THE RISK MANAGEMENT QUARTERLY

Volume I - 2017

EDITOR'S CORNER

The Risk Management Quarterly (RMQ) is the official journal of The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) and is published several times a year.

RMQ's Mission Statement: To enhance the quality of healthcare delivery through education, research, professional practice, and analysis specific to risk management issues.

This journal contains articles on a wide variety of subjects related to risk management, patient safety, insurance, quality improvement, medicine, healthcare law, government regulation, as well as other relevant information of interest to risk managers. The articles are usually written by ***AHRMNY*** members, so the journal serves as an opportunity for members to showcase their writing talents.

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Article Requirements: Maximum article length 3,500 words; Photos should be high resolution JPEGs (at least 300 dpi); AHRMNY will not publish articles promoting products or services.

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AHRMNY

INVITES YOU TO



SUBMIT AN ARTICLE

We are asking our readers to submit articles for future editions of the RMQ journal. We accept articles that focus on patient safety, environment or staff safety, risk management, claims management, insurance issues and other relevant topics. The deadline for submission and consideration for the next journal is March 31, 2017.



BECOME A MEMBER

We invite you to consider joining the New York Risk Management Chapter as a member. AHRMNY offers several types of memberships, including discounts for groups, students and long-distance members. Membership affords opportunities to keep current of relevant risk management issues and network with other industry professionals.



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We invite your organization to consider becoming a sponsor for one of our upcoming educational programs. AHRMNY is a non-profit corporation that provides education, networking and a forum for discussing healthcare risk management issues. Our programs are funded primarily through sponsorship donations and without your support it we could not continue as a resource to hospital associations, medical societies, and civic groups.

Contact AHRMNY at ahrmny@gmail.com or visit our website at www.ahrmny.com to learn more

PRESIDENT'S MESSAGE



It's official!!! The 2016-2017 Education Program of AHRMNY is underway. We opened with a webinar presentation on October 18th by board member Dylan Braverman, Esq. The topic was "The Reptile Theory". This theory incorporates the notion that human beings will always do what is necessary to promote safety and eliminate danger. In essence, according to the reptile theory, if jurors' reptile brains can be controlled, so can the outcome of a trial. Besides learning about this approach to litigation, we also identified ways to minimize technical challenges that will be valuable for future AHRMNY webinars.

Our next program featured many firsts….AHRMNY's first ever program in Long Island location at the beautiful DeMatteis Center in Greenvale, New York, Bruce Gitlin, Esq. our first ever presenter who is a plaintiff attorney and Melissa Kubit, Esq., our first ever presenter who is deaf and spoke about her professional experience as a practicing attorney and her personal experience as a deaf patient. The program was entitled "Resolving Americans With Disabilities Act Claims & Perspectives". Honorable Ruth B. Kraft set the stage with her thoughtful presentation on this important topic. Mr. Gitlin enlightened us with the plaintiff's perspective. Ms. Kubit shared an interesting professional perspective as well as engaging us with a touching personal perspective.

The Education Committee continues to work on future programs scheduled for 2017. AHRMNY will host an evening networking education event on March 30th at Lenox Hill Hospital and our annual all day education conference on June 9th at Andaz Hotel. A "Save the Date" email has been forwarded and we will send out full program with registration details very soon. AHRMNY is able to provide our members with these programs through the generous support from current sponsors that include Swiss Reinsurance Company and the law firm of Vigorito Barker Porter & Patterson.

AHRMNY is committed to being the risk management resource for healthcare professionals in communities beyond the metropolitan area. We recognize that the delivery of healthcare continues to move away from the traditional acute care setting. Accordingly, AHRMNY's Membership Committee is launching a targeted membership drive to invite our colleagues in outpatient settings to become a member of AHRMNY. Collaboration of professionals from diverse settings is a great way to spark an exchange of ideas while promoting safety and quality.

This edition of the RMQ reflects the Publications Committee's passion for and expertise in cultivating articles that inform us and challenge us as risk managers and patient safety advocates.

Warmest regards,

Mary Steffany

Mary K. Steffany, President
July 1, 2016 - June 30, 2017

A Human Factors Approach to Quality, Patient and Risk Management

Colleen A. Lee, MS, RN and Dena Goffman, MD

By the Numbers

Almost two decades after the publication of "To Err is Human" by the Institute of Medicine reported that medical error resulted in up to 98,000 deaths per year[1], preventable human errors continue to be a top concern for hospitals and healthcare organizations; and have proven quite difficult to mitigate. This landmark publication succeeded in changing the conversation by reframing the way healthcare providers and managers think about medical error and injury.[2] As Leape and Berwick noted in a five year follow up, three things were accomplished by this report: viewing the task of error prevention, enlisting the support of stakeholders, and changing practices.[2] Despite significant efforts by a variety of stakeholders including the federal government, there remains much work to be done.[2] A recent study by Makary and Daniel at Johns Hopkins University School of Medicine reports that medical errors account for over 251,000 deaths per year, and this may be an underestimate![3] Although this claim has generated controversy and some in healthcare point to flaws in Makary and Daniel's definition of error (too broad, not broad enough, failure to distinguish between expected complications and error), the fact remains that medical error continues to be a very real and vexing problem.[4]

The reason error in healthcare is such a pervasive problem is because those who provide care are human beings. Human beings are complex entities capable of great achievement as a result of highly developed minds and bodies. It is, however, this complexity which also predisposes humans to error. Numerous strategies to mitigate and prevent harm from medical error are being sought; and efforts to reduce preventable error are increasingly incorporating systems countermeasures.

Before attempting to address this pervasive problem, it is important to understand how error is defined and what types of errors exist. Medical error has been defined in several different ways: an unintended act (omission or commission) or one that does not achieve its intended outcome,[5] the failure of a planned action to be completed as intended (error of execution), the use of a wrong plan to achieve an aim (error of planning),[6] or a deviation from the process of care that may or may not cause harm to the patient.[7] Errors can occur on an individual or system level.[3]

As long as human beings are the primary providers in healthcare, error is to be expected[6]; therefore, understanding human factors and allowing this understanding to guide development of countermeasures is potentially one of the most effective improvement approaches.

Human Factors, Ergonomics and Human Factors Research

Human factors refer to environmental, organizational and job factors, and human and individual characteristics which influence behavior at work in a way which can affect health and safety.[8] Ergonomics is the application of scientific information concerning humans to the design of objects, systems and environment for human use.[9] Human factors and ergonomics must be linked to each other as together they provide the framework for a human factors approach to safety.[10]

Human factors include three areas that must be considered: the job, the individual and the organization. The job refers to the task that people are being asked to do and includes areas of focus such as the nature of the task, workload, the work environment, the design of displays and controls, and the role of procedures.[8] The individual refers to the competence, skills, attitudes and personality traits of the person being asked to do the job.[8] The organization, or the place in which the work is being done, includes workplace culture, resources, communication and leadership among other characteristics of the overall working environment.[8] In order to develop effective safety measures, it is critical to focus on all three aspects of human factors.[8]

Human factors research explores the environmental, organizational and job factors of humans interacting with systems, as well as the physiological and psychological characteristics which influence behavior at work.[9] The military and aviation industries have demonstrated how study of factors that affect job performance can lead to improved outcomes and reduced errors after evidence-based redesign of tasks or systems.[9] As healthcare begins to understand that a human factors approach is critical to improvement and transformation, healthcare leaders look to these industries as exemplars of safety and quality.

Types of Error

There are several different types of error described in the literature. The most common types of errors that occur in hospitals surround the use of medications.[11] Other types of error that occur in hospitals are: failing to detect an error, failure to check equipment unless required by a checklist, errors of omission, and general error in high stress, high stakes environments.[12] It is easy to see how each of these types of errors could occur as advances in medicine and technology have increased the complexity of health care and hospital systems. They illustrate some of the inherent risks related to human limitations.

The length of work shifts also contributes to the risk of error in healthcare. As a result of several well-known cases where patients suffered serious harm or even death due to residents working extended hours, restrictions on residents' work hours were implemented.[13] While restricting residents' work hours has had positive effects,

it has produced some unintended consequences for patient care, namely, an increased number of handoffs.[14] A patient handoff refers to the process of transferring the clinical care of a patient from one provider to another, and involves transfer of information, responsibility, and authority.[15] Handoffs occur frequently between providers of all disciplines. As a result of such frequent transfers of information there is an increased likelihood for error to occur.[15,16] Handoffs are recognized as such high risk events that the Joint Commission estimates that at least 35% of sentinel events are due to handoff errors.[17]

Potential Countermeasures: Human Factors Engineering and Just Culture

Human Factors Engineering (HFE)

Because both human beings and health care systems are so complex, the problem is multifaceted and difficult to solve. To reduce the effects of stress, fatigue, multitasking, complex tasks and procedures, and distracting work environments, hospitals must examine potential countermeasures through the lens of human factors engineering. According to the Agency for Healthcare Quality and Research, human factors engineering is a discipline "that takes into account human strengths and limitations in the design of interactive systems that involve people, tools and technology, and work environments to ensure safety, effectiveness, and ease of use".[18] Human factors engineering takes a systems approach to patient safety by acknowledging that human beings are fallible and will make errors.[6]

The Swiss Cheese model of human error is a popular visual schema that demonstrates how systems can contribute to human error and allow patient harm. This model asserts that harm results from flawed systems by allowing individual errors to slip through holes in multiple barriers.[6] Potential countermeasures involve ways of identifying the holes, making the holes smaller and ensuring that the holes do not align in order that an error may not reach the patient.[6]

According to Clark et al., the first step in reducing errors is to identify and categorize events.[19] Although this study focused on obstetrics, development of a comprehensive system for reporting and identifying near-miss events is applicable to any service, and would allow teams to focus safety efforts in the areas of greatest need by prioritizing according to severity.[19] A near-miss is defined as an unplanned event caused by error that does not result in harm to the patient, but has the potential to do so.[20,21,22] Four different categories of near-miss events are: high frequency-low hazard, high frequency-high hazard, low frequency-high hazard, and low frequency-low hazard.[19] Systems countermeasures like electronic medication administration records, computerized physician order entry (CPOE) and protocols requiring multiple checks have proven effective at reducing harm to the patient from high frequency-low hazard events such as medication errors, and patient failures are generally uncommon, usually detected before reaching the patient, and therefore, take lower priority and less resources than other events.[19] Unfortunately, the two most serious types of events, high frequency-high hazard and low frequency-high hazard, have few existing barriers in place; and those that do exist tend to be suboptimal.[19] High frequency-high hazard events tend to involve a provider's failure to respond and/or to follow protocol, while low frequency-high hazard events usually involve a physician-specific action such as a performance error.[19] The problem with these two types of hazard events is that they result almost entirely from difficulties with human interpersonal communication and chain of command.[19]

Some potential countermeasures previously implemented to prevent human error exemplify how human factors engineering can transform the work environment. One such example is the re-engineering of connectors for IV tubing and epidural catheters. Previously, they were interchangeable which created a high risk for medications to be administered via the wrong route. These connectors are no longer interchangeable making it almost impossible to administer medication via the incorrect route. The same has been done with connectors for oxygen, medical air, and anesthetic inhalants so as not to administer the wrong treatment. In reality, human factors engineering has even transformed the non-healthcare world in ways that have made human beings far safer. For example, the knobs on a stove used to be located at the back of the range top meaning that one had to reach over a hot surface to adjust the temperature. Most new stoves have the knobs located at either the side or the front of the range- a simple human factors engineering countermeasure.

If we are lucky, countermeasures to prevent human error are a simple matter of rearranging equipment or implementing systems for multiple checks such as has been the case in the realm of medication administration. Unfortunately, this is not the case for the most potentially harmful types of errors- high frequency-high hazard and low frequency-high hazard events.[19] These events usually have no physical aspect that can be changed to prevent them from recurring; but rather, they often involve human actions and interactions and, therefore, necessitate culture change.

Just culture

A critical step in attempting to address quality and safety in healthcare is to shift the culture from one of "blame and shame" to a just culture.[23] Traditionally in medicine, when an adverse event occurred, the case would be reviewed in order to determine who "caused" the event. This person would be blamed and often would face disciplinary action depending on the severity of the alleged transgression. This type of blame culture does nothing to encourage providers to report mistakes or near-misses and only encourages hiding the error.[23]

A just culture acknowledges the need to balance learning from mistakes and taking appropriate disciplinary action when needed.[24] A just culture recognizes that sometimes, despite following best practices, adverse outcomes occur.[23,24] In these cases, no providers are held accountable because they did nothing wrong. In very rare cases, providers violate a code of conduct, such as working while intoxicated, and are disciplined accordingly.[24] These two types of events (blameless adverse outcome and egregious behavior) are rarer leaving most cases to fall into the gray zone. Within the gray zone, it is acknowledged that best practices were not followed and involved providers are either consoled or coached in order that they might learn from the event.

One important aspect of just culture to consider is whether or not the system in which the individual works is responsible for the error to some degree.[24] Often, human error results from flaws in the system, such as a lack of standardization for common procedures or steps included in policies and procedures which are perceived as burdensome or unnecessary by the providers, thus leading to workarounds. Without addressing these systems flaws and simply disciplining individuals, healthcare organizations are destined to find the same errors recurring again and again.[24] Within a just culture, individuals are encouraged to report errors and near misses which ultimately provides opportunities for all to learn from the event and, when possible, to begin formulating potential systems countermeasures to prevent the same situation in the future.[24]

Corrective Actions

As part of any robust quality improvement initiative, adverse events and near misses must be reviewed in order that lessons might be gleaned for the future. The most significant cases are often reviewed through a root cause analysis or RCA. During an RCA, a multidisciplinary committee reviews an adverse event in depth with the aim of identifying a root cause or causes. Once a root cause has been identified, the critical work of formulating and implementing corrective action plans begins.

Several factors are important to consider when developing corrective action plans. The plan must be mapped to the root cause, written and communicated well to all personnel, have a process owner responsible for completing the action, and, when possible, pilot testing prior to system-wide implementation.[26] Corrective actions are only as successful as their strength.

Forcing functions, such as exist for medication administration and patient identification,[21] are the strongest types of corrective actions because they are the best at removing dependence on the human.[25] Checklists are examples of intermediate strength actions as they reduce but do not totally eliminate any chance for human error.[25] The weakest corrective actions are those that support or clarify the process but rely solely on humans.[25] Examples of weak corrective actions are writing or revising policies and educating personnel on the process.[25]

Summary

Human beings are complex and capable of great accomplishments; but at the same time, are prone to error. Healthcare has become increasingly complex over time. It is misinformed to think that human beings' propensity for error combined with an ever more complex healthcare delivery system does not put patients at risk. As long as human beings provide healthcare, error will occur. Rather than despair, it is crucial for healthcare leaders to address the inevitability of error from a human factors perspective. Doing so will allow for development of important systems countermeasures to mitigate error. Designing systems to make it easier for human beings to do the right thing all the time, and harder to make mistakes, is the best way to ensure safe, high quality care.

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Preventing Liability for Sexual Harassment by Creating a Culture of Civility

Joan M. Gilbride

Given the close quarters, intense pressures and at times informality of communication surrounding the provision of medical care, it is no wonder that healthcare facilities can be breeding grounds for harassment and sexual misconduct allegations and claims. Unlike an office setting, a hospital environment exposes patients and co-workers as potential victims of harassment, which not only often leads to lawsuits, but also negative publicity, legal fees and all types of complications and complexities. To avoid this quagmire, it is important that risk managers are aware of potential liability and ways to foster a safe working environment at a healthcare facility.
The seriousness of preventing sexual harassment and sexual misconduct grabbed the public's attention when earlier this year, a shocking news story reported a Mt. Sinai emergency room doctor was indicted for sexual assault of a patient. In graphic detail, the reporter described the sexual assault alleged by a patient who was sedated, but aware that she was being violated by a physician, and incapable of reacting. The type of sexual misconduct described by this patient is a nightmare for the patient and the hospital and, thankfully, happens rarely. To prevent this type of conduct and less egregious variations, it is crucial that employers implement training programs to promote an environment that encourages civility, peer reporting and clear avenues for complaining of sexual harassment and sexual misconduct in the healthcare profession.

As a first step, the employer must be aware of the risks before deciding which tactics would be most effective in preventing liability and determine whether its workplace culture needs to be transformed.

Risk Factors for Sexual Harassment and Sexual Misconduct

In June 2016, the United States Equal Employment Opportunity Commission (EEOC) Select Task Force on the Study of Harassment in the Workplace (the "Task Force") released a report. In its report, the Task Force identified factors that increase the likelihood of harassment in a workplace, which include characteristics typical of healthcare environments, such as: "high value" employees, significant power disparities, and decentralized workplaces.[2] Based on these factors, hospitals and healthcare facilities are extremely susceptible to allegations of a hostile work environment based upon harassment and indeed, to unknowingly allowing such circumstances to develop. The Task Force also noted that in addition to the expected legal and financial implications of sexual harassment, harassed employees were found to be less productive, and employers often suffered reputational damage and risked losing patients.[3]

Understanding Potential Liability for Healthcare Facilities

In egregious events of sexual misconduct, like the case of the emergency room doctor at Mt. Sinai, under New York law, healthcare facilities face risks to the extent that the conduct was foreseeable. A hospital may be able to defend successfully against liability for a doctor's outrageous or near criminal behavior, but not against a hostile work environment that breeds such behavior. It is essential that healthcare facilities implement procedures to prevent harassment and successfully defend against allegations of harassment regardless of the legal risks.

A hospital's duty to protect patients and visitors as a caretaker is governed by a standard of foreseeability.[4] New York courts have limited the duty to protect persons lawfully present on a hospital's premises from the reasonably foreseeable criminal or tortious acts of third persons.[5] For example, a New York hospital faced potential liability, when a male nursing assistant allegedly sexually assaulted a female patient while preparing her for a surgical procedure. The court found in favor of the hospital and held that plaintiffs failed to show the hospital knew or should have known of the assailant's propensity for the conduct that caused plaintiff's injury. In a decision rendered by the Appellate Division, First Department, the court found that it was not reasonably foreseeable that a hospital's independent contractor would sexually assault a patient while conducting her vaginal sonogram, and the patient therefore was not entitled to recover on her negligent supervision claim against the hospital. In that case, the court considered the sufficiency of the independent contractor's background check on its employee and examined whether the hospital was on notice of the independent contractor's employee's potential for violence or sexual abuse.[6] The hospital was lucky that its independent contractor thoroughly vetted its employee and plaintiff failed to rebut the lack of reasonable foreseeability based on the background check. Although the court found in favor of the healthcare facility in these cases where patients sued, when a hospital is sued as an employer by its own employee, it is less likely to avoid liability.

In *Salamon v. Our Lady of Victory Hosp.*, a former employee attempted to hold the hospital liable for conduct of a doctor on staff.[7] The hospital argued it was not liable as a matter of law for the harassing conduct of a doctor who was not an employee, but an independent contractor. Id. The federal district court in *Salamon* denied the hospital's motion for summary judgment, finding the Second Circuit had not definitively ruled on the question of whether an employer can be liable for a non-employee's harassing conduct.[8] The court recognized, however, that the Second Circuit limited any potential liability for non-employees to "instances in which the employer provided no reasonable avenue of complaint or knew of the harassment but did nothing about it."[9] Thus, an employer could be exposed to liability for even a non-employee's conduct if the employer does not have a complaint procedure in

place. As such, not implementing a complaint procedure or failing to educate your employees about an existing procedure can exponentially increase risk.

Harassment often involves multiple missteps by more than one employee. A recent case[10] involved allegations of harassment against a nurse's colleague where one long term pediatric nurse alleged she was harassed by another long term nursing employee; the harassment included late night phone calls, adjusting the plaintiff's label on her underwear and discussing plaintiff's medical history with other employees.[11] In addition, plaintiff claimed that she suffered harassment from her treating physician, a surgeon who worked at the same facility[12] and made comments to her while at work that she perceived as references to her personal medical history; for instance, her physician referenced the movie *40 Year Old Virgin,* teased plaintiff about getting pregnant when she mentioned taking vacation to visit a male friend and made comments about her not having children. Plaintiff also alleged that she complained to human resources about the harassment, but nothing was done. In the Complaint, plaintiff implicates several actors who allegedly contributed to her damages: a fellow nurse, a doctor and human resources staff. The court denied the hospital's motion to dismiss as to negligent retention and supervision, hostile work environment sexual harassment, and disability discrimination.

Another scenario which has potential for posing great risk to healthcare facilities is relationships that might occur between interns and residents in medical teaching facilities. If the facility allows or empowers a resident in his or her second year of postgraduate residency (PGY2) to supervise and direct a first year postgraduate student (PGY1) the facility may be liable for sexual harassment based on PGY2's behavior. It is not hard to imagine two postgraduate students dating, but if a PGY2 uses his or her supervisory position to persuade the PGY1 to go on a date, this can pose serious risk for the hospital. Environments where supervisors do not constantly observe their subordinates and are not trained to spot troubling inappropriate behavior are more likely to breed a culture of acquiescence rather than a culture of civility. Managers and supervisors are the heart of an employer's prevention system.

Implementing Solutions[13]

Regardless of the legal outcome, the defendants will be forced to pay substantial legal fees and the incident can have lasting effects on the hospital's reputation. Accordingly, preventative measures are in everyone's best interest. As noted previously, to create a culture in which employees believe that the organization will not tolerate harassment, managers and supervisors must receive clear messages of accountability. Compliance training translates those expectations into concrete actions that managers and supervisors are expected to take – either to prevent harassment or to stop and remedy harassment once it occurs. Employers should begin by taking complaints of sexual harassment and misconduct made against their current employees very seriously and evaluating current employees to ensure employees who demonstrate a propensity toward such misconduct are not retained.

Compliance training provides managers and supervisors with easy-to-understand and realistic methods for dealing with harassment that they observe, that is reported to them, or of which they have knowledge or information. This includes practical suggestions on how to respond to different levels and types of offensive behavior, and clear instructions on how to report harassing behavior up the chain of command. Training should also stress the affirmative duties of supervisors to respond to harassing behavior, even in the absence of a complaint. This training should be tailored to the specific worksite, organization, and/or industry, so that the examples used are helpful to managers and supervisors.

The EEOC encourages strong anti-harassment policies that provide a clear explanation of prohibited conduct and assurance of protection from retaliation. Compliance training is essential, but focusing on steps to avoid legal liability may fall short of preventing a hostile work environment and a culture of harassment. The EEOC recommends creating a culture of civility by training with specific goals in mind as a "holistic effort" to prevent harassment, which should also include accountability and leading by example.

The goals of training should be to educate employees and supervisors, to ensure that employees understand what is considered harassment in the workplace and empower supervisors by creating procedures for complaint follow-up. Understanding what is not appropriate is the first step towards preventing a volatile work environment or changing an already toxic one. The EEOC also suggests that trainings educate employees about the external consequences (including reputational harm) of conduct that rises to the level of illegal harassment. A senior leader's attendance at the training is the strongest expression of support (as an alternative, a video of a senior leader introducing the training could be shown, or a memo from leadership sent prior to the training). Trainings should be interactive and take place at least every other year to demonstrate the employer's commitment to preventing harassment. Also, the trainings should evolve to ensure they are relevant and grab employees' attention with new content.

The EEOC Task force recommends "bystander intervention training" and "civility training" given that incivility is a harbinger of a hostile work environment.[14] This type of training focuses on what employees and

supervisors should do, rather than what they should not do. The training alone, however, is not enough. The employers who are most successful in preventing harassment have taken other steps to convince employees that they will not be tolerant of sexual harassment. The EEOC suggests that prior to training, employers should provide their employees with avenues for complaints (such as a hotline).

A proactive employer that is focused on creating an environment of civility through adequate training and leadership will reduce the likelihood of sexual harassment and sexual misconduct in the workplace. These strategies not only make the workplace safer, but lower the possibility of flagrant sexual misconduct as well as liability and the economic and intangible impact on an employer's business.

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ABOUT THE AUTHOR



Joan is the managing partner of KBR's national Employment Law Practices Team. Her practice focuses on the representation of management in employment litigation and complex commercial litigation which includes includes insurance coverage litigation and professional liability defense. Practicing law since 1987, Joan has obtained extensive pre-trial, trial, and appellate experience in both individual and class actions in federal and state courts throughout the country. She has been admitted to practice on a *pro hac vice* basis in numerous states and often manages complex litigation on a national basis. Joan has tried many cases to verdict over the past twenty-six years and has been involved in media-intensive class action litigation. She litigates and arbitrates before administrative agencies as well and is well-versed in ADR proceedings.

Save The Dates

2017 Educational Programs

- MARCH 30TH 5:30-9:30 PM
  Evening Networking Event
  Lenox Hill Hospital, NYC
  - Early Resolution of Claims by Mediation
  - AIG Claims Study

- JUNE 9TH 8:30 AM - 3:30 PM
  Annual Conference
  Andaz Wall Street, NYC
  - Speakers and Topics TBD

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R I S K Y B U S I N E S S

What Motivates Us to be Better?

By Pamela Monastero, MBA

This quarter's column explores individual and organizational motivation to 'be better.' The inspiration for this piece is threefold: first and foremost, a passion for patient safety and the dynamics of organizational behavior; second, a recent article published by Austin and Pronovost,[1] that looks at core processes of care, with a view towards intrinsic and extrinsic sources of motivation; and third, a personal interest in motivational theory. The Austin and Pronovost article describes the drivers of individual provider motivation within the framework of the organization to gain quality improvement. No discussion would be complete without consideration of the study of organizational behavior, which is simply described as the culture (e.g. corporate culture) and behavioral norms of a particular organization. Individual behavior cannot be studied without corresponding consideration of the behavior of the organization and their interconnectivity.

There is a plethora of academic literature on theories describing individual drivers of motivation, as well as discussion within the study of organizational behavior. Comparisons of theories of motivation range from Herzberg's[2] Two Factor Theory (motivator, hygiene) to Maslow's[3] Hierarchy of Needs (self-actualization, esteem, belonging, security, physiological) to McClelland's[4] Acquired Needs Theory (achievement, power, affiliation) to McGregor's[5] X Y Theories, among others. Cognitive theories, which explain the thoughts and decision-making around the expenditure of effort (e.g. Expectancy Theory[6], Equity Theory[7] and Goal Setting Theory)[8] are also enlightening in terms of deciphering individual motivation.

The Austin and Pronovost piece reviews care processes and the underlying motivation of providers. In terms of extrinsic motivators, the article touches on publicly reported data and pay-for-performance. The authors maintain that transparent reporting of performance helps ensure accountability of performance ranging from individual clinicians to governance. As regards intrinsic motivators, the authors explore the training of clinicians in improvement science (e.g. lean sigma, teamwork, culture change) to provide clinicians with the skills they need to drive the improvement work; peer learning is also described as an engaging and supportive process. They maintain that quality improvement work that is led by, and engages, clinicians offers the opportunity for the work to be both meaningful and sustainable. The author's state that the academic literature reviewed is supportive of approaching quality improvement in a systematic way, including the key elements of communication, infrastructure building, training, transparency and accountability.[1]

Although not specifically mentioned in the Austin and Pronovost article, additional extrinsic motivators for clinicians to 'be better' may be attributed to the costs of professional liability insurance (e.g. where there is a direct correlation between premium costs and claims exposures) and medical liability reform, or exposure to high profile cases (e.g. media or regulatory attention) that can negatively impact a clinician's reputation, career prospects or credentialing. Although these motivators result in behavior that can best be described as 'avoidance of punishment' vs. an innate desire to perform better, they are nonetheless extrinsic factors that may motivate individuals to deliver higher quality outcomes and to focus on opportunities to proactively reduce patient harm as a result. Based on academic literature, it is believed that intrinsic motivators are likely more powerful and sustainable.

Core Processes of Care

In the Austin and Pronovost piece, the authors state that "frontline clinicians serve as the catalyst for all endeavors to improve quality. Ultimately, changes in how clinicians deliver care is what drives improvements in the performance of care delivery and patient outcomes. The motivation of clinicians serves as a driving force behind these changes" and, therefore, the article focuses on both intrinsic motivators (focused on the individual, e.g. drive for achievement, purpose, etc.) and extrinsic motivators (representing factors based on rewards and punishments, e.g. pay-for-performance). The article references Herzberg's[2] theory on motivation; Herzberg identified that factors which are outside of the individual and outside of the individual's specific job/nature of work (e.g. wages, workload, working conditions, job hierarchy, status, etc.) may not necessarily increase job satisfaction. Herzberg maintained, however, that the absence of these factors (e.g. poor working conditions) can create dissatisfaction (or hygiene factors, see below).[1] Herzberg's hygiene factors are better known as extrinsic motivators and the theory recognizes that true motivation comes from within the individual.

According to Austin and Pronovost,[1] motivation in health care quality processes can be categorized as follows:

1. Extrinsic factors, such as monetary rewards or penalties based on performance, are used as incentives (or sometimes as disincentives) to try to achieve differences in performance. The article looks at publicly reported performance data vs. pay-for-performance data. The author's state that publicly reported performance data is more effective in motivating clinicians to improve their own performance. In illustration, they cite several clinical collaboratives, one of which compares New York State's publicly reported performance on percutaneous coronary intervention outcomes with the same collaborative study in Michigan. In the Michigan collaborative, the performance data was not publicly reported. Findings indicate improved performance at a greater speed in the New York collaborative. In contrast, the author's point out that pay-for-performance data generated conflicting results, citing both U.S. and international studies, suggesting that the mixed success is multifactorial.

2. Intrinsic factors, such as satisfaction in a job well done or a desire of betterment or growth and learning, can also be used to improve performance in core processes of care. The article explores the four-element framework developed by The Armstrong Institute for Patient Safety and Quality at John Hopkins Medcine[9] which includes: (1) defining and communicating clear goals; (2) creating enabling infrastructures; (3) engaging clinicians and creating communities to support peer and organizational learning; and (4) establishing transparent reporting and ensuring accountability. Each element is explored in detail and the article contains a table describing the application of the quality improvement framework in terms of improving core processes of care for patients with persistent asthma and improving the rate of inhaled corticosteroids initiation at emergency department discharge.

The *Improving performance on core processes of care* article puts forth five key points:

- Extrinsic motivation for clinicians to improve quality has a mixed record, intrinsic motivation is more powerful;
- Goals for improvement work should be clearly defined and clearly communicated to clinicians;
- Clinicians must be supported with an enabling infrastructure to ensure quality improvement work is as easy as possible;
- Quality improvement work should include clinicians participating in peer learning communities; and
- Clinicians and organizational leaders need transparent reporting of performance and shared accountability to that ensure goals are met.[1]

Overview of Popular Motivational Theories

1. Herzberg's[2] Two Factor Theory (motivator, hygiene): as previously mentioned, this is a two-dimensional paradigm of factors affecting people's attitudes about work. Herzberg describes factors such as organizational policy, supervision, interpersonal relations, working conditions and salary as hygiene factors, not motivational factors. The absence of hygiene factors can create job dissatisfaction but their presence does not motivate or create satisfaction. He cites five factors that are strong determiners of job satisfaction: achievement, recognition, the work itself, responsibility and advancement. Herzberg maintains that hygiene factors (dissatisfiers) produce only short-term changes in job attitudes and performance and those motivators (satisfiers) were associated with long-term positive effects on job performance. Because this theory was developed based on industrial settings, there has been criticism of its validity outside of the industrial sector.

2. Maslow's[3] Hierarchy of Needs: (self-actualization, esteem, belonging, security, physiological): this theory puts forth that there is a general pattern of needs recognition and satisfaction that people follow in generally the same sequence and that an individual cannot recognize or pursue the next higher need in the hierarchy until his/her currently recognized need is substantially or completely satisfied. Needs are usually depicted as a pyramid with the survival need at the broad based bottom and self-actualization at the narrow top. From bottom to top, the needs are: physiological (thirst, sex, hunger), safety (security, stability, protection), love and belongingness (avoidance of loneliness, to love/be loved, sense of belonging), esteem (self-respect, respected by others) and self-actualization (fulfill one's potentialities).

3. McClelland's[4] Acquired Needs Theory (power, achievement, affiliation): an individual's specific needs are acquired over time and are shaped by one's life experiences. Most of these needs can be classified as achievement, power or affiliation. The need for achievement underlies Maslow's self-actualization and also has similarities to Herzberg in maintaining that high achievers are interested in Herzberg's motivators and low achievers are interested in Herzberg's hygiene factors. In terms of motivation: (a) for those who have the need for power (these individuals exhibit behaviors conducive to organizing, motivating and leading others); (b) for those who need a sense of achievement (these individuals are results oriented, like to reach a goal and be recognized for it, and like reasonable challenges); and (c) for those who have the need for affiliation (these individuals seek acceptance and belonging and like being part of a team).

4. McGregor's[5] X Y Theories: is also rooted in Maslow's self-actualization level of motivation and is based on the assumption that self-direction, self-control and maturity control motivation. Reward systems must correspond to intrinsic factors if staff is to be motivated. The theory explores management of two different types of workers: Theory X states that management believes that workers will do as little as possible to get by and thus require a great deal of direction. Theory Y maintains that management believes that workers are interested in doing their best and, given the freedom, will perform well.

Overview of Cognitive Theories

1. Expectancy Theory[6] (V. Vroom): the intensity of work effort depends upon the perception that an individual's effort will result in a desired outcome. Individuals are motivated when they believe that putting in more effort will yield better job performance, better job performance will lead to organizational rewards (e.g. salary increase, promotion, etc.) and that predicted organizational rewards are valued by the employee. This is a theory that proposes that people are motivated by their conscious expectations of what will happen if they do certain things, and are more productive when they believe their expectations will be realized.

2. Equity Theory[7] (J.S. Adams): a concept that people derive job satisfaction and motivation by comparing their efforts (inputs) and income (outputs) with those of others in the same or other firms. In other words, fairness and equity are key components of a motivated individual and that when an individual identifies inequities (whether in inputs or outputs), they will seek to adjust their input to reach their perceived equity or, conversely, become de-motivated. A simple example is staff doing the same work for different pay.

3. Goal Setting Theory[8] (E. Locke): a technique based on the concept that the practice of setting specific goals enhances performance and that setting difficult goals results in higher performance than setting easier goals. Simply stated, goals indicate and give direction to staff about what needs to be done and how much effort is required and that a main source of motivation is the attainment of a challenging goal. The technique calls for clear, unambiguous and measurable goals with deadlines. Goals should be challenging and realistic with relevant rewards, including appropriate feedback.

Organizational Behavior

Organizational behavior is an interdisciplinary field with roots in sociology, psychology, communication and management and it complements organizational theory, which focuses on organizational and intra-organizational topics, e.g. human resource studies. Organizational behavior examines human behavior in the work environment and determines its impact on job structure, performance, communication, motivation, leadership, etc. Facets of organizational behavior, in addition to leadership, include decision making, team building, motivation, job satisfaction, etc., all of which are relevant to management in determining resource allocation, delegation of duty and motivation. Importantly, organizational behavior focuses heavily on corporate culture, which can be difficult to define but extremely relevant to how organizations behave. [10]

Human Factors Engineering

While not specifically linked with literature on motivation and organizational behavior, human factors engineering is an important consideration when discussing motivation and de-motivation (e.g. Herzberg's hygiene factors or dissatisfiers). "Human factors engineering is the discipline that examines human strengths and limitations in the design of interactive systems that involve people, tools and technology, and work environments to ensure safety, effectiveness, and ease of use. A human factors engineer examines a particular activity in terms of its component tasks, and then assesses the physical demands, skill demands, mental workload, team dynamics, aspects of the work environment (e.g., adequate lighting, limited noise, or other distractions), and device design required to complete the task optimally. In essence, human factors engineering focuses on how systems work in actual practice, with real—and fallible—human beings at the controls, and attempts to design systems that optimize safety and minimize the risk of error in complex environments." It is a discipline that has been applied to improve safety in many industries, e.g. aviation, automotive, nuclear power, etc. In the healthcare industry, human factors engineering has been applied to the redesign of anesthesia equipment, resulting in reductions in injuries and deaths in operating rooms. Human factors engineering reinforces the following:

1. *Usability testing*--the testing of new systems and equipment in real-world conditions to help identify potential problems and unintended consequences, e.g. implementation of new technology and the avoidance of staff workarounds which can arise from flawed or poorly designed systems;

2. F*orcing functions*—these prevent unintended or undesirable actions from being performed or permits performance only after another action is first taken, e.g. removal of concentrated potassium from nursing units;

3. *Standardization*—standardizing equipment and processes wherever possible to increase reliability, information flow and minimize staff cross-training, e.g. use of one defibrillator across the organization, implementation of checklists, etc.; and

4. *Resiliency efforts*—acceptance that unexpected events will occur and focus on detection and mitigation before events escalate. *Resiliency efforts* focus on the anticipation of events and adapting to change to recover from system anomalies.

According to Agency for Healthcare Research and Quality (AHRQ), "human factors principles are underutilized in the examination of safety problems and in designing potential solutions. An example cited by AHRQ of a failure to consider human factors principles is the implementation of computerized provider order entry (CPOE) where *usability testing* was not considered in examining potential consequences (e.g. interfacing) of CPOE with electronic medical records. One study[11] demonstrated that commercial CPOE systems generally did not detect potentially unsafe orders."[12] Consider provider and staff motivation in scenarios when human factors engineering principle have not been considered. One such example would be the implementation of a new electronic medical record. Human factors principles of *usability testing, forcing functions* and *resiliency efforts* would be essential facets for a successful roll-out. However, without appropriate testing and planning, staff training, education and hands-on support, staff and providers will likely respond emotionally with fear, frustration and anger, rejection and, not to mention, the strong possibility of being involved in an avoidable patient safety error. The inherent stress in learning new technology would be somewhat mitigated if end users felt supported and had clarity on expectations. Appropriate analysis and planning, utilizing human factors engineering principles, can likely contribute to mitigating de-motivation or dissatisfiers.

Conclusion

The *Improving performance on core processes of care* article cites numerous supportive studies that describe the motivational impact of publicly reported performance data vs. pay-for-performance data on quality improvement, as well as collaborative learning and strategies to improve provider engagement in practice improvement. While some of the literature is promising, the healthcare industry may very well be in the early phases of exploring motivational theory as it relates to practice improvement. We are an industry comprised of highly educated, highly motivated individuals with strong professional ethics and dedication to quality improvement. We need to capitalize on this unique strength to better connect with the individual provider, understand their interconnectivity with the organization and the motivational factors that push us to "be better."

REFERENCES ON PAGE 27

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Risk Management Quarterly Journal (RMQ), is designed to support both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to pamela.monastero@nyumc.org or mail to AHRMNY utilizing the RISKY BUSINESS form. The form permits confidentiality.

Capitalizing on your Actuarial Report

By Andy Hoffman, FCAS, MAAA and Richard Frese, FCAS, MAAA

The actuarial report is a powerful tool that evaluates the success of risk management. Communication with an actuary may be seen as intimidating because actuarial analysis is often complex, resulting in key points of the actuarial analysis that are sometimes not fully understood by risk management personnel. The following will provide insight and background on critical topics to discuss with an actuary to enhance recognition of your insurance program, better manage its liabilities, and maintain appropriate actuarial analysis for the needs of the program. In addition, we will share best practices when working with an actuary.

Common uses and goals of actuarial analysis

Actuarial analysis is often required because of accounting, and financial reporting, and captive domicile requirements. It is critical for financial statements to reflect an accurate estimate of the liabilities and exposures of a company. When an actuary determines the unpaid claims liability, sometimes referred to as reserves, he or she is providing an estimate of the amount of future claims payments. An auditor will also review the reserves and may perform an independent test of the adequacy of the reserves. In addition, if a healthcare system has a captive, then the actuary may need to provide a certified actuarial opinion of the reserves. This is dependent on the domicile of the captive.

Self-insurance programs have been common since the 1970s, with many formed during the first medical malpractice crisis. With turnover since then, current management may not be aware of the initial reasons for the self-insurance program or whether it still serves its purpose. Actuarial analysis and feasibility studies can evaluate the risk profile of the institution and help determine an appropriate structure of a self-insurance program. With revaluation of an insurance program, it may make sense to reevaluate the actuarial needs too.

Other users of actuarial analysis frequently include captive management, brokers, and the insurance markets. It is also common for the actuarial report to be provided to regulators and underwriters. The actuarial report should be used by risk management to showcase its program and differentiate itself in the marketplace.

Communication of program and changes

Communicating important facts and changes in your program helps an actuary provide more accurate estimates. There are many important areas to consider, the first of which should be loss experience. The actuary will want to know if there has been any significant loss experience and what caused it. This could be for a single large claim, several medium-sized claims, a change in frequency of smaller claims, or another significant change. This information allows the actuary to determine how the loss experience impacts the estimates. Other loss-related changes that should be communicated to the actuary are changes in reserving or payment philosophy. The actuary's estimates will be impacted if the reserves are set more conservatively or claims are paid more quickly. Actuaries can adjust for these changes but only if they know about them.

Any changes in exposure, retentions, insurance premium, or financial reporting decisions should also be communicated to the actuary. Significant changes in exposure need to be discussed in detail, such as new facility acquisitions, new physician group acquisitions, moving a specific department from a self-insurance program to commercial insurance, or any other large change. Changes in retention will directly affect the actuarial analysis and should be communicated to the actuary at the beginning of the study. Insurance premiums are useful to actuaries when determining estimates on both net and gross bases. Financial reporting standards may require you to record both in financial statements. Any changes in the presentation of your financials, such as in the discount rate or the percentile at which management wants to book liability, should be relayed to your actuary.

Actuarial estimates are not exact. They are point estimates within a range. Some institutions want to be more aggressive (seeking a lower estimate within the range), knowing that a future bad loss or losses will cause a large increase. Others want to be more conservative, in case of a future large loss, to reduce the variation in the estimates. Various approaches can be appropriate depending on each organization but it is important to communicate your own strategy to your actuary.

Loss development

Actuaries estimate ultimate losses, which can be defined as the total losses when all claims are reported and paid. Ultimate losses = paid losses + case reserves + incurred but not reported (IBNR) losses. The paid losses are known, case reserves are a known value but are estimated, and IBNR is unknown. It is the actuary's job to estimate this unknown portion of losses, or IBNR.

The four components of IBNR are development on known cases, newly reported losses related to events previously occurred (pure IBNR), reopened cases, and cases in transit. Development on known cases and pure IBNR are typically the largest parts of the unknown losses. The development on known cases is the increase in the values of cases that have already been reported. For example, a case is reported and an initial reserve of

$50,000 is put up for the case. The case is then increased to $500,000 later the next year. The increase from $50,000 to $500,000 is development on a known case. This is normal and expected for medical malpractice and workers' compensation.

Pure IBNR is the amount estimated for losses that have occurred but have not yet been reported. They are the cases that have happened, but that you do not know about yet, which can commonly happen in medical malpractice. Reopened claims are claims that were previously closed but then have further development. Reopening of cases is usually more common for workers' compensation than it is for medical malpractice. The last piece and smallest part of IBNR is claims in transit, which are reported events that have not yet made it into the loss data reported to the actuary.

The actuary will estimate claim development based on the program's own experience, to the extent that it is credible; however, development varies by type of coverage, jurisdiction, and limit. Claims-made coverage is coverage for claims reported during the policy period. Occurrence coverage is coverage for claims that occur during the policy period. Claims-made coverage has a shorter tail than occurrence coverage, which means the losses will be reported and paid sooner for claims-made coverage. The jurisdiction of a claim greatly impacts development. Some states have caps on awards while others do not. Some jurisdictions just give larger payments than others. For example, two identical claims, one in New York City and one in rural New York, would probably be awarded different amounts.

The actuary must also determine how much credibility to give to the program's own loss development pattern versus an industry pattern. Typically, the larger the program, the more credibility an actuary would give to the program's own loss development. A stand-alone hospital may not have enough credibility to use its development pattern. In addition, smaller stand-alone hospitals will have greater variability from large losses. A single large loss at a large facility or system may not have much of an effect on the overall estimates, but a single large loss at a small facility can cause a significant change in estimates. This, of course, varies depending on the amount retained by the facility. The larger the amount retained, the larger impact a single claim can have on the results. Risk management should ensure that they are given credit for the experience.

Trends

The actuary will adjust estimates for changes in exposure, measured as occupied bed equivalents, frequency trend, and severity trend. Changes in exposure show how much the facility or system has grown over time. For example, if two stand-alone hospitals merged, the actuary would adjust for the change in size of the program. Frequency trend accounts for the expected change in the number of claims per year over time. Severity trend accounts for the change in average cost per claim over time. Historically, claims have become more expensive over time. Trends may be estimated directly for a large health system but industry trends are commonly used for stand-alone hospitals in actuarial analysis.

Judging reliability of actuarial estimates

The best way to determine the quality of an actuary's estimates is to evaluate ultimate losses. Variability in liability estimates does not indicate variability in an actuary's estimates. Ultimate losses minus paid losses equal the unpaid claims liability. Liability may be a function of timing of the payments. The key is to focus on the change in ultimate losses because this affects the bottom line.

However, because of the nature of medical malpractice, it may be better to look at the total change in ultimate losses across all years rather than the change in them for an individual year. Medical malpractice is a highly variable line of business, depending heavily on whether or not a large loss occurs in a given year. Typically, a few years will have worse experience than others. In a new year, the actuary does not know much about the loss experience for the year, and won't for a few years. Because of this, an expected ultimate loss is usually selected. The expected ultimate loss is close to an average but years will very rarely end up at the average. This means that the actuary will have to adjust the ultimate loss for that newest year to be either greater or lesser as more information about the year is known. These adjustments are expected, but there will be upward and downward adjustments for each accident or report year so that, in total for all years, the ultimates remain flat. Workers' compensation is typically not as variable and can usually be compared by year more easily than medical malpractice.

The actuary will rely on multiple methods. There will be times when actuarial methods may break down and not produce logical results. It is key that the actuary step back and review results from multiple perspectives. Management should also provide thoughts and comments on the actuarial results because they know the program best and can provide additional insight to the actuary.

Accounting presentation of financial results and decisions

The presentation of liabilities is determined by accounting standards and also by captive domicile. Liabilities and loss forecasts may be estimated on a discounted or undiscounted basis. The higher the discount rate assumption, the lower the liability, while the lower the discount rate assumption, the higher the liability.

Management usually supplies the actuary with any discount rate assumption, but the assumption must be supported. Typical methods of support include the historical return on segregated assets, using a corresponding return from a bond where the duration matches the average payment length, or using the risk-

free rate. Any change in market conditions may warrant an adjustment to the discount rate assumption. An actuary can also easily provide results using different discount assumptions, so that management will be able to see the sensitivity of the discount rate assumption.

Loss estimates may be provided at the actuarial central estimate, formerly known as the best estimate, or presented at a percentile. The higher the percentile, the lower the probability of losses being greater than the estimate. Contingency margins are proportional to the number of losses and the size of the hospital or health system. The more losses and more consistency there are in the losses, the lower the contingency margin.

Financial reporting requirements are periodically updated and should be confirmed among all parties. One of the more recent changes is Financial Accounting Standards Board (FASB) Accounting Standards Update (ASU) 2010-24, requiring healthcare entities to present reserves on a gross of insurance basis as well as on a net basis. The purpose of this is to better disclose the potential credit risk of the excess or reinsurance purchased.

Management should discuss any tail liability that may need to be recorded on the financial statements. For example, a program may purchase commercial insurance for a physician group but need to record a tail liability if the physicians are offered claims-made coverage from the entity. An acquired physician group might also be offered prior acts coverage, exposure occurring during prior employment activities, in which the liability to the entity will be increased.

Healthcare entities often argue that their organizations will always maintain insurance coverage for claims without lapses in coverage and thus the risk of loss will always be transferred to a third party (i.e., an insurance carrier). Therefore, there is no need to accrue a liability for malpractice costs because insurance will ultimately reimburse their organizations for losses paid. However, accounting literature specifically states that the existence of an insurance policy, by itself, provides no assurance that the losses will be paid by a third party. Therefore, a healthcare entity insured under a claims-made policy should recognize the estimated cost of claims that have been incurred but not reported, or the tail claims, if those costs are probable and can be reasonably estimated.

Working with the right actuary

There are a few key items for management to think about regarding engaging with an actuary. Medical malpractice is a unique insurance coverage where not all actuaries have significant experience. Understanding the nature of the coverage and its intricacies takes years to master. Actuarial models that work well in other insurance coverages may not be appropriate or may need to be altered and tailored. Experience in a particular captive domicile, jurisdiction, and with prior mergers and acquisition will improve the accuracy of the calculations and make the process more smooth.

An unbiased actuarial estimation is often ideal. When an actuary is connected to a broker or captive manager, management may have cause to question that person's independence. When going through a merger and acquisition, this becomes even more critical because an actuary usually represents the interest of his or her client. Management may also encounter a situation where the same actuary or firm is on both sides of the deal. When there is any doubt about transparency, it may be best to hire an independent actuary. This will allow an additional, outside perspective to quantify any bias in the original actuarial estimates. The independent actuary may also act as a facilitator in any conversations between the actuaries. Be prepared for complex discussions if two actuaries argue in defense of their estimates.

It is also important for an actuary to be able to communicate well to management and explain complex concepts in understandable terms. The actuary should be able to communicate concepts to the board, which sometimes includes physicians, as well as senior executives and risk management. This communication should include an understanding of the results, drivers, and changes.

Advanced uses of actuarial analysis

An allocation and/or benchmarking report should be tailored to the specific goals of management. Goals might vary among: 1) simple to understand, 2) easy to communicate, 3) easy to administer, or 4) stable over time. Management will need to decide the amount of reliance on exposure, losses, or a blend of the two, and whether any loss caps should be imposed to reduce the impact of large losses on the allocation. When benchmarking a program, management should compare its program on an "apples to apples" basis, meaning an equivalent exposure and risk profile. The actuary can assist management with this exercise. As goals and priorities may change over time, the actuary can help modify the allocation or benchmark to align with the new goals. By creating "skin in the game" through an allocation, risk management may be able to better control losses.

A risk manager may consider ensuring maximum insurance savings through a retention analysis. This analysis should determine the "working layer" of losses on an empirical basis and is best completed by a source independent of the insurance carrier when reviewing renewal premium quotes. Proper retention varies depending on company size, lines of business, risk appetite, and variability of historical losses. An institution with more equity and cash flow may be able to handle the risk associated with a larger retention. Higher limits bring higher variability for retained losses within a year. Ultimately, an appropriate risk level must be decided by management. Management will also need to add other

premiums and expenses to determine the total cost of risk (TCOR). If one division within a program has losses that significantly vary from other divisions, management might consider adjusting the retention specifically for this division, which will help contain the commercial premium to a reasonable level. An assessment of the historical frequency of large losses and projection for the future may influence the decision of the self-insured retention.

A safety study will help identify loss drivers that will enhance the ability to create solutions. Even though frequency may be improving, severity may be increasing. An actuary can identify the correlations between losses and associated demographic characteristics. With a detailed loss run, it is easy to identify causes of losses, better or worse performing divisions, and high-severity and most frequent types of claims. The risk manager can then implement an appropriate plan but may also want to consider completing a cost-benefit analysis of safety initiatives. Risk managers need to ensure credit is received for the prevention activities implemented for all exposures. An in-depth safety study will demonstrate the effect of a safety program on losses. This can also be used to support the case for risk management and gain support from senior executives. Predictive analytics is taking a safety study to the next level by looking at all interactions of variables within the data. This can only be done by large health systems.

An actuarial feasibility study can determine appropriate coverages to include. Historically, captives have been used for property and casualty (P&C) coverages such as medical malpractice liability, general liability, workers' compensation, and auto liability. Healthcare entities have long used their captives for insuring non-employed physicians, especially when acquiring physicians, and to pick up prior acts or nose coverage. Some captives have also been used to offer tail coverage to physicians at more affordable prices than commercial insurance. Adding other P&C coverages, such as directors and officers liability, errors and omissions insurance, and even cyber liability, has become more common. Depending on circumstances, even adding a warranty exposure such as on medical equipment may be appropriate and save the entity money. Recently, captives have expanded to include employee benefits such as medical and life insurance, accidental death and dismemberment, long-term disability, and retiree benefits.

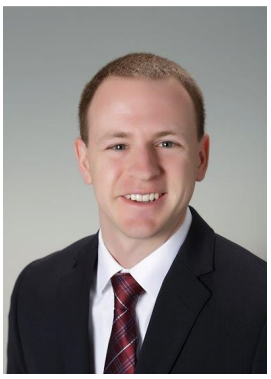
The costs of an insurance program can be reduced when credit for risk management is evident in the actuarial report. Excess or reinsurance premiums might be reduced when underwriters review the actuarial report. Even collateral held, such as for workers' compensation exposures, may be reduced through solid actuarial analysis. Sometimes, collateral held by a carrier may be estimated solely on industry data and there may not be any consideration to a program's own experience. The actuarial report can be used as a tool to differentiate the program.

Conclusion and best practices

Management should set the expectations with the actuary. The actuary will need to be informed of any strategic goals by management to ensure all members are on the same page. Clearly outline the scope, the deadlines, and the role of the actuary. There are many factors and decisions that go into an actuarial analysis. While some of the instructions are provided by management, the actuary should be able to support any of his or her assumptions. Management will value an actuarial report that is estimated with no conflicts of interest and/or hidden agendas. This type of analysis will be a foundation for fruitful discussions for all parties. Successful actuarial analysis will showcase a program and also reveal areas for improvement.

Management should request that the executive summary of the actuarial report contain exactly what is needed. In addition, management may want a second opinion or outside look by a different actuary. The actuary may complete an analysis completely "blind," where the results of any other actuarial analysis are not initially shared. Results of other analyses may then be shared after draft results are produced. This often is an effective strategy in determining differences between any actuarial analyses and may best be discussed face to face.

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MEMBER SPOTLIGHT



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Pamella George's background includes Surgical ICU RN with CCRN Certification. She has been in Risk Management for seven years and currently serves as Director of Risk Management at the Community Campus of SUNY Upstate University Hospital for the past two years.

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Ruth Nayko co-presented with her Allied World underwriting colleagues, "The Zika Virus: Impact and Implications" on July 28th at the 2016 Florida RIMS Educational Conference held at The Ritz-Carlton in Naples, Florida. The impact and implications faced by Healthcare Organizations, Public Entities, Employers and other industries when managing and responding to the real and perceived threats of the Zika Virus were addressed. The Zika Virus continues to be an evolving situation with new information learned daily.



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Lesli Giglio and Tiffany Wickes-DeMillio presented at ASHRM National Conference in October during bite size learning session on the research project they conducted at St. Francis Hospital titled: "Incorporating Innovative Technology to Enhance Patient Safety". This project was funded by ASHRM with a $40,000 grant.

Lesli Giglio was recently promoted to System Vice President, Risk Management, Patient Safety and Chief Privacy Officer at Catholic Health Services of Long Island. She was previously the Director of Risk Management, Regulatory Affairs and Privacy Officer for St. Francis Hospital.



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The Impact of the *Vissichelli* Decision in Defending Nursing Homes Against the "Insanity" and "Continuous Treatment" Tolls

By Keith L. Kaplan and David A. Beatty

Plaintiffs in nursing home litigation often assert claims for care provided over many years, with some of the claims occurring outside the applicable limitations periods. While defendants under such circumstances will assert the statute of limitations defense, plaintiffs may invoke the "insanity" and/or "continuous treatment" tolls in order to extend the limitations periods. This article explores a recent Appellate Division, Second Department decision involving these tolls, *Vissichelli v. Glen-Haven Residential Health Care Facility, Inc.*,[1] to guide the defense bar in developing a record and in preserving statute of limitations defenses. *Vissichelli* is a case in which the facility's documentation of the resident's relatively high level of mental functioning was beneficial to the defense and demonstrates to risk managers how documentation of a long-term resident's mental functioning can affect the outcome of litigation.

In *Vissichelli*, the plaintiff-estate representative had asserted causes of action for common law negligence, violations of PHL § 2801-d (New York's "nursing home statute"), gross negligence and wrongful death, but no made no claim for medical malpractice, and attempted to place the entirety of the decedent's five-year residency into controversy. The decedent-resident's relatively high-functioning mental status aided the defense's argument that the "insanity toll" did not apply, which meant that claims regarding care prior to the applicable limitations periods could not be litigated. The decedent had sustained bi-lateral hip fractures and developed a Stage IV heel pressure ulcer more than three years before the lawsuit was commenced, beyond the statute of limitations. The claims involving the hip fractures and pressure ulcer were also the most significant injuries alleged in the lawsuit. After discovery, the defendant-nursing home moved for summary judgment, in part upon statute of limitations grounds, contending that many of the plaintiff's allegations were time barred. In opposition, plaintiff invoked the "insanity" and "continuous treatment" tolls to argue that all claims were timely.

Defending Against the "Insanity" Toll

While identified as the "insanity" toll, CPLR § 208 more accurately extends the statute of limitations for "individuals who are unable to protect their legal rights because of an over-all inability to function in society" at the time the cause of action accrues.[2] This toll is highly relevant to nursing home litigation, as it concerns a resident's status. The evidence considered as to whether the "insanity" toll applies is similar to what is evaluated in determining a resident's degree of conscious pain and suffering. In nursing home litigation, such records ordinarily include mental health assessments, psychosocial histories, Minimum Data Sets and periodic charting of a resident's independence and mental status. In deciding whether or not the "insanity" toll applies, courts will consider a resident's ability to protect his or her own rights.

Defense counsel in *Vissichelli* anticipated the plaintiff's arguments about the decedent-resident's mental status as it related to the application of the insanity toll, and cited extensive mental health records and other discovery indicating his relatively high degree of mental sharpness. The decedent's nursing home records included regular psychological examinations covering general mental function, long- and short-term memory and decision-making that were largely positive. However, the care plan records presented some potential weaknesses related to the "insanity" toll, notably, a diagnosis of depression and occasional references to observing the resident for "forgetfulness" and "decrease [in] mental functioning." Other notes referred to his communication ability as "usually understood" and rated his daily decision-making and cognition as able to make "modified daily decisions with some difficulty in new situations only," which meant that he was not considered capable of "independent" daily decision-making. Some records even referenced the decedent's bouts of confusion or agitation, which after deposition questions were clarified as temporary events, related to his low-blood sugar and diabetes mellitus. Those few notes regarding depression, confusion and agitation posed a risk to defense of this case and thus clarity about mental functioning is essential.

The lack of uniformly positive nursing home records made developing the deposition testimony of the decedent's adult children essential to demonstrating a high level of mental function. The decedent's adult children testified as to their conversations with their father about sports, family and the advice he provided. They also answered questions about their father's refusals to participate in nursing home activities and his decision-making process behind such refusals. Even where the adult children commented on some diminished capacity when their father's blood sugar levels would be low, they

testified that such periods were temporary and infrequent. By inquiring about their day-to-day interactions with their father, the record firmly established he was "mentally sharp" most of the time throughout his nursing home residency, which documented an ability to function in society.

Ultimately, the Second Department in *Vissichelli* affirmed the motion court's dismissal of the vast majority of the claims asserted against the defendant-nursing home, including those claims arising prior to the expiration of the limitations periods. While the decision itself was relatively brief on this issue, oral argument of the appeal revealed some of the court's thoughts. Several members of the panel specifically asked plaintiff's counsel how the resident's children's extensive testimony about their father being "mentally sharp" could be rebutted. Counsel responded that the children were not medical experts and their testimony should not be substituted for that of the plaintiff's expert.

Fortunately, the Second Department did not appear to be impressed with this argument, given that the children visited and spent substantial time with their father, while the plaintiff's expert simply reviewed a few records after the decedent's passing in a litigation context and issued an opinion about how certain records failed to demonstrate capacity. As a result, *Vissichelli* stands for the proposition that developing comprehensive testimony about a resident being "mentally sharp" can lead to rejection of the "insanity" toll as a matter of law even if some care plan records are suggestive of less than perfect decision-making or independence.

Bringing Clarity to the Continuous Treatment Doctrine and Nursing Homes

Another basis for extending the statute of limitations is the "continuous treatment" doctrine, which tolls the statute of limitations in medical, dental or podiatric malpractice actions.[3] However, those final words of limitation have not prevented plaintiffs from raising this doctrine as an equitable or common law argument against hospitals or nursing homes, even where claims arise from general negligence.[4]

Undeterred by the statutory language limiting the doctrine to medical, dental or podiatric malpractice, the plaintiff in *Vissichelli* argued that the Second Department should apply the doctrine to nursing homes in cases arising under Public Health Law § 2801-d because the cause of action is profoundly similar to medical malpractice claims. This was an argument of law and policy. At oral argument of the appeal, plaintiff's counsel spoke about the similarities between nursing home care provided by nurses or nursing assistants and medical malpractice by physicians and hospitals.

Additionally, plaintiff's counsel pointed out that physicians and psychologists regularly saw the resident throughout his stay and even prescribed medication. He further argued that residents faced the same sorts of risks of damaging relationships with their care providers that backed the continuous treatment doctrine for physicians. Counsel then analogized the case to the common law continuous treatment doctrine that courts apply to attorneys, architects and related professionals.

The Second Department ultimately rejected the plaintiff's argument and relied on precedent where the First, Second, and Fourth Departments refused to extend the continuous treatment doctrine in analogous circumstances. Even during oral argument, however, members of the court were skeptical and pushed back on the plaintiff's position, noting that *Vissichelli* was not a malpractice action. The Second Department in *Vissichelli* thereby closed the door on the continuous treatment doctrine as a toll for time-barred claims under Public Health Law § 2801-d.

Thinking About Your Record

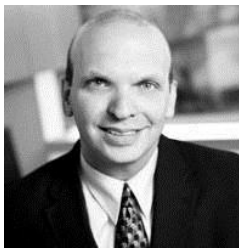
Nursing home defendants cannot avoid the unfortunate truth that many elderly or incapacitated residents suffer from some form of diminished capacity. An inability to protect one's legal rights can manifest in many ways, including dementia, complaints of confusion or agitation, depression, related psychological or even severe physical impairments. However, the *Vissichelli* decision shows the bench and bar that trial courts should not automatically apply the "insanity" toll to cases involving nursing home residents merely because the resident required permanent placement in a nursing home or were not fully independent in all decision-making.

Through well-planned discovery, even a somewhat ambiguous nursing home record may give way to in-depth deposition testimony revealing that a resident was in fact capable of protecting his or her rights and that untimely claims must be dismissed upon limitations grounds. The facts behind the *Vissichelli* decision show that defendants can develop their record on the "insanity" toll through a resident's hobbies, activities, conversations, interactions, and social engagement. Similarly, *Vissichelli* helps show that defendants can clarify nursing home records that describe a resident as "confused" and they could flesh out testimony showing that a resident engaged with those around him or her through advice, decision-making, and memory-related facts. Such testimony can support an argument that even residents with less than perfect mental capacity were capable of protecting their legal rights.

Ultimately, the decision as to whether the record should be developed to combat the anticipated invocation of the "insanity toll" involves consideration of several factors. A case with significant damages or liability exposure for timely-asserted claims, compared to any asserted untimely claims, probably should not be developed in the same fashion as the record in *Vissichelli*. Defense counsel in a case presenting significant exposure in connection with timely-asserted claims will likely be better off developing a record that demonstrates a resident's diminished mental status, and such may be beneficial as to the damages claims. However, in the proper case, developing a record highlighting a resident's mental sharpness will strengthen a statute of limitations defense and can limit the issues in controversy, thereby mitigating or possibly eliminating the risk of an adverse liability verdict. Accordingly, counsel should carefully consider as part of their litigation strategy whether developing evidence about a resident's high or low degree of mental sharpness is helpful in defending each case. If the facts and strategy permit, *Vissichelli* is a prime authority to present to a motion court for support in obtaining the dismissal of time-barred claims based on the "insanity" toll and also for showing that the continuous treatment doctrine does not toll claims under Public Health Law § 2801-d and those based on general negligence.

REFERENCES ON PAGE 27

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Navigating the Risks of the Affordable Care Act

By Diane Fernald, RN, JD, Kevin Kelly, MPH, Daniel O'Brien, LNHA, and Bill Martin, BS

Since the inception of the Affordable Care Act (ACA) in 2010, the healthcare industry has been significantly impacted, and the medical malpractice environment is no exception. It is estimated that the number of insured individuals in the United States has increased by more than 16 million since the ACA's passing in 2010 (The Affordable Care Act is Working, 2015).[1] This increase in the patient population, coupled with shifting reimbursement mechanisms from fee for service to "pay for performance", is forcing healthcare organizations to find creative, cost-effective ways of delivering care while combatting the unprecedented risk management exposures that accompany the mandated changes brought on by the ACA.

At the same time the ACA is being implemented and 16 million new patients are becoming insured, we are seeing radical shifts in the way care is delivered. The use of Electronic Health Records (EHRs) is increasing rapidly; however, little focus is being placed on the associated risks and legal concerns. Additionally, healthcare organizations are forming patient centered medical homes to better manage patients through the care continuum. As a result, hospitalists are becoming more and more prevalent in acute care settings, as are mid-level practitioners in the outpatient arena. These new and expanded clinical roles also present increased risks and patient safety concerns. It is imperative that organizations proactively identify these risks and address the exposures.

Electronic Health Records

One of the major concerns with regard to EHRs is the push for rapid deployment of these systems. The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted in 2009 in an effort to increase the presence and potential positive impacts of technology in healthcare. This act mandated that healthcare organizations introduce EHRs and cease the use of paper records, or face significant economic penalties; however, as we have discovered, implementing EHRs is significantly more complex than was expected when HITECH was enacted. Not only are the efforts required to transfer data from paper to electronic records extensive, but the training that is required for EHR users is critical, complex, and time consuming, not to mention expensive for the organization. Further, unintended consequences can result in increased malpractice exposures if left unaddressed. Research indicates that 95% of 65 different ambulatory EHR systems reviewed have significant legal concerns from a malpractice perspective (Versel, 2011).[2]

Perhaps the most concerning issue related to the rapid deployment of EHRs is the risks and liabilities associated with metadata, or the data about data in the EHR (Viola, 2012).[3] In the context of an EHR, these data could include the time and date a chart entry was created, who created the note, and how long the provider spent creating the note. These data can also include when a lab result became available to a physician, when the lab result was read by the physician, and how long the provider spent viewing the results. Never before have we been able to determine exactly when a note was written, or who accessed a specific section of the chart or test results. Now, because of metadata, plaintiffs' attorneys have access to all of that information and more, and can use the information in a court of law. Increasingly we read about massive data breaches of patient information. There are significant financial penalties if these electronic records are accessed by the wrong people. Metadata has played a significant role in these breaches by providing a detailed account of who accessed what and when.

To mitigate your risk related to EHRs, consider:

1. Performing a periodic audit of your organization's providers' records to examine their documentation practices in real-life examples. This could include:
   a. The process of documenting after-hours telephone conversations between the patient and the primary care physician;
   b. Whether the medication list is being reconciled upon admission and before discharge.
2. Educating your providers on the finding of the chart audit. Highlight risky documentation practices observed in your own institution.
3. Developing and implementing an organization-wide work flow for your EHR with the purpose of guiding providers in how and where to document critical information in the patient chart.
4. Performing an environmental assessment of your outpatient physician practices to gauge your organization's adherence to your HIPAA and HITECH policies.

The Delivery of Care

In addition to the EHR, the ACA has also brought about an increased reliance on communication among healthcare practitioners. The ACA was one of the precursors to the formation of patient-centered medical homes, which are becoming increasingly prevalent across the country. These organizations "emphasize care coordination and communication to transform primary care into what patients want it to be", with the ultimate goal of reducing healthcare costs and increasing quality (Patient-Centered Medical Home Recognition).[4] This shift emphasizes the need for clear, consistent, closed-loop communication between the PCP, specialists, and other care providers to ensure smooth transitions of care between both the providers and varying care settings that may be involved. Any missteps that occur between these transitions of care can negatively impact patient care and patient experience, and result in increased costs to correct the mistake or "near miss".

Another change to our care delivery system has been the impressive growth in the number of hospitalists in the United States (Clark, 2014).[5] While this evolution has been geared to improve quality, reduce length of stay, and decrease readmission rates, it has also introduced communication risks associated with shift changes and transfer of care from one provider to another, exposing a significant risk to continuity of care. Both patient-centered medical homes and the increase in hospitalists have resulted in a need for frequent communication among healthcare providers in order to maintain continuity of care for the patient. Communication among healthcare providers has been identified as a root cause of patient events in medical malpractice and patient safety incidents. This risk needs to be addressed as the lack of inter-provider communication is identified in as much as 80% of cases based on research (Bailey, 2016).[6]

The rapid expansion of hospitalist medicine has not been the only major shift in how care is delivered. Under the new reimbursement structure aimed more toward bundled payments and accountable care organizations, there is increased pressure for midlevel providers (physician assistants and nurse practitioners) to assume a similar level of responsibility as primary care physicians. Some studies have found that midlevel providers "could perform as much as 80% of what physicians do" (Ronstrom, 2010).[7] And, at a time where we are looking at a shortage of nearly 63,000 physicians (Ronstrom, 2010)[7], this trend of adopting midlevel practitioners is particularly appealing. However, little consideration is being given to the impact this could have on medico-legal and risk management risk for the organization. And from an underwriting perspective, how are the risks associated with these practitioners being accounted for or insured against? If midlevel providers are faced with similar responsibilities as physicians, albeit with fewer years of schooling, should these practitioners be paying a more comparable rate for insurance as the physicians? For the 20% or more patient cases that a physician needs to see – how will this transition from midlevel provider to physician occur? Will the appropriate communication between providers take place? Or, do we run the risk that these patients may ultimately not be seen by the appropriate people, resulting in inadequate care and potential patient harm? In order for the midlevel model to be successful, systems will need to be put into place to ensure that care is escalated to the appropriate levels at the right time.

To mitigate your risk related to the delivery of care, consider:

1. Developing organization-wide policies and best practice guidelines that delineate roles and responsibilities related to:
    a. Patient communication
    b. Tracking and follow-up
    c. Ordering follow-up studies
    d. Etc.
2. Determine if there are specific situations or conditions with which a mid-level provider must consult with a physician. If possible, create a guideline to assist mid-level providers with the co-management of critical patients requiring more expert clinical intervention.
3. Obtain buy-in from your clinical/provider leadership on policies and guidelines. By securing buy-in, the organization is more likely to achieve compliance.
4. Educating your providers on the new organization-wide policies and best practice guidelines. Make this a required aspect of the provider's job, and attach an incentive or consequence to facilitate higher compliance. Additionally, develop a tracking mechanism to ensure all providers are aware of the new policies and guidelines

Maintaining a Culture of Safety

As you educate your organization on the risks of the ACA and implement changes to work flows and policies, keep in mind that maintaining a culture of safety in the midst of significant organizational change can be challenging, particularly when you consider all of the processes and standards that must be coordinated throughout different entities. Consider strategies for creating buy-in among the providers so they are part of the decision making process at the systems level. Cultural resistance to change can often be one of the most difficult challenges to overcome.

To facilitate the development of a "safe culture", consider:

1. Developing system-wide councils or committees, each responsible for a respective piece of the puzzle. This can help integrate the entities within the organization on a more granular level. The focus of these teams should remain on maximizing safety and improving outcomes for patients.
2. Incorporating a Committee or Subgroup of the system-wide councils at each institution to ensure that each entity has the opportunity to provide input. This new structure will increase inter-departmental communication, and facilitate the development of best practices.

It appears reasonable to conclude that we can count on "change" being a constant theme of the healthcare landscape in the coming years. Stay tuned.

REFERENCES ON PAGE 27

ABOUT OUR AUTHORS



With deep experience in medical malpractice, long-term care, professional liability defense, and life sciences, Diane Fernald serves as executive consultant for MRM Group. Her experience also includes defense and risk management in OBRA, HIPAA, HITECH, and MSPA compliance. Prior to MRM Group, Diane was a medical malpractice defense attorney, a nursing home administrator, and a director of nursing and several long-term care facilities in Massachusetts. Diane has a Juris Doctor from Western New England University, and a Bachelor of Science in Nursing from American International College.



With over 25 years in the healthcare and insurance industries, Kevin Kelly co-founded MRM Group™ in 2003, and serves as the company's president and CEO. His expertise includes operational, management, and consulting activities spanning hospitals and healthcare systems, physician group practices, and academic medical centers. Prior to co-founding MRM Group, he spent two years as the executive director of the signature programs at UConn Health In this role, he directed the business plan development and implementation process of the university's three principle health care business strategies. Kevin is a graduate of Providence College and Yale University. He sits on a variety of business, academic and philanthropic boards and is a frequent lecturer on the topics of healthcare financing, delivery, and risk management.



MRM Group's vice president of client services, Daniel O'Brien has over 20 years of healthcare experience, primarily in long term care, senior wellness, rehabilitation, and Medicare Advantage program development. Prior to joining MRM Group™ where he manages the company's client services, Dan was the regional director of network and business development for United Healthcare Corporation. Dan graduated from Gettysburg College with a degree in Business Administration, received his license in nursing home administration from the University of Connecticut School of Health Systems Management, and is a member of numerous healthcare associations in the state of Connecticut.



In his current role as Senior Project Manager at MRM Group, Bill Martin is responsible for overseeing the project management activities for both the education and consulting departments. In this capacity, Bill enjoys a role of constant quality improvement to increase team efficiency while improving product value and maximizing customer satisfaction. He also serves as an integral part of the business development team, leveraging his intimate knowledge of Company offerings to form and maintain strategic business alliances. Bill holds a Bachelor's of Science from the University of Connecticut School of Business.

Annual Conference Summary

June 3rd 2016 – Holiday Inn Midtown NYC



Mary Steffany and the Education Committee did an outstanding job with the June Annual Conference which had 121 attendees at the Holiday Inn Midtown. Throughout the day attendees were able to visit with our exhibitors: APS; ELM Exchange; I CORP Investigations; Sedgwick; and RL Software for Safer Healthcare. Our gracious sponsors included: Lewis Johs Avallone Aviles, LLP; Aaronson Rappaport Feinstein & Deutsch, LLP; Kaufman Borgeest & Ryan LLP; MCB Law; McAloon & Friedman; Medical Liability Mutual Insurance Company (MLMIC); Shaub Ahmuty Citrin & Spratt, LLP; DOPF P.C.; Famuso, Kelly, Swart, Farrell, Polin & Christesen, LLP; RL Software for Safer Healthcare; Allied World Assurance Company; Berkshire Hathaway Specialty Insurance; Phelan, Phelan & Danek, LLP; and Willis Towers Watson.

The day began with our keynote speaker Kristofer L. Smith, MD, MPP, Senior Vice President and Medical Director, Northwell Health Solutions who presented a "Journey to Value Based Care: Reevaluating Risks and Opportunities." Value is defined as achieving the Triple Aim which includes better care, improving health and lowering costs. Value is further defined as "The health outcomes achieved that matter to patients relative to the cost of achieving those outcomes" by Thomas H. Lee, MD and Michael Porter. National trends include risks shifting to providers, Federal requirements-Medicare, Medicaid reform, and direct contracting. The Health Care Transformation Task Force is a recently formed private-sector alliance including 20 major health systems and payers that is aimed at accelerating the healthcare industry's transformation to value-based care. They are committed to putting 75 percent of their businesses in the next five years into value-based payment arrangements, which will hold providers accountable for the cost of care, quality of care and health of the population. The Centers for Medicare and Medicaid Services are committed to value-based care for Medicare, targeting greater than 50% of payments in alternative models by 2018. Starting in 2016, participation in bundled payments for hip and knee replacements is mandatory, forcing providers to focus on the total cost of procedures for surgery to post-acute care. Total cost targets are set and trended by region, fueling local competition on performance. For Medicaid, funding composition shift from implementation goals to performance over the course of the DSRIP program, making Medicaid payment based almost entirely on performance by 2020. Mergers are driving the negotiating power of national insurance companies on cost and quality. An example of employer direct contracting is General Electric who has contracted with four hospitals in different parts of the country to provide hip and knee replacement surgeries to employees through a bundled payment system. There are four (4) categories of new payment structures: Category 1 Fee for Service-No Link to Quality & Value-Payments based on volume of services regardless of necessity or quality; Category 2 Fee for Service-Link to Quality & Value-At least a portion of payments or bonuses vary based on the quality or efficiency of the care; Category 3 Alternative Payment Model (APMs)Built on Fee-for-Service Architecture-Some payment linked to the management of a segment of the population or care episode. Payments triggered by delivery of services, but opportunities for shared savings or 2-sided risk; Category 4 Population-Based Payment-Payment not directly triggered by service but by attribution. Clinicians and organizations are paid and responsible for care of a beneficiary for a long period (e.g. greater than or equal to one year). Substantial upside and downside risk. Services such as patient care coordination, not typically reimbursed in fee-for-service models, become aligned financially with value-based programs. This provides the business case to invest in care managers, social work and resource specialists.

There were two morning breakout sessions. "Patient Safety Organizations: How Can a PSO Help Your Organization Mitigate Risk and Make Care Safer?" was presented by Ann Louise Puopolo, BSN, RN, Vice President, Enterprise Patient Safety, CVS Health. It was concern about accumulating evidence of safety problems that led to passage of the Patient Safety Quality Improvement Act (PSQIA) of 2005 which provided federal and state privilege and confidentiality protections used to conduct patient safety activities. It allows for data sharing within a protected environment and requires careful articulation with risk management, and legal information, to maintain protections. Congress enacted the PSQIA to remove barriers to improving patient safety.

Collection and analysis of information healthcare errors is essential to improving patient safety. The PSQIA encourages these activities by creating strong federal protection for patient safety work product (PSWP) that prevents such information from being disclosed to third parties and requires it to be kept confidential. The PSWP privilege "will facilitate an environment in which health care providers are able to discuss errors openly and learn from them" according to the House of Representatives Report 109-197 (2005). The two legal concepts in the PSQIA trigger PSWP confidentiality obligations and allow healthcare providers to assert the PSWP privilege are patient safety organization (PSO) and patient safety evaluation system (PSES). A PSO is a corporate entity whose purpose is to improve patient safety. A PSO can be a stand-alone business or a subsidiary of a healthcare provider. HHS regulations provide that the "mission and primary activity of a PSO must be to conduct activities that are to improve patient safety and the quality of healthcare delivery." To be certified by the Agency for Healthcare Research and Quality (AHRQ), a PSO must satisfy HHS regulations concerning basic policies and procedures for collecting and analyzing information about patient safety in a secure and confidential environment. The PSES collects, manages and analyzes information for reporting to a PSO. The PSES collects information to improve patient safety (e.g., reports about medical errors and "near misses"); determines which data that are collected will actually be reported to the PSO and become privileged PSWP; reviews and analyzes data and makes recommendations about improving patient safety, healthcare quality and outcomes; takes action when needed to mitigate concerning basic policies and procedures for collecting and analyzing information about patient safety in a secure and confidential environment. The PSES collects, manages and analyzes information for reporting to a PSO. The PSES collects information to improve patient safety (e.g., reports about medical errors and "near misses"); determines which data that are collected will actually be

reported to the PSO and become privileged PSWP; reviews and analyzes data and makes recommendations about improving patient safety, healthcare quality and outcomes; takes action when needed to mitigate harm or improve patient care; and conducts root cause analyses, risk assessments and other in-depth analyses. There are several types of PSWP: information that could improve patient safety which is collected for the purpose of being reported to a PSO, and is reported to a PSO e.g., safety event reports and root cause analyses; information that could improve patient safety which is developed by a PSO for the conduct of patient safety activities e.g., patient safety and quality meeting materials to include meeting minutes and analysis of a collection of root cause analyses; and information constituting the deliberations or analysis of a PSES e.g., analysis of safety event reports conducted within the PSES, analysis of root cause analyses conducted within the PSES and the fact of reporting information, such as a safety event report to a PSO. A key point is that it is only the analysis or PSWP that is PSO protected. The facts or actions that you took are not protected. The PSWP privilege provides broad protection against disclosure. In summary the methodology around a PSO is continual optimization to reduce risk which includes inputting safety data, analysis, initiatives, and impact measures.

The other morning breakout session was "Privacy and Security in Healthcare: A Review of the Current Risk, Enforcement and Litigation Environment." It was presented by David L. Hall MBA, JD, Partner and Michelle DeBarge, JD, DIPP/US, Partner, Wiggin and Dana LLP. The laws including HIPAA, FTC Act, Other Federal Law, State Statutes and Regulations as well as Common Law (Breach of Privacy, Negligence, etc.) were briefly discussed. The enforcers of these laws include HHS-OCR, State AGs, FTC, and private individuals (through civil lawsuits, including class actions). Several recent OCR Resolution agreements were discussed for portable electronic media, patient authorization and business associate agreements. A number of Attorney General Enforcement cases were discussed. Additionally, several FTC actions were discussed followed by steps to prevent FTC actions. These ten steps are from https://www.ftc.gov/tips-advice/business-center/guidance/start-security-guide-business. The ten steps are:

1. Start with security
2. Control access to data sensibly
3. Require secure passwords and authentication
4. Store sensitive personal information securely and protect it during transmission
5. Segment your network and monitor who's trying to get in and out
6. Secure remote access to your network
7. Apply sound security practices when developing new products
8. Make sure your service providers implement reasonable security measures
9. Put procedures in place to keep your security current and address vulnerabilities that may arise
10. Secure paper, physical media, and devices

Class Action horror stories were discussed including Stanford Hospital and Clinics and two business associates. A spreadsheet of 20,000 patients' health information was posted to a website for more than one year. Days after sending a breach notice to patients, a patient filed a $20 million class action lawsuit. In September, 2015, the parties reached a $4.125 million settlement.

In summary, the following Top 14 Lessons were provided:

1. Incorporate compliance into your governance structure
2. Perform breach preparedness exercises
3. Train, train, train
4. Be prepared, especially if reporting a breach
5. Size of your organization doesn't matter
6. Encrypt your mobile devices
7. Perform a thorough risk analysis, and then update if often
8. Dispose of PHI properly
9. Pay special attention to internet-based document sharing applications
10. Cooperate with the government
11. Follow your NPP and your policies
12. Take complaints from patients, consumers, employees, and vendors seriously
13. Vet your vendors
14. It's not all about OCR and HIPAA-pay attention to state law and what your AG and the FTC think.

Following the morning breakout sessions, the annual business meeting was held immediately following lunch. Robert D. Martin, AHRMNY President 2015-2016 was commended for his accomplishments during his year of leadership. Election results were announced with acknowledgement of re-elected and new members to the AHRMNY Board and Emeritus Board.

There were four afternoon breakout sessions. "The Informed Consent Process: It's More Than Just a Form" was presented by Chris J. Allman, JD, CPHRM, Director of Risk Management, Compliance & Insurance, Garden City Hospital/Prime Healthcare. Generally, informed consent includes a proper discussion between a physician and a patient, and covers all relevant aspects of a proposed treatment. The elements of informed consent include voluntarism, disclosure and competence. Voluntarism means the consent to medical treatment should be given exclusively by the patient's free will, without coercion or undue influences and pressures. Disclosure is the presentation of relevant and accurate information, including the nature of illness, the proposed treatment and its risks and benefits and all reasonable alternatives to proposed treatment, including no treatment at all. To be considered competent, a person should be capable of all of the following: understanding the provided information; appreciating the remote consequences of the treatment; and making and expressing a reasoned medical choice. In the absence of competency or a designated Patient Advocate in a Durable Power of Attorney for Healthcare, the physician might have to rely on a surrogate decision-maker. Mechanisms for surrogate decision-making include advance directives, legal guardians, and family members in a strict hierarchy that varies from state to state. Some patients, incapable of deciding about medical treatment, may still retain capacity to appoint a proxy agent, and in this case their choice should be respected. Informed consent is a process and a form can never replace the information exchanged between the patient and health provider. "Exchange" is key and the provider and patient must both provide information and understand what is to happen before the process is complete. The consent form is the documentation that the process took place. Informed consent does not extend to other treatment unless it was an unexpected emergency and unable to wait for consent. Per NY Statute, the person providing the professional treatment or diagnosis is responsible for obtaining informed consent. If the patient is clearly incompetent (i.e., unconscious or delirious) and needs emergency care, the state law permits a life-saving treatment in the absence of consent. This emergency exception to consent is based on the "reasonable man" standard, in

which the law assumes that if the patient were competent, he or she would accept a life-saving treatment, because it is in his or her best interests. For minors, the provider must have the consent of the custodial parent or legal guardian for treatment unless emancipated by court order, marriage or military service, or for certain procedures/circumstances in an emergency. The patient has the legal right to revoke consent or refuse to give consent. The patient's revocation should be documented and the reasons noted in the patient's chart. If a plaintiff's counsel can show the patient was not provided sufficient information to allow for an informed consent, he/she will not have to show that you breached the standard of care. In summary, the consent takeaways include: informed consent is a process, not a form; should be a discussion, not a lecture; requires voluntariness, disclosure and competence; always be sure you are obtaining consent from the proper person (patient or surrogate); consent, or lack thereof, is a patient's right; and documentation, even in an emergency.

"Working to Reduce Avoidable Patient Suffering" was presented by Victor R. Klein, MD, MBA, CPHRM, Vice Chairman, Quality & Patient Safety, Obstetrics & Gynecology Service Line, NorthWell Health and Maria Torroella Carney, MD, FACP, Chief, Division of Geriatric and Palliative Medicine/Assoc. Professor Hofstra Northwell School of Medicine. Patient suffering is sorted into the two categories of unavoidable and avoidable. With unavoidable suffering, the provider/patient advocate goal is to mitigate and with avoidable suffering, the provider/patient advocate goal is to eliminate. Unavoidable sources of patient suffering with diagnosis include: symptoms of disease including pain; loss of functioning; and fear or anxiety arising from the implications of the diagnosis for health and functioning. Unavoidable patient suffering with treatment include: post-operative pain; loss of functioning; fear or anxiety regarding outcome of treatment; fear or anxiety due to unfamiliar processes, disruptions in daily life, and loss of comfort; and side effects of treatment. There are avoidable sources of patient suffering associated with healthcare delivery system dysfunction. These avoidable sources of patient suffering include: ineffective communication with patient/family; misdiagnosis; unnecessary wait times; unnecessary pain resulting from failure to identify and treat Hospital-acquired conditions; fear or anxiety resulting from lack of coordination and teamwork; and lack of respect shown to patient resulting in loss of trust in providers and advocates. Suffering was defined by Eric Cassel, MD in 1995 as "a specific state of severe distress induced by the loss of integrity, intactness, cohesiveness, or wholeness of the person, or by a threat that the person believes will result in the dissolution of his or her integrity." How Americans die has changed significantly from 1900 to 2000. In 1900 the average age of death was 46 years and in 2000 was 78 years. In 1900 death was rapid and sudden and in 2000 there was a disability phase of 2-4 years before death which is an unintended consequence of a longer life. Thus, we now have a phase of death which follows a phase of advanced illness. The *Coalition to Transform Advanced Care* states advanced illness occurs when one or more conditions become serious enough that general health and functioning decline, and treatments begin to lose their impact. Suffering can be measured. Suffering should be measured with metrics so that it can be reduced. The NQF Suffering Initiative includes communication, care coordination, healthcare decision-making, multiple chronic condition management, disparities and culturally competent care. The presentation concluded with the following Ten Steps to Avoid Suffering:

1. Ask patient and/or family
2. Check yourself (What are we doing to contribute to patient's suffering?)
3. Show professionalism, respect and courtesy
4. Build an attitude of trust
5. Address suffering from disease
6. Avoid suffering from treatment (e.g. Complications)
7. Avoid suffering from dysfunction of system (e.g. chaos and confusion, lack of coordination)
8. Individualize care-understand the goals for the patient
9. Minimize the sense of abandonment
10. Measure suffering.

"Hot Topics in Behavioral Healthcare" was presented by Carolyn Reinach Wolf, Esq., Executive Partner, Abrams, Fensterman, Fensterman, Eisman, Formato, Ferrara & Wolf, LLP and Heidi McMullan, MSN, RN-BC, Chief Nursing/Patient Safety Officer, Philhaven Behavioral Healthcare.

It was discussed during the presentation that ECRI # 3 of Top 10 Patient Safety Concerns is inadequate management of behavioral health issues in non-behavioral health settings. Providing clinicians the opportunity to develop skills in working with patients with behavioral health needs can address this. Clinicians can be trained in Question, Persuade and Refer (QPR) Training; Therapeutic Crisis Intervention (TCI); and provided training from the Crisis Prevention Institute (CPI) who offers nonviolent crisis intervention training. Behavioral Emergency Response Teams can also be implemented similar to Code Blue Teams. The *Joint Commission SE (Sentinel Event) Alert*, Issue 56, February 24, 2016, "Detecting and treating suicide ideation in all settings" was discussed. This alert addresses risk factors and screening tools; assessment; safety measures; treatment; discharge plans; staff education; and documentation. Contracts for safety are no longer used; instead a Safety Plan is collaboratively developed when a patient is identified at risk for suicide. The content of the Safety Plan and the patient's reaction to and use of it should be documented as should all other care and referral of patients with suicide risk. Additionally, the NY Secure Ammunition and Firearms Enforcement Act (SAFE Act) that was adopted on January 15, 2013 was discussed. The SAFE act imposes a mandatory duty for mental health professionals to report when they believe patients may pose a danger to themselves or others and allows law enforcement to remove firearms owned by patients reported to likely be dangerous. The reporting requirement extends to "mental health professionals," defined in the law as four professions: physicians (including psychiatrists and primary care physicians), psychologists, registered nurses and licensed clinical social workers. All reports statewide must be made using an online reporting system that is available through the New York State Office of Mental Hygiene (OMH) website. Disclosure under the SAFE Act is not a HIPAA violation since it is required by law. The decision to report or not to report, when made reasonably and in good faith, will not subject the mental health professional to any civil or criminal liability. Assisted Outpatient Treatment (AOT) known as "Kendra's Law" in New York is court-ordered treatment for the person's mental illness and supervision in the community with the goal of preventing "a relapse or deterioration" per N.Y. Mental Hygiene 9.60. The AOT can be utilized as part of a safe and appropriate discharge plan from an inpatient psychiatric facility to address safety concerns if the patient has a history of being a danger to self or others and/or has a history of non-compliance with treatment. AOT is for individuals who are "unlikely to survive safely in the community without supervision."

Annual Conference Summary
(Continued)

"Managing Credentialing Risks for Age, Health and Impairment" was presented by Samuel J. Furci, MPA, President & CEO and Patricia Furci, RN, MA, Esq., Principal, Furci Associates, LLC. It was conveyed that physician impairment refers to situations in which practitioners are rendered unable to perform their professional responsibilities adequately because of a variety of health problems including: medical disease, psychiatric problems and substance abuse per "Physician Impairment by Substance Abuse", *Medical Clinics* Volume 81, Issue 4, Patrick G. O'Connor, MD, MPH, Anderson Spickard Jr, MD. The Federation of State Physician Health Programs, Inc. (FSPHP) on their website recognizes that addiction, psychiatric disorders and other medical conditions can be potentially impairing, however, "impairment" is a functional classification. Professionals diagnosed with these conditions may or may not demonstrate "impairment." It was further discussed that the AMA has defined physician "Impairment" as "the inability to practice medicine with reasonable skill and safety due to 1) mental illness 2) physical illnesses, including but not limited to deterioration through the aging process, or loss of motor skill, or 3) excessive use or abuse of drugs, including alcohol." It was also discussed that when practitioners reach their 60s and 70s, there is a significant and progressive decline in cognitive and physical skills per the American Health Lawyers Association 2013. It was conveyed that organizations should determine if they have appropriate policies to address practitioner issues related to age, health or impairment. The medical staff bylaws should address physician age and health issues that are not impairment. Additionally, there should be a process to address allied health practitioner age and health issues that are not an impairment. Policies need to reflect specific state and federal reporting and monitoring requirements. Lastly, polices should reflect the required elements for practitioner rehabilitation.

The annual conference concluded with attendee networking.



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