some background on *Reginelli* may be in order. In that case, suit was brought against Monongahela Valley Hospital (MVH) and UPMC Emergency Medicine, Inc., d/b/a Emergency Resource Management, Inc. (ERMI) for the actions of an emergency medicine physician (Dr Boggs). ERMI contracted with MVH to provide emergency medical services in its ED, but there was no other connection between the two. The director of the ED (an ERMI employee) kept a “performance file” on each of the ED physicians who worked at MVH, including Dr Boggs. The performance file was not used to grant hospital privileges. The plaintiff sought discovery of the performance file, which was contested by both MVH and ERMI. The Supreme Court of Pennsylvania held that ERMI was not one of the types of health care provider specified in PRPA, hence its performance documentation was not protected from discovery. It allowed discovery of the performance file.

In this case, using logic that is difficult to follow, the court held that there was a difference between a “review committee” and a “review organization.” Peer review information obtained or generated by a review committee would presumably be protected from discovery, but the same type of information obtained or generated by a review organization would not be protected. This makes sense in *Reginelli*, where MVH had a review committee and ERMI was a review organization. The court held, in this case, that St Clair Hospital was a review organization with respect to information generated by others, which meant that it was not protected.

The Superior Court affirmed the decision of the trial court and held that the credentials file was discoverable.

RISK MANAGEMENT CONSIDERATIONS:

This decision eviscerates and emasculates the protections of PRPA for hospitals that hold peer review information generated by others in a medical staff member’s credentials file. It is one thing to have to disclose medical staff applications, license verifications, and proof of insurance, but another thing entirely to have to turn over letters of reference, NPDB reports, and claims histories from insurance companies. This will incentivize references to give misleading or false letters of reference for bad doctors for fear of discovery, or hospitals not to seek letters of recommendation, not to check malpractice claims histories from insurance companies, and not to check with the NPDB. It also will incentivize hospitals to refrain from gathering any sensitive information about a physician’s performance that was generated by another entity. Peer review protections exist to allow free and candid discussions of a physician’s performance. This decision will squelch those free and candid discussions.

This decision flagrantly defies federal law with regard to the NPDB. The HCQIA specifically provides that “Information reported under this subchapter is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity ...” 42 USC. § 11137(b)(1). Additionally, if that was not bad enough, the HCQIA provides that “Any person who violates paragraph (1) shall be subject to a civil money penalty of not more than \$10,000 for each such violation involved.” 42 USC. § 11137(b)(2). This means that St Clair Hospital will violate federal law if it discloses the NPDB reports in Dr Petraglio’s credentials file.

It is hoped that this decision will be appealed to the Supreme Court of Pennsylvania and logic and order will be restored to the jurisprudence of Pennsylvania’s peer review statute. Failing that, there may be ways to avoid this in the future. One way would be to only have one file on each physician—his or her peer review file. This, however, may be problematic if nonconfidential materials (medical staff application, license verification, etc.) are mixed with confidential materials (peer review information, NPDB reports, etc.). Since courts dislike evidentiary privileges in general, a court may decide that the hospital was overreaching and trying to improperly protect that which cannot be protected.

A better option would be to have two files: a credentials file and a peer review file. There should not be *any* information about the provider’s performance, past or present, in the credentials files. Anything that relates to the provider’s performance must be in the peer review file, and this file must be considered by the peer review committee in any decision about granting, suspending, denying, or terminating clinical privileges. In short, if the facility determines that something may be discoverable, then it should go in the credentials file. If it is sensitive and subject to peer review protection, then it should go in the peer review file.

Peer review protection is a cherished commodity and hospitals in states that have it should always strive to protect it. If it is not protected, it will be lost, as it has been in many states. The quality of care will undoubtedly suffer in the absence of robust discussions about a provider’s care.

Leadbitter v. Keystone Anesthesia Consultants, Ltd., No. 1414 WDA 2018 (Super. Ct. Penn. February 12, 2020).

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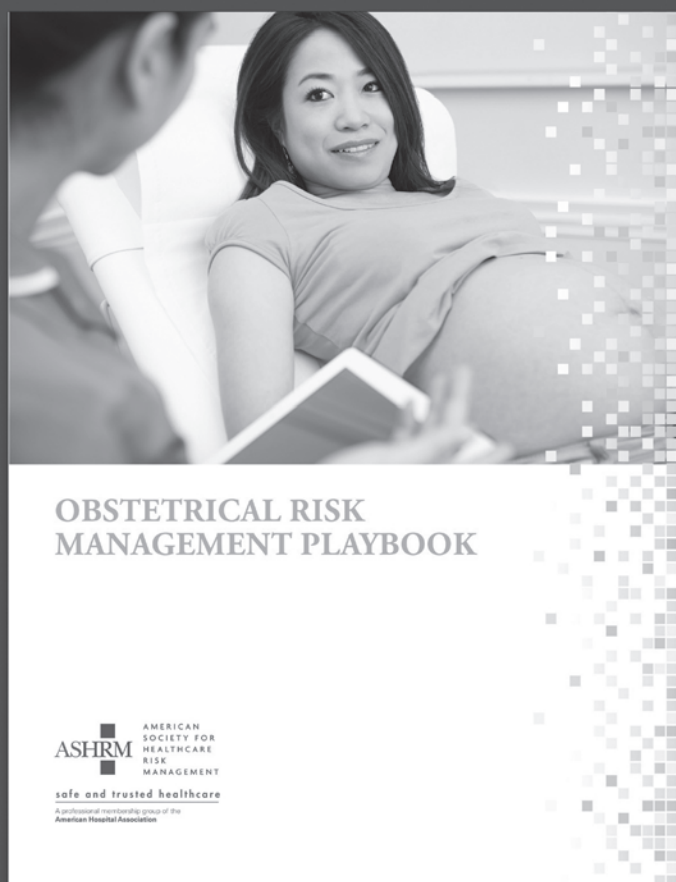
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