CPHRM EXAMINATION PREP COURSE

Handouts

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TAB 6 Health Care Operations

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Continuing Education Credits:

13.0 Risk Management Credits will be available to all participants who attend both days of the training course and complete an after program evaluation. Certificates will be emailed within 2-4 weeks after program.

Program evaluation link will be emailed to all participants

Please contact us should you have any questions or need additional information at ahrmny@gmail.com or 973-641-5311

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

AHRMNY The Association for Healthcare Risk Management of New York, Inc.

TAB 1 - Informational Flyer



CPHRM Exam Prep Course
January 7-8, 2020

The Association for Healthcare Risk Management of New York, Inc. (AHRMNY) is pleased to announce that registration is now open for our CPHRM Exam Prep Course. Space is limited – reserve your space here.

What is CPHRM?
CPHRM stands for Certified Professional in Healthcare Risk Management.

The designation is conferred by the American Hospital Association Certification Center (AHA-CC), a division of the American Hospital Association (AHA), to formally recognize healthcare risk management professionals who exhibit broad-based knowledge of the field and a commitment to continued professional growth. Risk management professionals are evaluated using a peer-reviewed examination tool and then, upon receiving the CPHRM designation, are required to periodically renew the designation by providing proof of continuing education.

The prep course is designed to help prepare eligible risk management professionals take the exam. The course focuses on content areas that may require a more in-depth review, as well as identify familiar content areas of the CPHRM Exam detail in the CPHRM Candidate Handbook and Application.

The CPHRM Exam launches new changes, effective Jan. 2, 2020 and our chapter's prep course will incorporate these new changes.

Continuing Education:
This program is approved for 13.0 contact hours toward the fulfillment of the requirements of ASHRM designations (CPHRM, FASHRM, and DFASHRM).

Continuing Education Certificates will be distributed 2-4 weeks after prep course.

AHRMNY
The Association for Healthcare Risk Management of New York, Inc.

COURSE INFORMATION

Location:
Mount Sinai-Union Square
10 Union Square East, 2nd Floor Auditorium
New York, NY 10003

Time:
9:30 AM – 5:45 PM (both days)
Detailed agenda will be provided in handout packet

Meals:
On your own
Many places to eat in area – will provide a list of nearby restaurants in handout packet

Prices:

$35	AHRMNY Member
$65	Other ASHRM Chapter Member
$100	Non-member*

*Membership Incentive: Nonmember attendees can join AHRMNY and attend CPHRM Course at the member rate

Faculty:
Douglas J. Borg, MHA, ARM, CPHRM, DFASHRM
Vice President, Risk & Quality
Premier Insurance Management Services

Josh Hyatt, DH.Sc., MHL, MBE, DFASHRM, CPHRM, HEC-C
Principle Consultant, Founder
Hyatt Healthcare Consulting Services

Handouts
Course handouts will be emailed to registered attendees two weeks before prep course.

Additional study materials available at the ASHRM bookstore
- CPHRM Prep Guide
- CPHRM Self-Assessment Exam
- Risk Management Handbook for Health Care Organizations

Have questions? Contact us….

AHRMNY
PO Box 4200, Grand Central Station
New York, NY 10163
ahrmny@gmail.com
973-641-5311

TAB 2 - Agenda

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CPHRM Exam Prep Course Agenda

Day 1

Time Slot	Topic	Min
9:30 a.m. – 10:15 a.m.	Welcome, Introductions, & Overview	45
10:15 a.m. – 11:00 a.m.	Health Care Operations	45
11:00 a.m. – 11:15 a.m.	Break	15
11:15 a.m. – 12:15 p.m.	Health Care Operations	60
12:15 p.m. – 1:30 p.m.	Lunch Break	75
1:30 p.m. – 2:00 p.m.	Health Care Operations	30
2:00 p.m. – 3:00 p.m.	Clinical/Patient Safety	60
3:00 p.m. – 3:15 p.m.	Break	15
3:15 p.m. – 5:15 p.m.	Clinical/Patient Safety	120
5:15 p.m. – 5:45 p.m.	Day 1 Questions/Wrap Up	30

Day 2

Time Slot	Topic	Min
9:30 a.m. – 11:00 a.m.	Risk Financing	90
11:00 a.m. – 11:20 a.m.	Break	20
11:20 a.m. – 12:30 p.m.	Risk Financing	70
12:30 p.m. – 1:45 p.m.	Lunch Break	70
1:45 p.m. – 3:20 p.m.	Claims & Litigation	95
3:20 p.m. – 3:30 p.m.	Break	10
3:30 p.m. – 5:45 p.m.	Legal & Regulatory	135
5:45 p.m.	Day 2 Wrap Up/Questions	

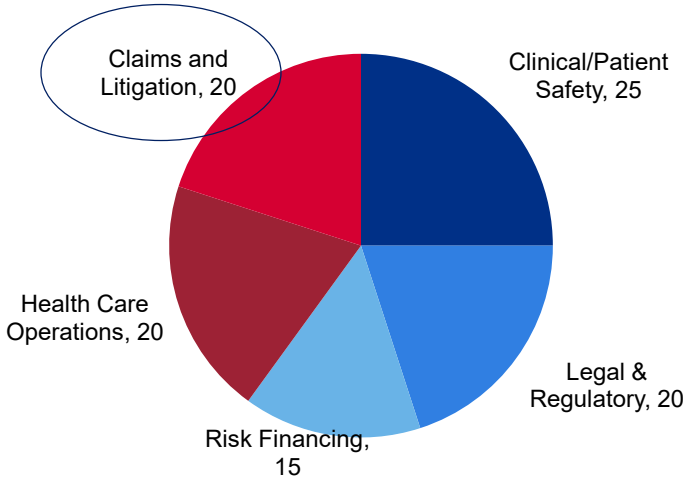
TAB 3 - Claims & Litigation

Claims and Litigation

ASHRM References Legend

ERMPB	Enterprise Risk Management Playbook
RFPB	Health Care Risk Financing Playbook
CLPB	Health Care Claims & Litigation Playbook
Fundamentals	Health Care Risk Management Fundamentals
OBPB	Obstetrical Risk Management Playbook
PSPB	Patient Safety Risk Management Playbook

CPHRM Exam



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Session Objectives

- Examine the claims management process from the occurrence of the event to resolution of the claim
- Distinguish between a claim, a potentially compensable event, and a lawsuit
- Describe the types of liability
- State the value of collecting claims data

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Claims Management Program

- Leadership support & commitment
- Formalized approach
- Based on risk finance model
- Supported by technology



ERMPB p. 27-30
Fundamentals p. 13, 60, 230, 253

Claims Management Process Overview



Fundamentals p. 219-239

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Identification of Claims

Identification of Potential Claims

- Enterprise wide- Recognize risk and implement prevention programs
- Risk mitigation for injured party and organization- safety of patient comes first. Disclosure is required.
- Early claim intervention- Resolve liability early and try to avoid a claim or lawsuit.
- Data drives risk prevention programs- Failure to address known issue negatively impacts claims defense.

CLPB p. 53-55

Sources to ID Potential Claims

Formal source examples	Informal source examples
• Complaints & grievance • Incident reports • Environmental rounds • Risk assessments	• Anonymous reports • Family comments

CLPB p. 53-55

Reporting Claims to Leaders

- Report to Leadership
  - New claims may trigger press coverage
  - Open and closed case summary
  - High exposure cases
  - Impact to risk financing program
  - Cases going to trail

CLPB p. 129

Data Collection

- The quality of the data you collect will impact the effectiveness of your risk assessment.
- Consistency- Personnel changes are a given, have a process that documents data consistently.
- Taxonomy- Can be organization specific, but failing to use industry taxonomy is hurtful to benchmarking and analysis.

Fundamentals p. 66-67, 77-80, 238
CLPB p. 129, 135-137

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Taxonomy Example

A patient was ordered a narcotic post-surgery. The pharmacy prepared the medication, however doubled the dose ordered. The patient arrested and did not survive.

- What is the injury- death
- Category of medication- analgesic
- Cause- Dispensing
- Type of Dispensing Error- Pharmacy incorrectly prepared the medication
- Contributing Factors- Inattention to detail

Fundamentals p. 66-67, 77-80

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Loss Run

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Fundamentals p. 66-67, 77-80

EXAMPLE FACILITY LOSS RUN

Valued as of: 1/23/2019

Claim Number	Claimant Name Injury Description	Status	Loss Date	Notice Date	Coverage	Indemnity Reserves Indemnity Paid	Expense Reserves Expense Paid	Incurred Total
123456	PATIENT, SUZIE	O	06/22/18	06/26/18	HPL	250,000	100,000	350,000
	PT DEVELOPED ISCHEMIC BOWEL POST SURGERY AND DIED					0	0	
345678	DOE, JOHN MD	O	05/10/18	07/30/18	EPL	25,000	24,425	50,000
	WRONGFUL TERMINATION OF EMPLOYMENT					0	575	
15123111	PATIENT, JOHN	F	07/31/18	08/27/18	PPL	0	0	36,250
	ADVERSE MEDICATION REACTION RESULTING IN BLISTERS AND POSSIBLE SCARRING					11,250	2,320	
15858555	CRASH, DON	O	09/06/17	09/20/18	AUT	25,000	21,214	50,000
	HOSPITAL AMBULANCE AUTO ACCIDENT IN ROUTE TO A CALL					0	3,786	
21252525	WHISTLEBLOWER, JOE	O	08/30/18	10/29/18	D&O	500,000	500,000	1 ,000,000
	ALLEGED BILLING SCHEME ON PHYSICAL THERAPY CHARGES					0	0	
Grand Totals: 5 Claims						800,000 11 ,250	645,639 6,681	1,486,250

-1-

1/23/2019
1:20:05PM

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Contributing Factors

- The goal is not endless data.
- Collect and use data that will benefit the organization and make impactful changes.

Fundamentals p. 66-67, 77-80

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Historical Data – Evaluating Organization's Loss Experience

Place of Occurrence	Litigation Type	Claim Resolution	Claim Description	Cause Allegation	Nature of Injury
OB/GYN	Suit – No Trial	Negotiated Settlement	Fetal Demise due to Failure to Treat Abruption	To timely recognize fetal distress	Delayed/ Didn't Treat
OB/GYN	Suit – No Trial		Seen in OB Triage as OP EVAL HTN. ADM 4 Days Later for Scheduled C/S and Found to have Fetal Demise	To timely recognize fetal distress	Failed to timely recognize fetal distress
OB/GYN	Suit – No Trial	Negotiated Settlement	Placental Abruption and Emergency C/S - Fetal Demise	To timely recognize fetal distress	Delayed emergency C-section
OB/GYN	Suit – No Trial	Dismissed with Prejudice		G3 P2 39Wks Gest Low Apgars Transferred to NICU Elsewhere	To timely recognize fetal distress

CLPB p. 129, 135-137
Fundamentals p. 56-67, 77-80, 238



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Question

The process of reviewing loss runs includes

a) Reassigning cases to other attorneys if warranted.
b) Verifying the accuracy of claim demographics.
c) Checking the dollar amount established in reserves for each claim.
d) Analyzing peer review data and production of documents.

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Investigation and Analysis

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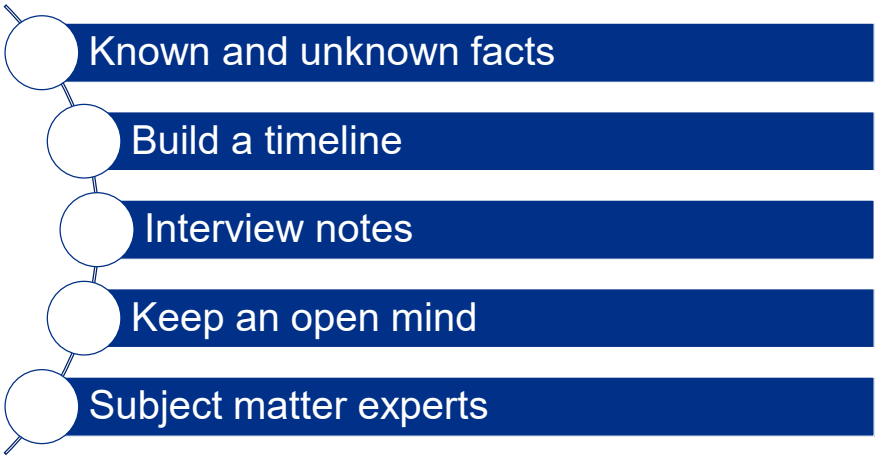
Investigation

- Responsible person
- Evidence collection
- Interviews
- Investigation process goals
- Documents collection
- Comply with statutes and regulations

CLPB p. 55-61
Fundamentals p. 232-235

18

Determining the Facts



CLPB p. 61

Investigation Summary

- Injured party information
- Co-defendant information
- Description of injury, date of injury and date of discovery
- Interview(s) summary
- Fact summary
- Expert(s) review summary
- Evaluation of damages
- Evaluation of liability
- Application of standard of care, laws and regulations

CLPB p. 53-63

Conduct a Simple Investigation

Investigation

You are the risk manager and you came to work this morning and found out that someone fell on the loading dock. That's all that is known. Who's the injured party? What's your assessment of the liability? Follow through the steps of the investigation.

Investigation Results – pg. 1

- Injured party- 50 y.o. unemployed married female with 1 adult child fell in the parking lot.
- Injury- 1/1/2019 at 5 am fall on snowy dock steps fracturing her right leg
- Co-defendant- snow removal company
- Interview summary- 1 witness who stated claimant parked in a non-public parking area, exited the vehicle and climbed the loading dock steps to enter the facility. She fell on the stairs and injured her leg. The steps were slick with snow.

Investigation Results – pg. 2

- Fact summary- Video surveillance confirmed the witness summary above. The snow began at midnight and the event occurred at dawn before business hours.
- Evaluation of damages- fracture was a non-displaced fracture which was casted and expected to heal in 6-8 weeks. No lost wages.
- Evaluation of liability- area clearly marked for employees only and the snow removal company arrived before business hours. Liability is strongly disputed.
- Application of SOC, etc- NA in this scenario.

Analysis and Classification of Investigation Above

- Responsible parties- individual or committee analyzes and classifies the event
- Fact driven- consistency is king
- Evidence supported- a picture speaks a thousand words
- Technology- store information and data summaries for future needs

RFPB p. 87
Fundamentals p. 12-13, 85-87
CLPB p. 137

Claims Reporting

- Insurer(s) reporting requirements
  - Seriousness of injury
  - Reasonable anticipation of claim
  - Status and pre-trial reports
- Internal
  - Leadership
  - Public relations
  - Human Resources
- Compliance with laws or regulations
  - SMDA mandatory for serious injury or death

RFPB p. 123-125
CLPB p. 67, 118-119, 127,
Fundamentals p. 235-236, 257-260

Insurance Reporting Definitions

Potentially Compensable Event

- a. An occurrence for which a claim can be reasonably anticipated but for which no claim has yet been asserted;
- b. An event for which there are grounds or contributing factors found after investigation, worthy of compensation being awarded the claimant

Claim

- Formal notification (generally in writing) that monetary damages are being sought for an alleged injury

Lawsuit

- Formal legal action filed in court

RFPB p. 258-259
CLPB 67-69
Fundamentals p. 87, 235-236, 259-260

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Question

A potential compensatory event is an

a) adverse event that has been reported to an accreditation body.
b) event that may occur identified by a FMEA.
c) event that has occurred but has not been reported.
d) adverse event that might result in a liability claim.

Claims & Litigation PB p. 53

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Coverage Determination and Reporting

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Coverage Determination Overview

Party covered by policy?	• Duty to defend
Loss within policy period?	• Claim would be covered
Cause of loss covered?	• Medical negligence, intentional tort i.e. assault and battery • Duty to pay damages
Types and amount of damages covered?	• Compensatory, non-compensatory, punitive
Location covered?	• Course and scope v. moonlighting
Exclusions?	• Assault & battery, sexual abuse • Reservation of Rights letter

RFPB p. 201-205
Fundamentals p. 236, p. 256-260

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Insured or Uninsured?

Insured parties

- Duty to defend
- Reservation of rights
- Additional insurance

Uninsured parties

- Indemnification analysis
- Insurance limits
- Erosion policy
- Consent
- Joint and Several
- Agency

RFPB p. 201-202
Fundamentals p. 256-259
CLPB 91, 113

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Types of Liability



Fundamentals p. 231
CLPB p. 33-35

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Types of Liability

Professional Liability/Medical Malpractice (PL)

Professional negligence by act or omission by a health care provider in which care provided deviates from accepted standards of practice in the medical community and causes injury or death to the patient.

Claim example- Failure to diagnose timely such as cancer

RFPB p. 22, 29-30
Fundamentals p. 192-194, 275-276, 282
CLPB p. 12, 22

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Types of Liability

Employment Practices (EPL)

EPL claims involve wrongful acts arising from the employment process or violation of the legal rights of the employee

Claim examples include

- Non-discrimination
- Civil rights
- Age
- Disability
- Sexual harassment
- Whistleblower



RFPB p. 22, 29-30
CLPB p. 35-46, 119-126
Fundamentals p. 192-194, 282

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Types of Liability

Directors & Offices (D&O)

D&O insurance covers actions or inactions in the governing or management of an entity.

Claims examples include

- False claims against the government payers
- Financial losses due to mismanagement



RFPB p. 22, 28-29
CLPB p. 47, 119-120
Fundamentals p. 192-194, 281-282

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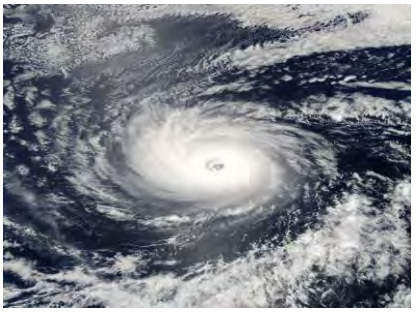
Types of Liability

Property Insurance

Property insurance provides financial reimbursement for damages to real property due to covered perils

Claim examples include

- Flooding
- Hurricanes
- Tornadoes



RFPB p. 22, 29-30
CLPB p. 46-47, 126-127
Fundamentals p. 192-194, 277, 282

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Types of Liability

Automobile Insurance

Automobile insurance provides coverage for owned or leased automobiles involved in damage to a 3rd party (liability) or organization's property (comprehensive- 1st party)



Claim examples include

- Ambulances
- Employees driving own cars for work

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Types of Liability

Other types of coverages

- Aviation
- Helipad
- Underground storage tanks
- Cyber
- Fidelity (Crime)
- Fiduciary (ERISA)
- Builders risk



Claim example- A crash of a medical air ambulance may involve helipad, aviation, professional liability, workers compensation and general liability

CLPB p. 14

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Question

When reading a mammogram film, a radiologist fails to identify and document a small tumor. The tumor grows and cancer cells spread to other areas of the patient's body. Which liability type would be involved in this scenario?

a) GL
b) PL
c) EPL
d) D&O

Negligence Elements - The 4 D's

- Duty to exercise reasonable care: "Standard of Care"
- Duty breached
- Direct or proximate causation: "injury"
- Damages resulted

Fundamentals p. 230
CLPB p. 23-25

Standard of Care

- Must be established by an expert opinion unless
  - Obvious and common knowledge
  - Cause under the exclusive control and negligence of the defendant (res ipsa loquitur: "the thing speaks for itself")
  - Violation of a statute or regulation (per se)



CLPB p. 27, 33
Fundamentals p. 185, 220

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Question

A malpractice lawsuit was brought on July 1, 2018 for a delivery that occurred in 2000. The facility had an flood in 2017 that destroyed all evidence of any OB policy and procedures (P&Ps) until newly written in 2018. The 2018 P&Ps now reflect practices that exceed the SOC. Since the facility had no P&Ps to prove their care was premised on the SOC in 2000, the facility could be held to the SOC defined in their

a) 2018 P&Ps
b) 2017 P&Ps
c) 2010 P&Ps
d) 2000 P&Ps

Fundamentals p. 363

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Tort Reform Impacts



- Cap on damages
- Intent to sue notification
- Affidavit of merit
- Limit on attorney fee allocation
- Joint & Several abrogation
- Contributory negligence
- Venue shopping
- Mandatory ADR
- No fault insurance or state victim or patient compensation fund

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Reserving

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Funding Reserves

Unfunded

- Paid out of operating expenses at time of loss

Funded

- Money set aside is called reserves

RFPB p. 44-45

Setting Reserves

- Liability reserves- restore the claimant to the their pre-injury state
- Affect liability reserves:
  - Art
  - Venue
  - Plaintiff attorney
  - Joint & several liability
  - Actuarial projections
- Expense reserves- pay legal fees and expenses to defend litigation

CLPB p. 64-67, 133-135

Legal Theories

Vicarious liability (general category)

Imputed liability on one person for the actionable conduct of another based on the relationship between the two parties

CLPB p. 32
Fundamentals p. 188, 232

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Legal Theories

Respondeat Superior (specific category)

- Employer responsible for the acts of their employees if the alleged wrongful act is within the course and scope of their employment
- Employee has to also have been found liable to find employer (master) liable

Fundamentals p. 188, 232

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Legal Theories

Ostensible or apparent agency

- Agent is person authorized by a principle to act for them
- Implied when the principle intentionally or from want of ordinary care makes another person believe the agent is their agent even when they are not an employee

Fundamentals p. 32, 183-184, 188, 232

48

Legal Theories

Corporate negligence

- The directors and officers:
  - Duty of care in their diligence to make decisions
  - Remain informed about business of the organization
  - Inquire about problems that may arise

Fundamentals p. 32, 183-184, 188, 232

Claims Management Strategies

Pre-litigation Strategies

- Informed consent must be performed before any procedure
- Having high regard for providers reduces the likelihood of suits
- Transparency and full disclosure is critical
- Settle claims early and fairly

Fundamentals p. 60, 236-237
CLPB p. 17-22

Strategies for Litigation

- Alternative dispute resolution (ADR)- process designed to resolve disputes in a manner that avoids the cost, delay, and unpredictability of the traditional adjudicatory process.
  - Arbitration (binding and non-binding)
  - Mediation (non-binding)
  - Negotiation

CLPB p. 92-95
Fundamentals p. 60, 236-237

Question

An advantage of alternative dispute resolution (ADR) is that it is:

a) More expensive
b) Takes more time
c) Less hostile
d) A public event

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Claim File Management

- Correspondence
- Diary
- Expenses
- Expert Reports
- Investigation documentation
- Legal documents
- Medical Records
- Reserve history



CLPB p. 63-66

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Lawsuit Process

- Pleadings
- Discovery
- Pre-Trial Phase
  - Mediation/arbitration
- Trial
- Settlement

Fundamentals p. 222-223

Pleadings

Receipt of Complaint or Summons

- Includes the pleadings or statement of facts
- Received via process server
- Defined process to notify named parties
- Assignment of counsel



CLPB p. 69, 86-87
Fundamentals p. 224-225

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Answer

- Answer
- Cross claims
- Joinders



CLPB p. 86-87

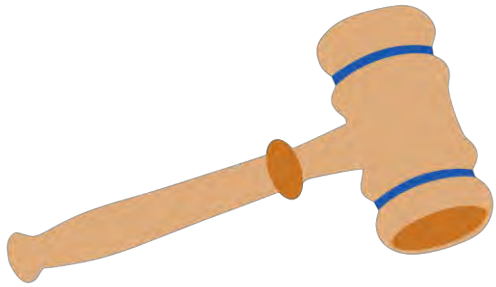
Pre-Trial

- Discovery
  - Interrogatories
  - Depositions
- Motions
  - Summary Judgement
  - Motions in Limine

CLPB p. 85-99
Fundamentals p. 222-225

Trial Phase

- Witness
  - Expert
  - Fact
- Evidence
- Bench vs. Jury trial
- Motions
  - Directive verdict
  - Mistrial
- Verdict



CLPB p. 28, 91, 100-104
Fundamentals p. 226-228

Post-trial Phase

- Motions
  - Request for new trial
  - Judgement not withstanding the verdict (JNOV)
  - Appeal
    - Affirm
    - Reverse & remand

CLPB p. 105-106
Fundamentals p. 228

Settlement

- Negotiation
  - Represented and unrepresented claimant
  - Guardian ad litem
- Settlement agreement
  - Motion to dismiss without prejudice
- Reporting requirements
  - National Practitioner Data Bank (NPDB)
  - State licensing agency
  - Medicare

CLPB p. 107-114
Fundamentals p. 236-238



Question

What is the first step of the claims management process?

a) Reporting
b) Identification
c) Investigation
d) Settlement

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Resolution

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Pre-litigation Settlement

Four reasons to settle pre-litigation

1. Financial

2. Reputation

3. Right thing to do

4. Customer recovery

CLPB p. 69

Settlement

Negotiation
- Represented and unrepresented claimant
- Guardian ad litem

Settlement agreement
- Motion to Dismiss with prejudice

Reporting requirements
- National Practitioners Data Bank (NPDB)
- State licensing agency

CLPB p. 71,110-112, 141-142, 147-148
Fundamentals p. 236-238

Litigation Management Debrief

Ask the questions;
1. How well did the parties communicate?
2. Were legal fees controlled and reasonable?
3. Was the selection of counsel effective?
4. Were there surprises in the defense of the claim?

CLPB p. 78

Batch Claims

How will handling claims as a batch be advantageous to the organization?

Example- A health organization has had an equipment malfunction that resulted in the potential loss of 15 irretrievable human specimens. The insurer had made the risk manager aware this event will be a batch claim.

- Financial impact
- Loss history
- Reporting

CLPB p.50-52

Questions



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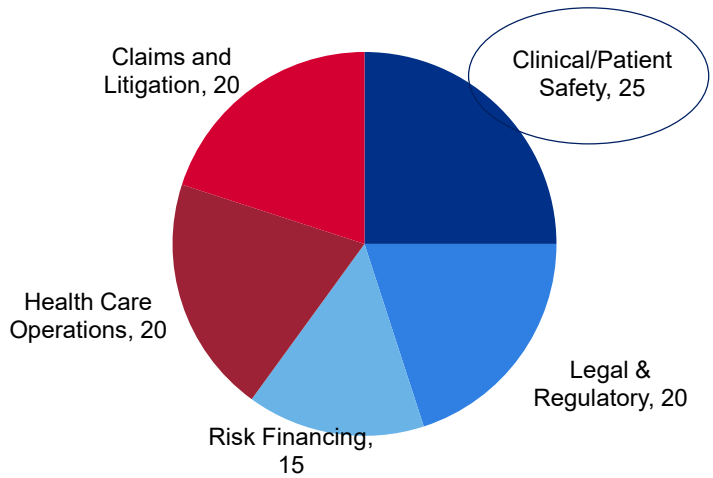
TAB 4 - Clinical & Patient Safety

Clinical/Patient Safety

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PSPB	Patient Safety Risk Management Playbook
POPB	Physician Office Risk Management Playbook
RCAPB	Root Cause Analysis Playbook

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Objectives

- Identify the clinical areas that provide the greatest risk exposures in healthcare
- Discuss the importance of having a patient safety infrastructure to support a patient safety program
- Review new rule for Patient Safety Organizations and/or Hospital Engagement Network affiliation
- Explain the Just Culture concept and its impact on reporting patient safety events
- Describe the components of a high reliability organization
- Summarize the concepts behind the study of Human Factors
- State the NPSF patient safety goals
- Identify the primary organizations that influence patient safety initiatives in healthcare
- Discuss the value of patient and family participation in patient safety
- Summarize the components of a successful disclosure

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Patient Safety

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Patient Safety

- Studies
  - 1999
    - **"To Err is Human"**
    - The Institute of Medicine
    - Estimated that approximately 50,000 to 100,000 inpatients die each year because of **medical errors**
  - 2005
    - **"Crossing the Quality Chasm"**
    - Committee on Quality Health Care in America Project
    - Biggest challenge is to establish a "**just culture**" in the reporting of events

Fundamentals p. 62, 66-67, 125-126, 144, 150

5

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Patient Safety Infrastructure

Strategic	Operational
☐ Empowered Patient Safety Officer/Leader	☐ Structured monitoring & feedback process
☐ Interdisciplinary participation	☐ Communicate with key personnel from Board to frontline
☐ Integration of quality, risk & patient safety data	☐ Actively and publicly promote patient safety
☐ Patient Safety Committee	☐ Transparency and Disclosure
☐ Patient Safety Plan, P&Ps	☐ Patient and Family Engagement

Fundamentals p. 62, 95, 131-132, 138-145, 151-153, 163-164,199
PSPB p. 15-18, 44, 78, 94, 103

6

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Patient Safety Infrastructure

- Language of Safety
  - Taxonomy
    - Classification of Risk Exposures: Falls, Medication Errors, etc.
  - Nomenclature
    - Risk Exposure Type: Sentinel Events, Adverse Events, Medication Errors, etc.
- Severity levels

Fundamentals p. 138-145, 151-153, 163-164
PSPB p. 44, 78, 94, 103

7

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Patient Safety Infrastructure

Strategic

- Identify **patient safety as a focus** in all process and/or design improvement activities
- Identify patient safety as a **priority** and support patient safety initiatives
- Allocate **resources** for patient safety initiatives
- Monitor leadership's **contributions** to patient safety

Operational

- Provide patient safety **educational** programs
- Participate in patient **safety rounds**
- Request and review organizational monitoring **data** related to patient safety

Fundamentals p. 37
PSPB p. 15-18

8

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Patient Safety Challenges

- Communication and Teamwork
  - Healthcare is traditionally hierarchical
  - Personal communication styles of staff
  - Lack of common language (SBAR, ICUS, IPASS)
  - Addressed with other patient safety initiatives
    - Simulation training
    - Rapid Response Teams (RRT)
    - Walkroundstm
    - Patient engagement–participation in committees/RCAs
    - Critical incident debriefing



Fundamentals p. 138-142

9

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The risk manager receives an event report stating an anticoagulation medication was ordered to be discontinued through physician order entry system. The pharmacy states the discontinuation order was not received, and the patient received four extra doses of the medication before the order was identified to discontinue. The risk manager should start the investigation with a focus on:

a) human factors
b) IT system interface
c) business intelligence (BI) reports
d) individuals involved in the process

http://www.healthit.gov/sites/default/files/ONC_HIT_SafetyProgramReport_9-9-14.pdf

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Culture of Safety

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Culture of Safety

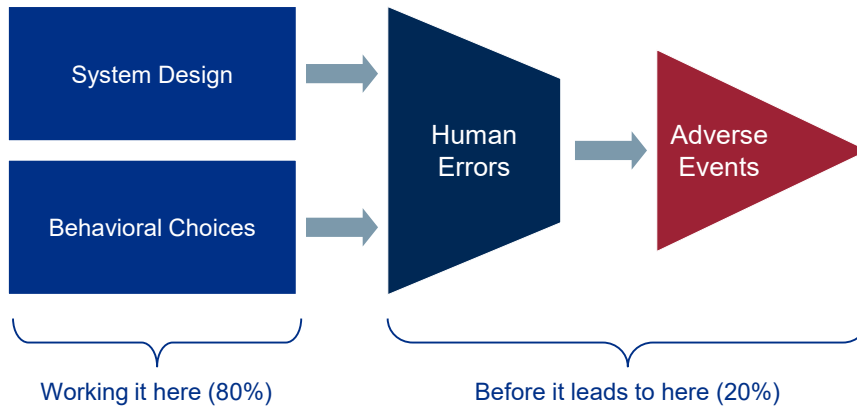
- An integrated pattern of individual and organizational behaviors, based upon shared beliefs and values, that continuously seeks to minimize patient harm that may result from the processes of care delivery

https://psnet.ahrq.gov
Fundamentals p. 131-134
PSPB p. 124-125

12

Culture of Safety: A Proactive, Learning Culture

David Marx



Fundamentals p. 131-135

13

Organizational Culture of Safety

- Looks at the system, environment, knowledge, workflow, tools and stressors that impact provider behavior
- Encourages reporting of errors and near misses which depends on maintaining trust, honesty, integrity and open communication with patients and between care providers
- Recognize that there will be some barriers

Fundamentals p. 131-135
PSPB p. 124-125

14

How We Use Safety Assessment Surveys

- "The delivery of survey results is not the end point in the survey process; it is just the beginning. Often, the perceived failure of surveys to create lasting change is actually due to faulty or nonexistent action planning or survey follow up."

Sorra J, Famolaro T, Dyer N, et al. Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report. Prepared by Westat, Rockville, MD, under Contract No. HHSA 290200710024C. AHRQ Publication No. 12-0017, February 2012. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/qual/hospsurvey12/index.html

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How We Use Safety Assessment Surveys

- Pre and Post Safety Interventions
- Utilize results for PI Action Plan
  - Understand your results
  - Communicate and discuss the results
  - Develop focused action plans
  - Communicate action plans and deliverables
  - Implement action plans
  - Track progress and evaluate impact
  - Share what works

Sorra J, Famolaro T, Dyer N, et al. Hospital Survey on Patient Safety Culture: 2012 User Comparative Database Report. Prepared by Westat, Rockville, MD, under Contract No. HHSA 290200710024C. AHRQ Publication No. 12-0017, February 2012. Agency for Healthcare Research and Quality, Rockville, MD.
http://www.ahrq.gov/qual/hospsurvey12/index.html

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High-Reliability Organizations

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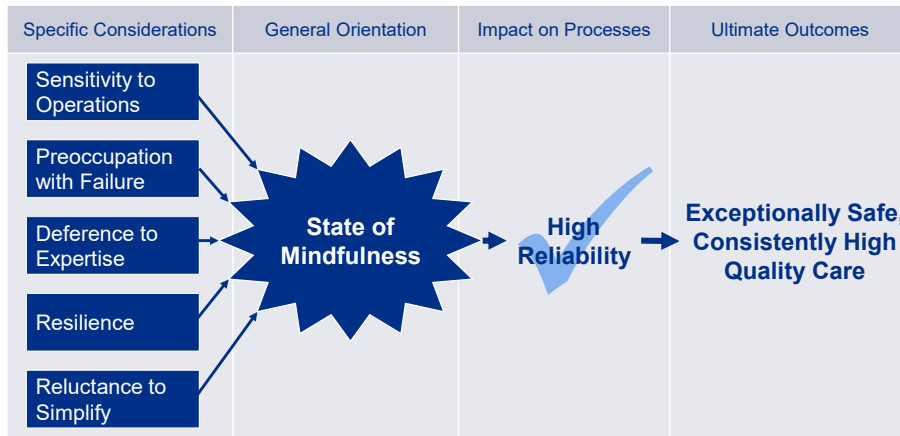
A High Reliability Organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.

PSPB p. 18-19

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HRO Concepts



Becoming a High Reliability Organization: Operational Advice for Hospital Leaders. AHRQ Publication No. 08-0022, April 2008, Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/qual/hroadvice/
PSPB p. 18-19

19

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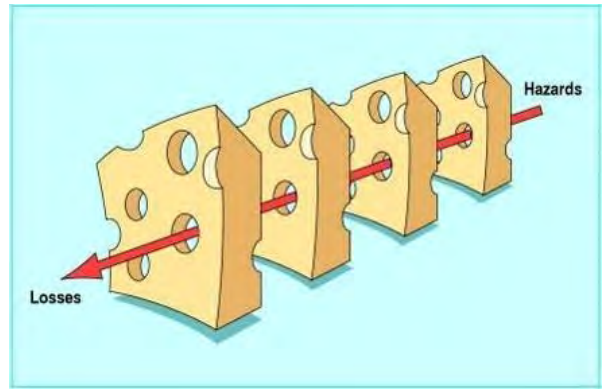
HROs: Key Attributes

- Leadership engagement, support
- Safety oriented culture; encourages reporting
- Flattened hierarchy; team-like operations
- Risk auditing: monitoring of activities to identify both expected and unexpected risks; constant vigilance
- Appropriate reward systems that encourage safety-related behavior
- Trust and transparency
- Acknowledgment of risk to learn from error; review of near misses and adverse outcomes
- Flexible management model to promote open communication

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Anatomy of Errors: Swiss Cheese Model



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Failure Mode Effects Analysis (FMEA)

- Method used to identify those risks inherent in care delivery
- FMEA is a proactive model designed to identify weak points, incidents or events before they occur
  - Different from RCA which is a reactive process and subject to "hindsight bias"
  - Promotes a redesign for safety philosophy
- The Joint Commission requires hospitals to select one high-risk process at least every 18 months upon which to conduct a proactive risk assessment (FMEA is one method)

Fundamentals p. 77-78, 129

22

Steps in the FMEA Process

- Identify project
  - Scope
- Assemble a team
- Diagram intended and actual process
- Identify potential failure mode
- For each failure mode identify the possible effects

Fundamentals p. 166

23

Steps in the FMEA Process

- Put new process in place
- Test and implement the redesigned process
- Identify and implement measures of effectiveness
- Implement a strategy for maintaining the effectiveness of the redesigned process over time

Fundamentals p. 166-168

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FMEA – Risk Priority Number

- Likelihood of Occurrence (1-10)
- Likelihood of Detection (1-10)
- Severity (1-10)
- Risk Priority Number = (Occurrence × Detection × Severity)

Steps in the Process	Failure Mode	Failure Causes	Failure Effects	Likelihood of Occurrence (1-10)	Likelihood of Detection (1-10)	Severity (1-10)	Risk Profile Number (RPN)	Actions to Reduce Occurrence of Failure
1								
2								
3								

- NOTE: 1 = Very likely it WILL be detected 10 = Very likely it WILL NOT be detected ~ Source: IHI



Fundamentals p. 166-168

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Which of the following is a characteristic of a high reliability organization?

a) Easy to use reporting systems
b) Early resolution of claims
c) A punitive culture system-wide
d) Top-heavy executive management structure

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Fair and Just Culture

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Fair and Just Culture

- "The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."
  - Dr. Lucian Leape, Professor, Harvard School of Public Health, Testimony before Congress on Health Care Quality Improvement

Fundamentals p. 132-133
PSPB p. 122

28

Fair and Just Culture: Why We Need It

- Only 2-3% of errors reported
- Most hospitals unaware of the extent of error
- Health care workers would report only what they could not hide
- Errors, as viewed by hospital workers and the public, are indicators of carelessness

- David Marx, A Just Culture Community

PSPB p. 122

AHRQ Suggestions for Fair and Just Culture

- Conduct regularly scheduled walk-arounds (Leadership Rounding) to learn about staff concerns regarding patient safety, and include all shifts
- Conduct monthly staff meetings and include a focus on patient safety
- Implement transparent and biweekly/daily “huddles”
- Educate hospital leaders about making error reporting anonymous, easy, convenient and non-punitive
- Set up a hotline for reporting errors and develop anonymous reporting forms
- Brief and debrief

https://ahrq.gov/patientsafety

AHRQ Suggestions for Fair and Just Culture

- Involve staff directly in the problem-solving process
- Charge Leadership, from Supervisor Level to Senior Leadership, with developing and implementing an annual action plan, hold them accountable and require periodic progress reports
- Allocate resources for safety needs identified by staff, i.e., buying safer beds, IV pumps, pyxis system upgrades, etc.
- Establishing a formal budget for patient safety initiatives
- Re-evaluate current disciplinary policies and procedures
- Empower all medical staff, hospital personnel, patients and families to immediately intervene whenever they feel the need to protect the patient from harm and prevent a medical accident without fear of retribution

https://ahrq.hhs.gov/patientsafety

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Fair and Just Culture Includes Leadership Rounding

- Purpose
  - Demonstrates support for making safety a high priority
  - Increase awareness of safety issues
  - Educate staff about safety concerns
  - Identify barriers to safety
  - Evens the playing field
- Follow-Up
  - Record the data
  - Initiate PI project
  - Inform the front line of trends/actions

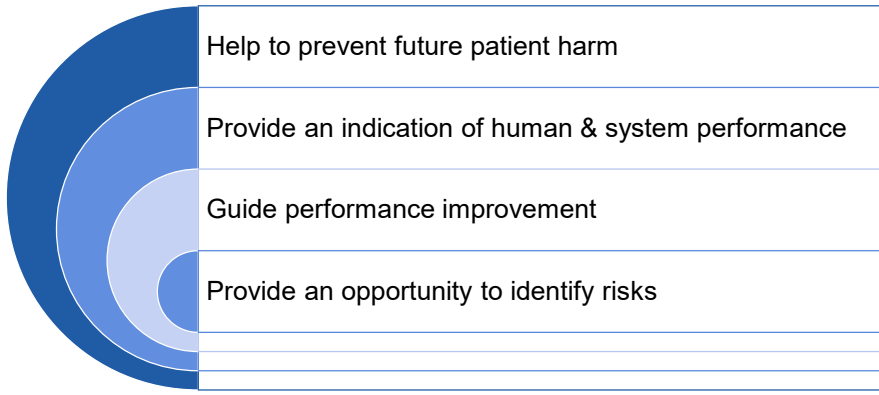


PSPB p. 59

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A Just Culture Encourages and Supports Reporting

- The Value of Reporting Events



PSPB p. 122

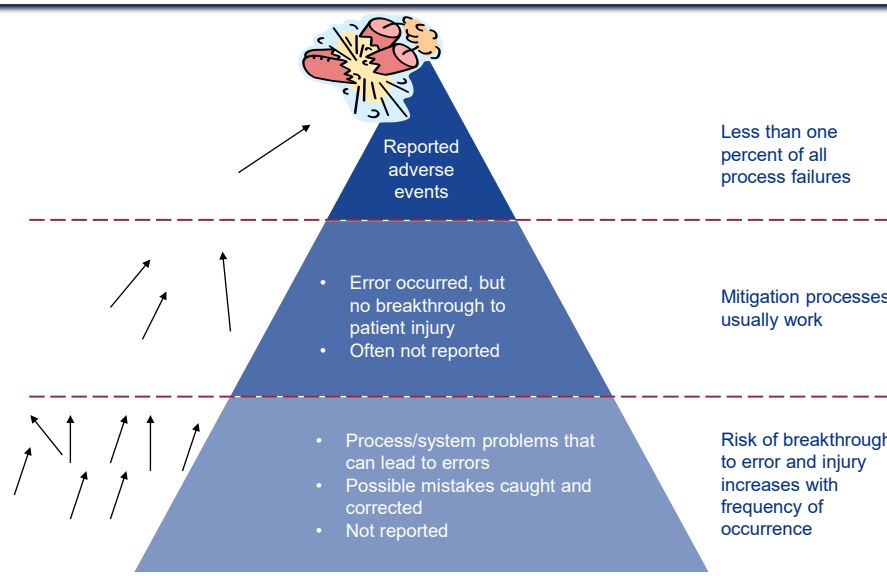
Tipping the Scales for a Fair and Just Culture



PSPB p. 16

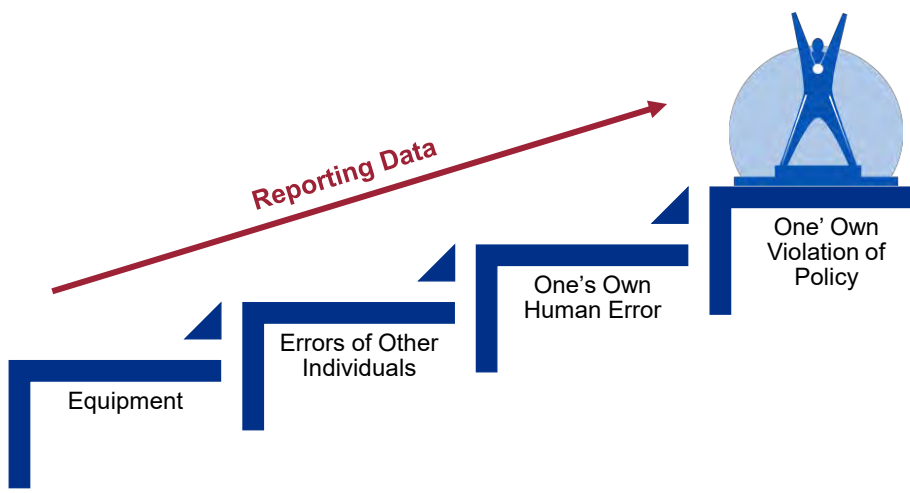
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Event and Near Miss Understanding



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Progressive Reporting as Culture of Safety Improves



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Organizational Trust



Firth-Cozens, J: Operational Trust: The keystone to patient safety. Qual Saf Health Care 13:56-61. Feb. 2004

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Mindfulness: Migration to Boundaries

- Work-arounds
- Interruptions
- Not listening to co-workers

- Adhering to standards of care
- Routine practices or guidelines
- Asking for help when uncertain
- Listening to co-workers when they raise a safety concern
- Policies and procedures
- Respecting colleagues

- Deviations from policies and/or procedures
- Deviations from best practices
- Not using chain of command

PSPB p. 20

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When an organization has a generative safety culture, staff shift and begins to report errors differently. Which of the following types of reporting is the highest level in the continuum of reporting data?

a) Errors of Other individuals
b) One's own violation of policy
c) Equipment
d) One's own human error

PSPB

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Patient Safety Focus

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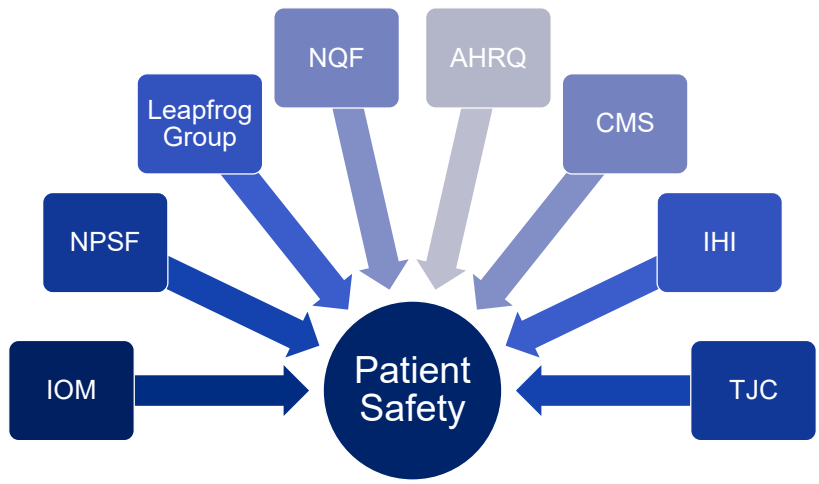
Patient Safety Focus

- Patient Safety Infrastructure
- Culture of Safety and Just Culture
- High Reliability Organizations
- Human Factors
- Key Influencers
- Patients as Partners
- Patient Safety Metrics
- Disclosure

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Key Patient Safety Influencers



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Looking for Risks in All the Right Places – High Risk Areas

Obstetrics

- Failure to identify non-reassuring fetal status
- Failure to complete a cesarean section
- Administration of oxytocin
- VBAC (vaginal birth after cesarean)
- Failure to use massive transfusion protocol for the hemorrhaging patient

Emergency Department

- Medical evaluation and transfers
- Communication issues
- Ostensible agency

OBPB p. 15-18, 23-27, 40-46, 78-80

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High Risk Clinical Areas

Surgical Services

- Retained procedural item
- Misidentification of the patient or the correct operative site
- Inadequate preoperative evaluation
- Outpatient surgery

Anesthesia

- Failure to properly intubate the patient
- Moderate sedation
- Patient care responsibilities

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High Risk Clinical Areas

Intensive Care Units

- Medication administration
- Use of monitoring alarms
- Medical management with multiple providers

Pediatrics

- Appropriate services and equipment
- Child abuse
- Patient safety
- Abduction

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High Risk Clinical Areas

Behavioral Health and Psychiatry

- Failure to prevent suicide
- Outpatient psychiatric environment
- Restraints
- Psychopharmacology
- Polypharmacy
- Electroconvulsive therapy
- Elopement
- Sexual or physical assault
- Rights of others
- Contraband-not identified upon initial assessments

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High Risk Clinical Areas

Radiology Services

- Management and avoidance of contrast media reactions or tissue damage associated with extravasation
- Failure to diagnose
- Failure to report results to appropriate provider in timely manner

Home Health Services

- Supervision
- Durable medical equipment
- Confidentiality of the medical record
- Security, employee safety

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High Risk Clinical Areas

Physician's Office Setting

- Training
- Timeliness of appointments
- Patient tracking and diagnostic follow-up
- Compliance with electronic medical records rules (ICD-10)

Long Term Care and Assisted Care

- Patient's rights
- Staffing
- Abuse
- Slip and falls
- Pressure ulcers
- Elopement
- Restraints
- Documentation

POPB p. 44-47, 95-98, 161-165

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Clinical Decision Support Tools

Clinical Practice Guidelines
- Systematically developed statements used to assist providers and patients in making decisions about appropriate health care for specific clinical circumstances

Practice Parameters
- Approved strategies for clinical management

Protocols
- Accepted procedure that includes explicitly recommended clinical steps

Algorithms
- Structured decision-making tree that provides divergent paths based upon response to previous raised question or scenario

Clinical Pathways
- Also known as care maps

Standards
- Generally accepted principles for patient management

OBPB p. 121-125
PSPB p. 40

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Residents who wander create a significant risk in long term care facilities. If electronic identification bracelets and exit alarms are used, the alarm should be able to be reset only at which of the following locations?

a) The nurses station
b) The administrator's office
c) A secure designated area
d) The point where the alarm was actually tripped

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Patients as Partners

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Patients as Partners in Patient Safety

- Creating readiness for patients:
  - Education
  - Health care literacy
  - Speak-up campaign
  - Decision-making
  - Disclosure and transparency
  - Fair and "just" culture
  - Teamwork



Fundamentals p. 142-145

52

Patients as Partners in Patient Safety

- Let's Talk!
  - Speak up
    - The Joint Commission (The JC)
  - Patient participation
    - Root Cause Analysis (RCA)
    - Failure Mode, Effect and Criticality Analysis (FMECA)
    - Patient Safety information
  - Rapid Response Team (RRT)
    - Driven by medical profession
    - Driven by patients (Condition H)

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Patients as Partners in Patient Safety

- Communication
- Education
- Empowerment
- Active partnership
- Patient and family centered
- Listen

Fundamentals p. 144-145

54

Patient Rights as Partners in Patient Safety

- Patient rights for empowered consumers and risk managers
  - Organization has multiple goals
    - Education of professional staff, leadership, frontline staff and others
    - To ensure quality consumer care and patient safety
    - To prevent claims that can impact the organization's business portfolio

55

Patient Rights as Partners in Patient Safety

- Foundations for the organization
  - Informed consent
  - Bill of rights
  - Consumer Rights and Responsibilities: 1997 Advisory Committee on Consumer Protection and Quality
    - Information disclosure
    - Choice of providers and plans
    - Access to emergency services
    - Participation in treatment decisions
    - Respect and discrimination provisions
    - Confidentiality of health information
    - Complaints and appeals
    - Consumer responsibilities

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Patient Rights as Partners in Patient Safety

- The “new patient”
  - Patients have become more educated consumers
  - New patient focus that addresses
    - Access
    - Choice
    - Affordability
    - Availability
    - Timeliness
    - Satisfaction
    - Quality
    - Rights

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Patient Rights as Partners in Patient Safety

- Increasing patient/consumer responsibilities
  - Individuals have legal obligation to exercise caution and refrain from negligent acts that result in injury to others
  - Individuals have duty to refrain from negligently exposing themselves to harm
  - Patients are required to assume increased control of their personal health care and to communicate their health care needs to their providers

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Patient Rights as Partners in Patient Safety

- Risk Interventions
  - Safety policies articulating support of the organizational mission and values
  - Posting patient rights
  - Credential staff on matters involving newly identified competencies
  - Promoting cultural knowledge and competent care
  - Training staff to improve communication and patient education skills

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Patient Rights as Partners in Patient Safety

- Risk Interventions
  - Grievance policies and appropriate execution of policies
  - Evaluating patient education and training
  - Addressing diversity through interdisciplinary quality improvement activities
  - Literacy testing on all patient education materials and tools
  - Assessing community needs



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A board member requests an explanation on why near miss reporting within the organization has doubled over the last two months although events with harm have decreased. The response reflecting a high reliability organization may be that:

a) a culture of preoccupation with failure increases reporting
b) the patient population was increased within the reporting timeframe
c) the unit managers have been made responsible for reporting
d) a mandatory reporting of quality measures has been activated

Understanding Patient Safety, Robert M. Wachter, MD, 2012 page 376

ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Process for Critical Events

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Sentinel Event

- Sentinel event – a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm or severe temporary harm
  - Complete a comprehensive systematic analysis for identifying the causal and contributory factors
    - Root cause analysis is the most common form of a comprehensive systematic analysis used
- Critical incident debriefing
- The Joint Commission requests voluntary reporting of sentinel events

Fundamentals p. 147-149
RCAPB p. 69

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Sentinel Event

- Root Cause Analysis (RCA) must be performed if:
  - Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital's emergency department (ED)
  - Unanticipated death of a full-term infant
  - Discharge of an infant to the wrong family
  - Abduction of any patient receiving care, treatment or services
  - Any elopement (that is, unauthorized departure) of a patient from a staffed around the-clock care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient
  - Hemolytic transfusion reaction involving major blood group incompatibility
  - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any patient receiving care, treatment, and services while on site at the hospital

RCAPB p. 71-72

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Sentinel Event

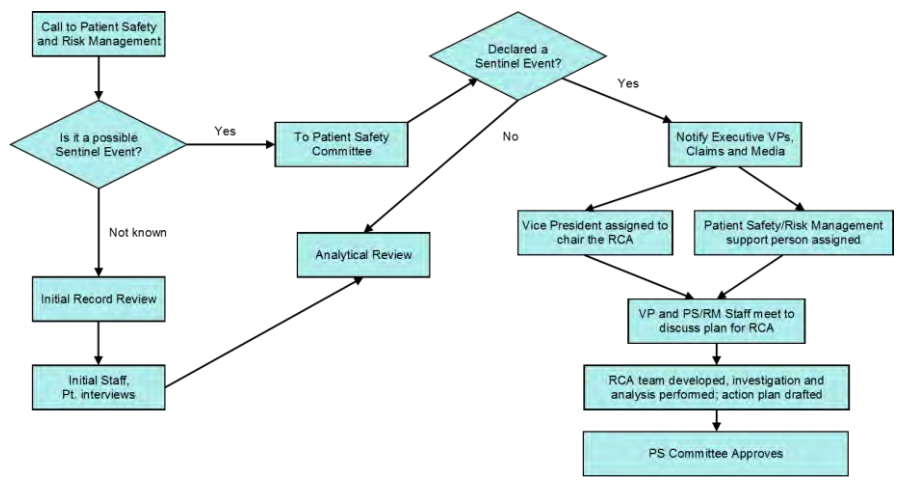
- Root Cause Analysis (RCA) must be performed if (continued):
  - Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital
  - Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
  - Unintended retention of a foreign object in a patient after surgery or other invasive procedure
  - Severe neonatal hyperbilirubinemia (>30 milligrams/deciliter)
  - Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field, any radiotherapy delivered to wrong body region, or >25% above the planned radiotherapy dose
  - Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
  - Any intrapartum (related to the birth process) maternal death or severe maternal morbidity

RCAPB p. 71-72

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Sentinel Event Process



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Which of the following is an accurate statement about reporting a sentinel event?

a) It is suggested that hospitals investigate sentinel events that result in death or serious injury.

b) Internal data is always protected under the state's peer review privilege.

c) The outside agency that the event is reported to will use this data in generating its report.

d) Hospitals are encouraged, but not required, to self-report these events to regulatory agencies.

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Patient Safety: Disclosure

- Definition: the delivery of news to the patient or family that they may not otherwise learn
- Purpose: to give patients/families information they need to make further decisions
  - Medical decisions
  - Decisions to pursue legitimate compensation
- It is not strictly related to medical error, nor necessarily to bad news

Fundamentals p. 152-154

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Key Concepts

- First obligation always to the immediate needs of the patient (stabilization, comfort, care, etc.)
- Obligation to discern facts from “hearsay”
- Obligation to come from a place of integrity
- Obligation to take care of the needs of providers and others involved in the incident

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More Key Concepts

- Recognize that disclosure is a process that will require multiple discussions, not an “event.”
- Recognize that the purpose of disclosure is not to avert litigation, but to respect the integrity of the patient/caregiver relationship.
- Whatever promises are made during this process must be kept; trust is at stake.
- Maintain close contact with the patient/family during the process. Do not put the onus of responsibility on them to maintain the relationship.

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Patient Safety Metrics

- Involves both reactive and proactive measures
  - Good catches resulting in a practice change
  - Number of FMEAs
  - Number of RCAs resulting in a P&P change
  - Sentinel events with and without disclosure
  - Number of disclosures involving risk management
  - Number of lessons learned from RCA that impacted more than 2 units
  - Participation in a periodic PS culture survey
  - Number of committees/family councils in which patients/families participate

PSPB chapters 6 and 7

71

Reasons to Disclose

- Right thing to do
- Patients expect it
- Professional responsibility
- Earn trust/possibly forgiveness of patien
- Supports patient safety initiatives
- Required by The Joint Commission for u outcomes



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Framing the Conversation

- Acknowledgement that adverse event occurred
- An explanation as to why it happened
- Statement that organization taking event seriously and investigating it
- Statement that organization taking steps to prevent similar event from happening
- An apology (as appropriate)

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The Four "R"s of Apology

- Recognition
  - Knowing when an apology is in order
- Regret
  - Responding empathetically
- Responsibility
  - Owning up to what has happened
- Remedy
  - Making it right

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Barriers to Disclosure

- Fear of legal liability
- Fear of loss of credibility and reputation
- Fear of loss of licensure
- Fear of punishment by organization or loss of job
- Feelings of vulnerability
- Difficulty in accepting role in error

75

System Barriers to Disclosure

- We've always done it this way
- Hierarchical structure of medicine
- Profession demands perfection
- Struggle with accepting even most well trained and competent can make mistakes
- Conflict of Interest

76

How to Determine Success

- A successful disclosure allows the patient and family:
  - To understand what happened
  - To understand the ramifications of the event
  - To have sufficient information to make future decisions (including seeking compensation)
  - To receive an apology from the organization
  - To begin to heal

77

Advantages of Reporting Sentinel Events

- Enables lessons learned to be added to The Joint Commission's sentinel event database and contributes to general knowledge of the causes of such events
- Provides for an opportunity to consult with The Joint Commission staff on development of RCA and action plan
- Sends a positive, proactive message to the public
- Promotes transparency

Fundamentals p. 149

78

Critical Incident Debriefing

- Can occur for any reason
- Do it when memories are fresh
- Include the members of the “team”
- Don’t “point fingers”
- Provide a safe environment of inclusion

Fundamentals p. 142
www.ahrq.gov/teamstepps

79

Critical Incident Debriefing

- An opportunity for individual, team and organizational learning
- The greater the specificity, the better
- What would we do differently next time?
- What did we do well?

What did we learn?



Fundamentals p. 142

80

Root Cause Analysis – RCA

- A process to identify the most basic causal factor or factors that underlie a variation in performance, including the occurrence of an adverse sentinel event
- It identifies changes that could be made in the system and processes – through either redesign or development of new systems or processes – that would improve the level of performance and reduce the risk of a particular event occurring in the future

RCAPB

When to do a Root Cause Analysis?

- Sentinel events
- Adverse events
- Near misses

Fundamentals p. 148
PSPB p. 62-63
RCAPB p. 10-13

Root Cause Analysis

What??	• Define the problem • Gather evidence/data
How??	• Identify issues that contributed to the problem • Find root causes
What now??	• Develop solution recommendations • Implement the recommendations • Observe the recommended solutions to ensure effectiveness

RCAPB p. 12-13

83

Preparing for a Successful RCA

- Interdisciplinary review that includes those closest to the process
- Focus on systems and processes rather than individual performance
- Analysis digs deep until all factors are identified
- Analysis identifies changes that can be made in systems and processes
- Typically takes a minimum of 3 one hour meetings

RCAPB p. 17, 30, 33, 69-70

84

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Different Methodologies of RCAs

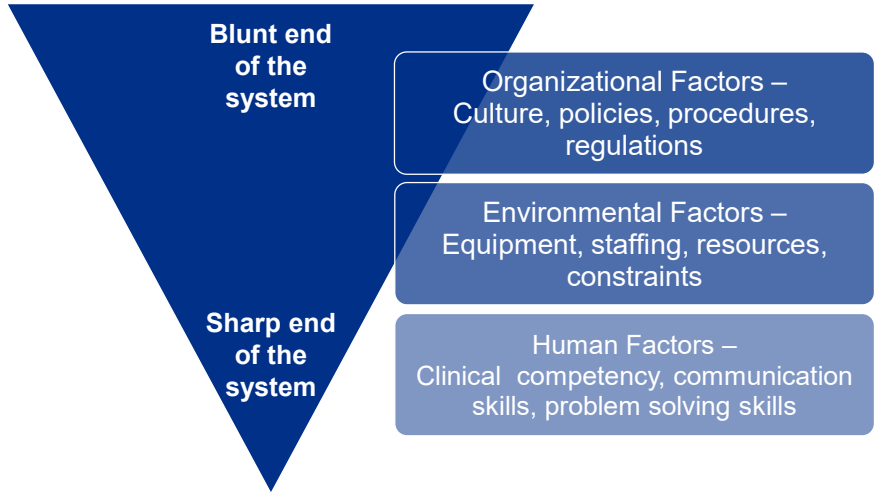
- Traditional (e.g. accrediting agencies- TJC)
  - Drill down via the framework
- HPI: Healthcare Performance Improvement
  - Focus on improvements to eliminate human error and events that cause error
  - Event prevention is not the result of good luck but achieved when the science of human error and event prevention is known and put into practice.
- RCA Squared (RCA2) : National Patient Safety Foundation
  - Prevention of future harm

RCAPB p. 33
The Joint Commission: www.tjc.org
Healthcare Performance Improvement: https://hpiresults.com
National Patent Safety Foundation: www.NPSF.org

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The Anatomy of Errors in Health Care

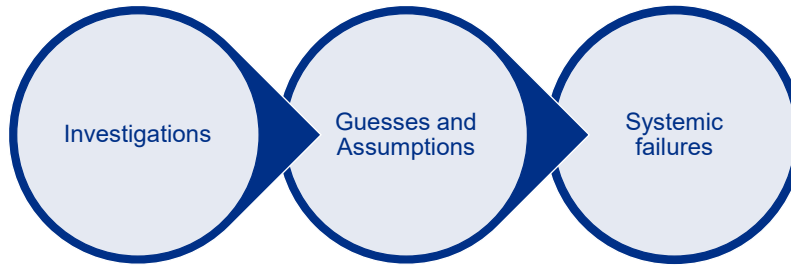


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Former Investigation Focus

- Traditional Healthcare Model



- Too simple
- Not in-depth
- Stopped at first or most logical explanation

- Part of process

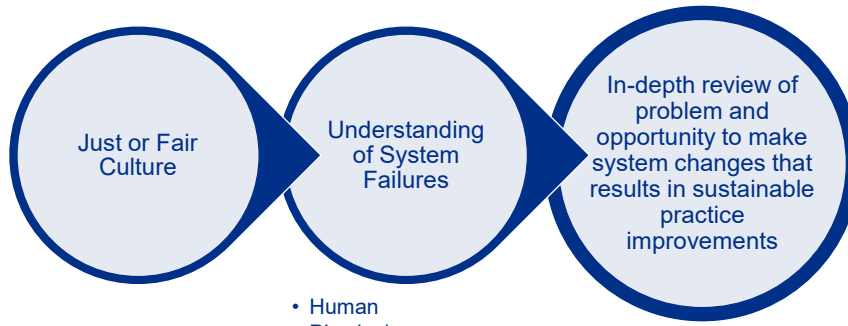
- Go unchecked
- Event repeated to greater degree

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Current Focus

- Investigations Should Represent



- Human
- Physical
- Latent

RCAPB p. 24, 29

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A patient safety professional shares that falls with harm continues to be a challenge despite rewriting of evidence based policies and education of nursing staff. In follow up investigations, it is revealed patients did not call for assistance even though all fall precautions were known and available to the patient. The next step should be:

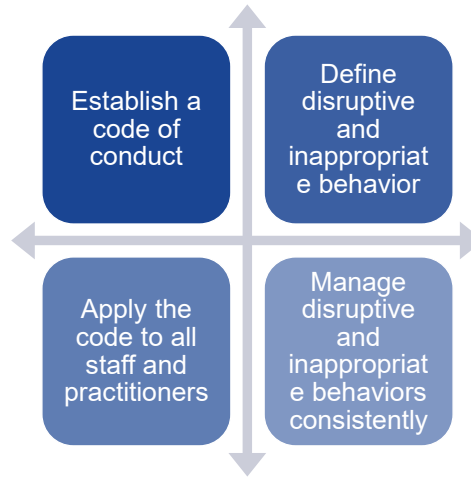
a) Look at policy and make necessary changes to reflect best practice
b) Involve patients who have fallen in the investigation process
c) Pull staffing ratios on the units with high fall with harm rates
d) Reeducate all the nursing units who have had falls with harm

Understanding Patient Safety, Robert M. Wachter, MS, 2012, page 376 (Errors caused by patients themselves)
Fundamentals book pp. 158-168

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Disruptive Behavior

Disruptive and Inappropriate Behavior



Fundamentals p. 134, 184
Insidious Intimidation Pearl 2nd Edition

91

Disruptive and Inappropriate Behavior

- Applies to employees, patients, families and visitors
  - Physical and/or verbal behavior
- Address in entity policy & procedure
- Conduct education around application of policy & procedure
- Provide counseling/support for staff involved if needed

Fundamentals p. 134-135, 184
Insidious Intimidation Pearl 2nd Edition

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Disruptive Behavior

- We often focus on aggressive behaviors such as throwing an instrument, yelling, cursing
- Spectrum of disruptive behavior-any form of non-team-work promoting behavior
- Working poorly together-unnecessary risk to staff and patients and health system

Fundamentals p. 134
Insidious Intimidation Pearl 2nd Edition

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Disruptive Behavior

- Profane/disrespectful language
- Sexual comments/innuendo
- Public criticism
- Outbursts of anger
- Intimidating behavior
- Intentional failure to adhere to policies
- Retaliation against reporting person

Fundamentals p. 133
Insidious Intimidation Pearl 2nd Edition

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Disruptive Behavior

- Disruptive behavior includes words or actions that:
  - Prevent or interfere with an individual's or group's work, academic performance, or ability to achieve intended outcomes
  - Threaten personal or group safety-aggressive or violent physical actions
  - Violate conflict of interest and compliance policies

Fundamentals p. 133
Insidious Intimidation Pearl 2nd Edition

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Failure to Address Disruptive Behavior

- Leads to:
  - Team members adopting negative mood or anger
  - Lessened trust -affects quality and patient safety
  - High turnover of staff-quit/withdrawn
  - Undermining the Culture of Safety



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Disruptive behavior by any health care team member threatens safety. Which of the following is the first step a risk manager should take when a report of disruptive behavior is made?

a) Report the behavior to administration and medical executive committee
b) Conduct education on the policy and procedure
c) Suspend the employee
d) Validate and verify the facts of the report

Fundamentals p. 62

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Data and Analytics

Use of Data in Patient Safety

- Data mining
- Data trending
- Analysis of events/data
- Event categorization – taxonomy
- RCA and FMEA tools
- Reporting events (clinical and non-clinical)
- Action plan

PSPB

Mining for Data

- What kind of audit tools do you have available?
  - Medical records - high risk chief complaints
  - Risk audit - high risk exposures (OB,ED, OR)
  - Claims audits - allegations (misdiagnosis, failure to rescue)
  - Risk data – written incident reports, medication events, falls, or surgical events
  - Patient complaints
  - Patient satisfaction surveys
  - Clinical indicators

PSPB p. 58-65

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Mining for Data

- Trigger tools
- RRT database
- Work-arounds
  - Identified by staff
  - Noted in observations of process
  - From claims data
- Near miss data
- Safety walk-rounds
- Infection Prevention
- Pharmacy data
- Ambulatory clinics
- Home health/DME
- SNF or Rehab

PSPB p. 58-65

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Mining for Data

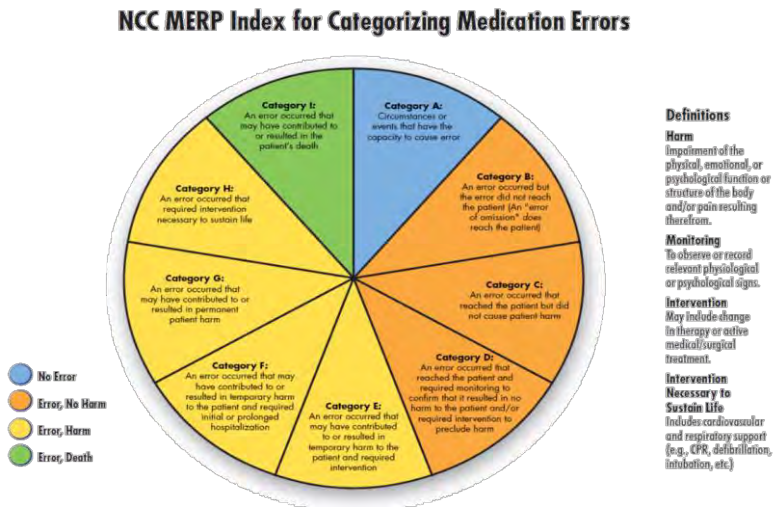
- Deficiencies
  - Confusion about the use of data
  - Analysis of rare events rather than large number of events
  - Multiple data steams without a defined process on how to view data
  - No central repository
  - Survey bias

PSPB p. 58-65

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Taxonomy: Error Index



PSPB p. 40-42

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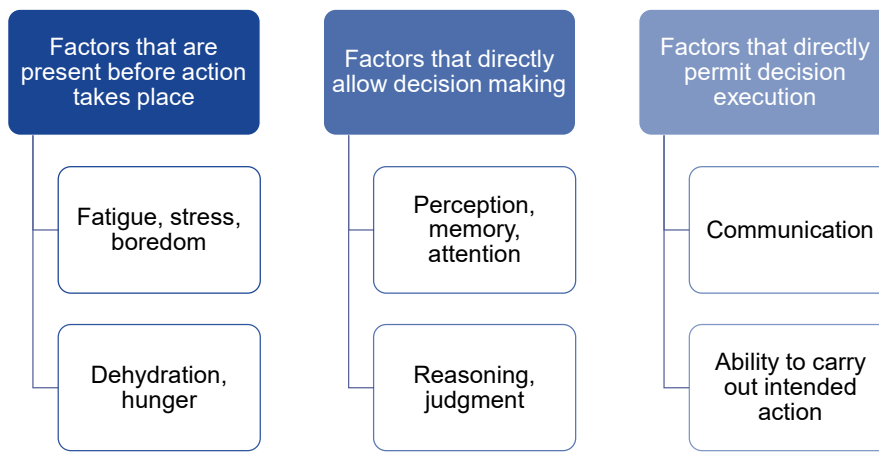
Human Factors

Human Factors

- "We can't change the human condition, but we can change the conditions under which humans work."
  - James Reason, PhD, Author of Managing the Risks for Organization Accidents and Human Errors

105

Issues that Impact Human Performance



Fundamentals p. 130-131
IHI Open School

106

Human Factors and Fatigue

- Fatigue can impact an individual's performance and personality
  - Reduce decision-making ability
  - Prolong response time
  - Increase lapses in attention
  - Negatively affect short-term memory
  - Lessen ability to multitask
  - Increase irritability, moodiness, and depression
  - Decrease ability to communicate

Fundamentals p. 130-131, 351
IHI Open School

107

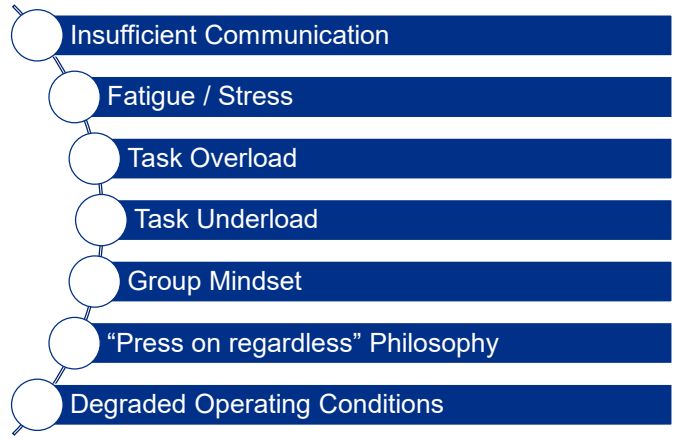
Human Factors: Mental Shortcuts

- Using biases or what is known as "cognitive dispositions to respond", such as:
  - Jumping to conclusions
  - Seeing what is already expected whether actually there or not
  - Bias toward action vs. non-action
  - Overconfidence bias
  - Sunk costs

Croskerry P. Achieving Quality in Clinical Decision Making: Cognitive Strategies and Detection of Bias. Acad Emerg Med 2002; 9:1184-1204.7.
PSPB p. 128

108

Human Factors that Reduce Situational Awareness



PSPB p. 135
https://www.ahrq.gov/teamstepps

109

Human Factors and Cognitive Concepts

- Why Humans Make Mistakes
  - Slips: tend to occur in situations that are so routine that they have become rote
  - Lapses: generally not visible because reflective of a memory failure
  - Mistakes: judgment failures that are more subtle and complex than slips; go undetected for period of time; left to differences of opinion when detected
    - Knowledge based
    - Rule based

PSPB p. 132-133

110

Patient Safety: Human Factors

- Active Failures
  - Highly visible errors with immediate consequences
- Latent Failures
  - May be hidden for years and generally rooted in organizational culture
  - Takes the right set of circumstances for the error to become visible or known

PSPB p. 127

111

Contributing Factors

- Team factors
- Individual staff factors
- Task factors
- Patient factors
- Work environment factors
- Organization and management factors
- Institutional context factors

RCAPB p. 34, 119
Vincent, et al., BMJ 1998

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Strategies to Reduce Human Errors

- Information
  - Warnings and labels
  - Posters
  - Memo's
- Training and education
  - Annual safety test
- Policies and procedures
- Standardization of processes
  - Order sets
- Designs to prevent errors – mistake-proofing



Fundamentals p. 130-131

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Human Error Reduction Strategies

- Simplification of tasks and processes
- Standardization
- Use of constraints and forcing functions
- Reduce reliance on memory
- Reduce reliance on vigilance
- Use of protocols and checklists
- Reduce handoffs
- Reduce need for calculations
- Avoid or reduce fatigue
- Heighten awareness of error prevention through communication and training

Fundamentals p. 130-131, 350-351

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Which of the following is an effective error prevention strategy?

a) Increasing the number of steps in a process
b) Increasing handoffs during a process
c) Developing additional double checks in a process
d) Developing a standardized order set for the process

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Other Patient Safety Concerns

CMS – Hospital Acquired Conditions (HACs)

- CMS to select conditions that are:
  - High cost, high volume or both;
  - Assigned to higher paying DRG when present as a secondary diagnosis; and
  - Could reasonably have been prevented through the application of evidence-based guidelines
- Requires hospitals to submit a claims report for discharges that include any of the selected conditions and to identify if the condition was present on admission (POA).

PSPB p. 63
Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 4 (Feb. 8, 2006)

117

The Joint Commission: Patient Safety Advisory Group

- Identifies the National Patient Safety Goals (NPSGs) and makes recommendations to The Joint Commission
- May recommend retirement of selected NPSGs to maintain the focus of accredited organizations on the most critical patient safety issues
- Reviews draft patient safety suggested actions for potential publication in The Joint Commission's Sentinel Event Alert patient safety advisory

Fundamentals p. 200

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Patient Safety Challenges

- Technology to Improve Patient Safety
  - EHR
  - CPOE
  - Barcoding
  - Robotics
  - A-ICU's
  - Smart Pumps



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AHRQ – PSQIA

- PSQIA of 2005
  - To improve patient safety and reduce the incidence of events that adversely affect patient safety
  - Creates "Patient Safety Organizations" (PSOs)
  - Establishes "Network of Patient Safety Databases" (NPSD)
  - Provides federal confidentiality protections for analyses and reports
  - Is completely voluntary

Fundamentals p. 84-85, 150, 200

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Questions



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TAB 5 - CPHRM Overview

CPHRM Exam Prep Course Overview

Meet your Presenters

Joyce Benton, RN, MSA, ARM, CPHRM, DFASHRM, DSA
- Independent Risk Control Consultant

Doug Borg, MHA, ARM, CPHRM, DFASHRM
- Vice President, Risk & Quality
- Premier Insurance Management Services

Karen Garvey, BSN, MPA/HCA, DFASHRM, CPHRM, CPPS
- Vice President, Safety & Clinical Risk Management
- Parkland Health & Hospital System

Josh Hyatt, DH.Sc, MHL, MBE(C), CPHRM, DFASHRM, HEC-C
- Principal Consultant
- Hyatt Health

Sherrill Peters, BSN, CPHRM, ARM, FASHRM
- Senior Director, Risk Management
- Community Health Systems

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CPHRM Certification

- Confirms, through rigorous examination, that you have mastered the knowledge required for your professional role
- Demonstrates a comprehensive verification of your qualifications
- Requires that you stay current in the field
- Managed by the AHA Certification Center

3

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Eligibility Criteria

Must fulfill both education/healthcare experience AND risk management experience

Education/Healthcare

- Baccalaureate degree or higher plus five (5) years of experience in a healthcare setting or with a provider of services to the healthcare industry
- Associate degree or equivalent plus seven (7) years of experience in a healthcare setting or with a provider of services to the healthcare industry and more…see candidate handbook.

Risk Management

- 3,000 hours or 50 percent of full-time job duties within the last three years dedicated to healthcare risk management in a healthcare setting or with a provider of services (e.g. consultant, broker, attorney) to the healthcare industry

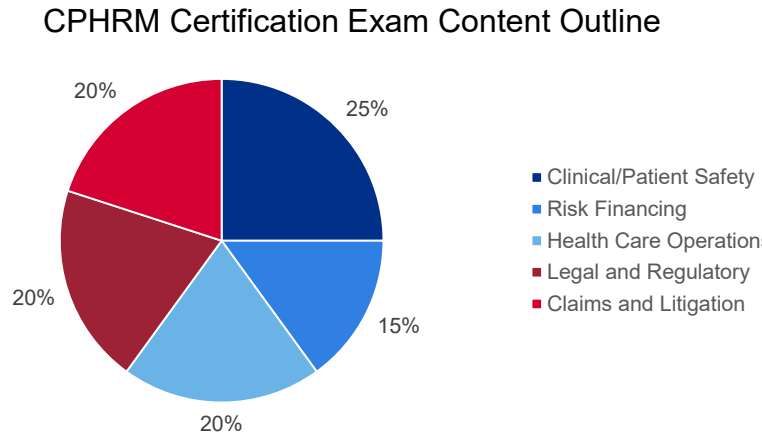
4

What is the Cost of the Exam?

- $275 for members of ASHRM and other American Hospital Association Personal Membership Groups
- $425 for nonmembers
- Each candidate may reschedule once free of charge at least 2 business days prior to a scheduled computer administration (must reschedule within 90 days).
- A second request to reschedule results in a fee of $100

5

What are the Exam Domains?



6

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What Types of Questions are on the Exam?

- 110 multiple-choice questions are on the exam and each has four possible answers.
- Only 100 of the questions are scored; 10 of the questions are “trial” items.

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How is the Exam Administered?

- Each exam is administered throughout the year at over 250 secure computer test sites throughout the United States. Locations of test sites and directions to each site are available on the AHA Certification Center website.
- The exam is administered by appointment only Monday through Saturday, 9:00 am to 1:30 pm (except major holidays).
- To gain admission to take the test, two (2) forms of identification must be presented.
  - Both forms must be current and include the candidate’s current name and signature
  - One must have a current photograph.
- You will have 2 hours to complete the exam.

8

What can I bring into the testing center?

- Personal belongings are not allowed in the testing room
  - Keys, wallet or items required for medical needs are allowed IF they are not used during the exam
  - Bags, watches, purses, hats, coats are not allowed in the testing room at any time
  - If you are found with a personal item, there is the possibility that you forfeit your exam administration
- Calculators are allowed
  - Can NOT be programmable
  - Can NOT have alpha numeric capabilities
  - Cell phone or computer calculator is NOT allowed
- Refer to AHA Certification Center Candidate Handbook for rules

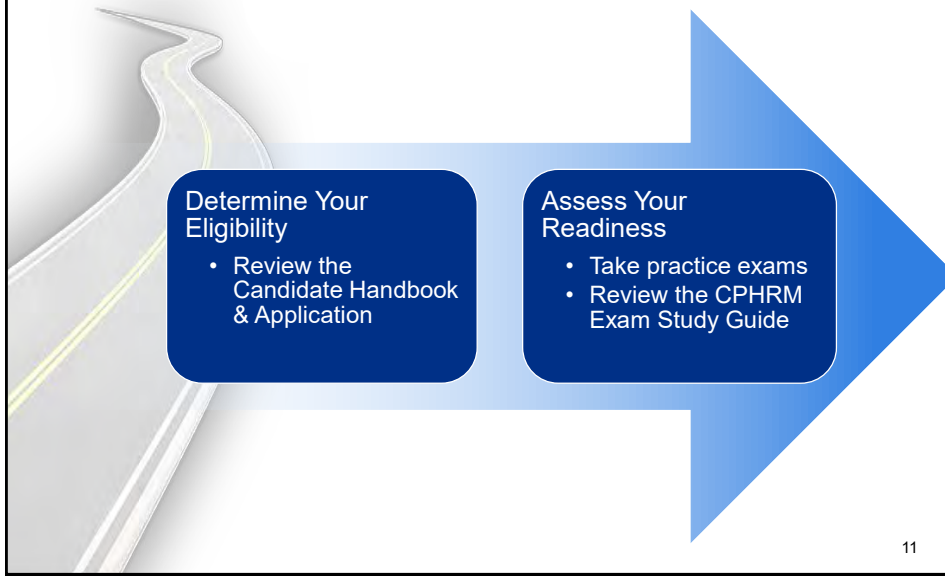
How do test takers know they passed?

- If taking the exam at a PSI testing center, test takers will know if they passed or failed before leaving the center
- A passing score is set for each exam.

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Roadmap to Achieving CPHRM Designation



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Exam Tips

- Tips
  - If you get stuck on a question, skip it and come back later. You only have 2 hours to complete the exam
  - Remember your learning style when developing your study plan
  - Use **multiple** approaches - don't rely on a single study method
  - Recruit a study partner
  - Do a drive-thru of the exam location – where is parking? Alternate route to location?
  - No cramming the night before
  - There is only one right answer
  - Think general risk management, not institution specific

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Resources

- Resources
  - CPHRM Study Guide: www.ashrm.org/pubs
  - Health Care Risk Management Fundamentals: www.ashrm.org/pubs
  - Multiple ASHRM Playbooks: www.ashrm.org/pubs
  - Self Assessment Exam: http://www.aha.org/certifcenter/proginfo/sae.shtml
  - The Joint Commission: www.jointcommission.org
  - NPSF: www.npsf.org

CPHRM Renewal

- Renewal process managed by AHA Certification Center
- Certification is valid for 3 years
- Renewed by retaking and passing the CPHRM examination

OR

- Documenting 45 contact hours of continuing professional education

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Where Can I Find More Information?

- For questions regarding the CPHRM Certification Program, contact the AHA Certification Center
  - Visit http://www.aha.org/aha/Certification-Center/CPHRM
  - Call (312) 422-3702
  - Email certification@aha.org

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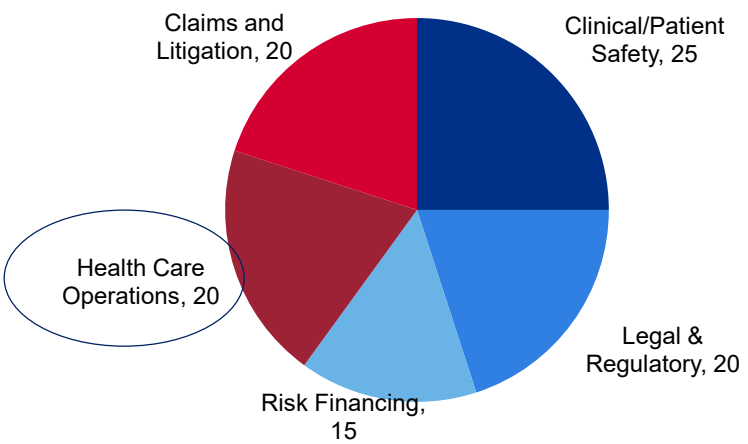
TAB 6 - Health Care Operations

Health Care Operations

ASHRM References Legend

ERMPB	Enterprise Risk Management Playbook
RFPB	Health Care Risk Financing Playbook
Fundamentals	Health Care Risk Management Fundamentals
OBPB	Obstetrical Risk Management Playbook
PSPB	Patient Safety Risk Management Playbook
POPB	Physician Office Risk Management Playbook
RCAPB	Root Cause Analysis Playbook

CPHRM Exam



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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Objectives

- Define enterprise risk management (ERM) and the benefits of an ERM program
- Identify the key components of developing a risk management program, including the risk management professional's role and responsibilities.
- Articulate key issues concerning health care organization governance
- Describe the elements and importance of policy and procedure management
- Discuss various aspects of employee and environmental safety
- Create a list of exposures that deal with organizational advertising liability

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Risk Management

"...the process of making and carrying out decisions that will assist in prevention of adverse consequences and minimize the adverse effects of accidental losses upon an organization. Making these decisions requires the five steps in the decision process (ARM)."

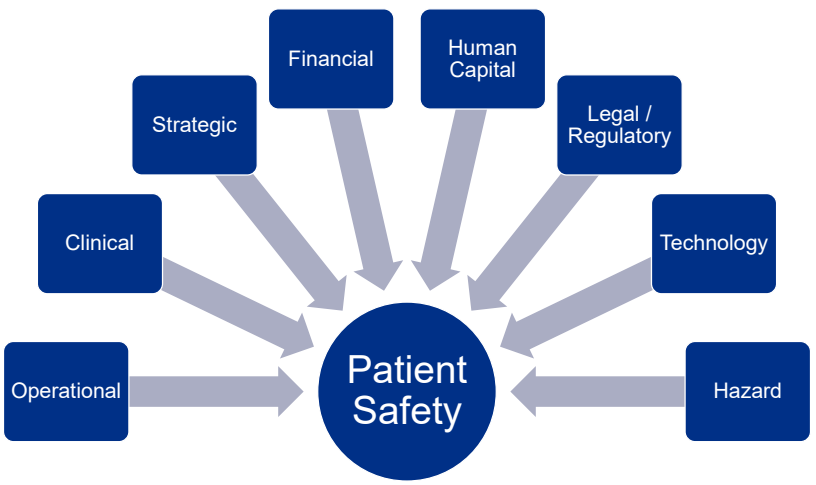
RFPB p. 87
Head G & Horn S, Essentials of Risk Management

ASHRM's ERM Definition

ERM in healthcare promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value.

ERMPB p. 33, 36
Fundamentals p. 14
ERM Pearls

Enterprise Risk Management



ERMPB p. 51
Fundamentals p. 14-18

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Risk Domains

Operational	Risks resulting from inadequate or failed internal processes, people, or systems that affect business operations.
Clinical / Patient Safety	Risks associated with the delivery of care to residents, patients and other healthcare customers, professional liability.
Strategic	Risks associated with the focus and direction of the organization—brand, reputation, competition, failure to adapt to changing times, health reform or customer priorities
Financial	Decisions that affect the financial sustainability of the organization, access to capital or external financial ratings through business relationships or the timing and recognition of revenue and expenses, and other lines of liability make up this domain
Human Capital	This domain refers to the organization's workforce. This is an important issue in today's tight labor and economic markets
Legal / Regulatory	Risks are generally associated with fraud and abuse, licensure, accreditation, product liability, management liability, Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoPs) and Conditions for Coverage (CfC), as well as issues related to intellectual property.
Technology	This domain covers machines, hardware, equipment, devices and tools, but can also include techniques, systems and methods of organization.
Hazard	This ERM domain covers assets and their value. Traditionally, insurable hazard risk has related to natural exposure and business interruption. Specific risks can also include risk related to: facility management, plant age, parking (lighting, location, and security), valuables, construction/renovation, earthquakes, windstorms, tornadoes, floods, fires.

ERMPB p. 52, 60-61
Fundamentals p. 14-18

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Benefits of an ERM Program

- A strategic, organizational framework for managing risk
- Understanding relationships (correlations) between risks
- Efficient and effective treatment of risks
- Risk prioritization
- An understanding and assessment of future risks
- A common risk taxonomy

ERMPB p. 36-37
Fundamentals p. 36
ERM Pearls

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Benefits of an ERM Program

- Promotion of transparency
- Support for board educational initiatives and framework for meeting financial disclosure requirements
- Better decision-making
- Allocation of limited resources
- Success of regulatory and compliance initiatives
- Formal linkages

ERMPB p. 36-37
Fundamentals p. 36
ERM Pearls



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ERM in healthcare promotes a comprehensive framework for making risk management decisions by maximizing which of the following?

a) Value continuum
b) Value initiatives
c) Value appropriation
d) Value creation

ERM Playbook and ERM White Papers

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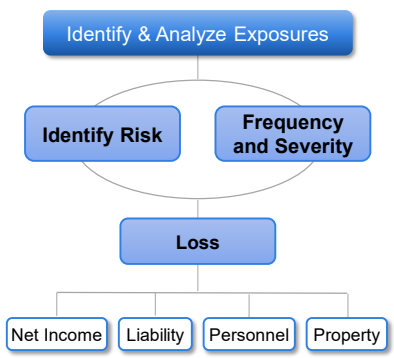
Risk Management Process



ERMPB p. 87-91
Fundamentals p. 45-50

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Risk Management Process



First…

- Identify **what** is at risk, **why** it is at risk, and **how** that loss will impact the organization.
- Type of value exposed to loss
- Potential cause of loss (peril)
- Extent of projected financial consequences of the loss

Resulting data is used to:

- Classify exposures (ERM domains)
- Prioritize resources
- Drive strategic agenda

ERMPB p. 55
RFPB p. 87
Fundamentals p. 12, 45-46, 66-67

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Systems for Risk Identification

Formal and Informal Risk Identification

- Informal Risk Identification Systems
  - Claims data
  - Medical record requests
  - Patient complaints
  - Standardized surveys and questionnaires
  - Personal inspections and walk-rounds
  - Committee minutes

RFPB p. 87
Fundamentals p. 75

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Systems for Risk Identification

Formal and Informal Risk Identification

- Informal Risk Identification Systems
  - Survey or regulatory reports
  - Recall notices
  - Experts (internal and external)
  - Hotline or grapevine
  - Collaborative relationships



RFPB p. 87
Fundamentals p. 75

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What is the main reason to have a patient grievance process?

a) Decreased litigation and claims
b) Regulatory compliance
c) Patient rights
d) Protection of the organization

Fundamentals p. 198-199

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Systems for Risk Identification

Formal and Informal Risk Identification

- Formal Risk Identification Systems
  - Incident reporting
  - Occurrence reporting and screening
  - Sentinel event tracking
  - Failure mode, effect and criticality analysis
  - Device reporting and tracking logs

RFPB p. 87
Fundamentals p. 12, 45-46, 67-68

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Systems for Risk Identification

Formal and Informal Risk Identification

- Formal Risk Identification Systems
  - Security reports
  - QI reviews
  - Peer review data
  - Root cause analysis
  - Never events tracking

RFPB p. 87
Fundamentals p. 12, 45-46, 67-68

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Incident Reporting

- Incident definition
  - Any happening that is not consistent with the routine care of a particular patient or an event that is not consistent with the normal operations of a particular organization
- Injury is not a requirement – “near harm” events should be reported as well

Fundamentals p. 12, 66-72, 74, 76

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Incident Reporting

- Reporting systems should include a process for structured follow-up and referral to quality improvement efforts to improve safety.
  - Sentinel Events
  - Root Cause Analysis
  - FMECA



Fundamentals p. 12, 66-72, 74, 76

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Which of the following has significant impact on whether incident reports are discoverable?

a) TJC Standards
b) State Statutes
c) Federal Guidelines
d) Organization Policies

Fundamentals p. 76-77

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Risk Assessments

- Structured approach
  - High-risk areas or activities
  - New services, procedures or technology

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Risk Assessments

- Common elements
  - Staff interviews
  - Tour of physical space
  - Review of policy/procedure or documentation
  - Observation

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Risk Assessments

- Benchmarking
  - Accreditation and regulatory specifications
  - State/national professional and clinical standards



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Which of the following is NOT a benefit of an external benchmarking project?

a) Learn about the problem solving methods used by other teams
b) Use the resources of internal experts to assess and identify the requisite skills of external experts
c) Learn information about competitors that can be used to gain an advantage in the marketplace
d) Facilitates comparisons between corporate cultures and may identify administrative/leadership development needs

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Risk Analysis

- Taking a closer look…
  - Consistent coding
  - Aggregation and analysis of trends
  - Identification of high-risk behaviors and failed systems

Fundamentals p. 77-80, 85-94

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Risk Analysis

- Taking a broader view…(ERM)
  - The potential severity of the loss associated with an identified risk
  - The probability that such a loss will occur
  - The frequency of such a loss

Fundamentals p. 77-80, 85-94

Risk Ranking Process

Risk Ranking Overview

- Provide an initial means of prioritizing assessed risks based upon assessments of **Impact** and **Likelihood**.
  - Risks were assessed assuming the effectiveness of existing risk management activities.
- Used to identify a risk's position on a **Risk Map**.

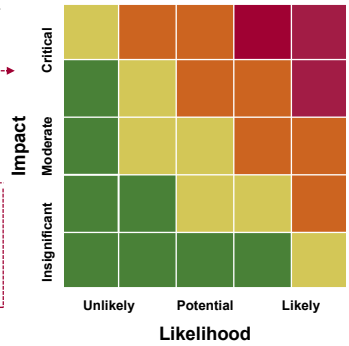
Risk Ranking Calculation Steps

- Multiply the **Impact** and **Likelihood** for each risk.
- Reference the product against a range of values.
- Assign one of four risk rankings (very high, high, medium or low) based upon referenced range.

Risk Ranking

Rank	Range
Very high	Greater than ***17.0***
High	Greater than ***10.0***, but less than ***17.0***
Medium	Greater than ***5***, but less than ***10.0***
Low	Less than ***5.0***

Risk Ranking Matrix



ERMPB p. 62-65, 80; RFPB p. 155

Sample Risk Assessment Scales: Likelihood

Rating	Description	Characteristics
5	Almost Certain/ Already Occurring	• In System/Process: Knowledge-based decisions by trained person • Controls: Not working/may not exist • Expected to Occur: Daily/weekly
4	Likely	• In System/Process: Rule-based decisions by trained person • Expected to Occur: Annually
3	Potential	• In System/Process: Automated or controlled by trained person • Controls: Preventative, not detective • Expected to Occur: Every 2 – 5 years
2	Unlikely	• In System/Process: Highly automated with validation and monitoring • Expected to Occur: Every 5 – 20 years
1	Rare	• Controls: Preventative and detective • Not expected to occur

ERMPB p. 78

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Sample Risk Assessment Scales: Impact

Rating	Financial	Patient Safety	Operations/Process	Reputational	Legal/Regulatory
5 Critical	• Cash: Results in <20 days cash on hand • Property damage: >$250,000 • Key contract loss • Loss of business	• Death/permanent disability • Event: Suicide/rape/ child abduction	• Significant labor relations event • Workplace safety: multiple lost time injuries/recordable incidents • PHI/PI Breach: >100	• Significant brand impairment; loss of significant market share • Sustained, negative media coverage • Customer satisfaction: <85%	• Loss of license • State/Federal investigation
4 Major	• Cash/expense: $150,000 • Property damage: $100,000 - 250,000 • Additional unexpected capital required	• Substantiated boundary or code of conduct incident • Major or critical health incident • Non-compliance with Standard of Care	• Loss/significant turnover of key personnel • IT systems disruption • Workplace safety: Lost time and recordable incidents • PHI/PI Breach: <100	• Temporary but significant negative media coverage • Customer satisfaction: 85-88%	• State/Federal inquiry (not investigation)
3 Moderate	• Cash/expense: $50,000 • Property damage: $10,000–100,000	• Upward trend in minor health incidents • No clinical continuity	• Loss of or increased turnover in key positions • Operational disruption or increased costs due to regulatory change	• Negative media mention (state) • Customer satisfaction: 88-90%	• Corporate non-compliance with financial impact • Insurance access implications
2 Minor	• Cash/expense: $10,000 • Property damage: <$10,000	• Minor health incidents; patient not knowledgeable of failure	• Distraction in employee base	• Customer satisfaction: 90–94%	• Minor violations (e.g., auto)
1 Insignificant	• Insignificant property damage or impact to cash	• No impact on the delivery of care		• Customer satisfaction: >95%	

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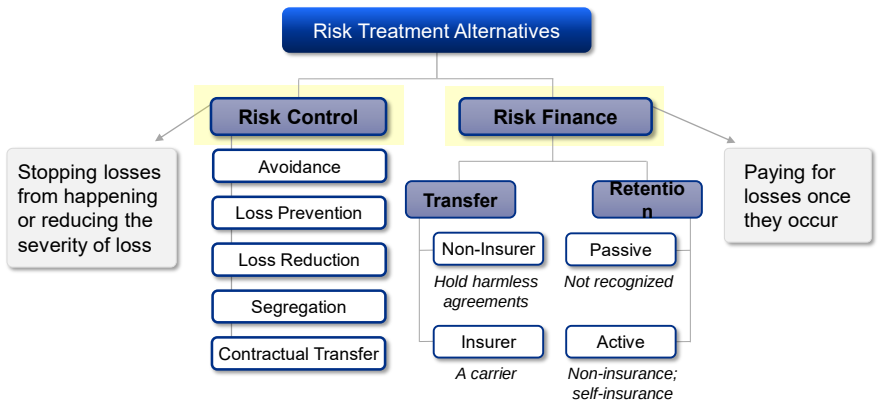
Sample Formulas

Likelihood	x	Impact	=	Risk Score
(a value 1 to 5)		(a value 1 to 5)		
1	x	1	=	1 (lowest possible score)
5	x	5	=	25 (highest possible score)

(Likelihood	+	Velocity)	x	Impact	=	Risk Score
(a value 1 to 5)		(a value 1 to 3)		(a value 1 to 5)		
(1	+	1)	x	1	=	2 (lowest possible score)
(5	+	3)	x	5	=	40 (highest possible score)

ERMPB p. 78

Structure of the Risk Management Process



Fundamentals p. 46-49
RFPB p. 88-90, 142

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Addressing the Risk

Examination, Selection, and Implementation of Alternative Risk Treatments

- **Risk Control** - stopping losses from happening or reducing the severity of the loss
- **Risk Financing** - paying for losses once they occur

Fundamentals p. 77-80, 85-94
RFPB p. 88-90

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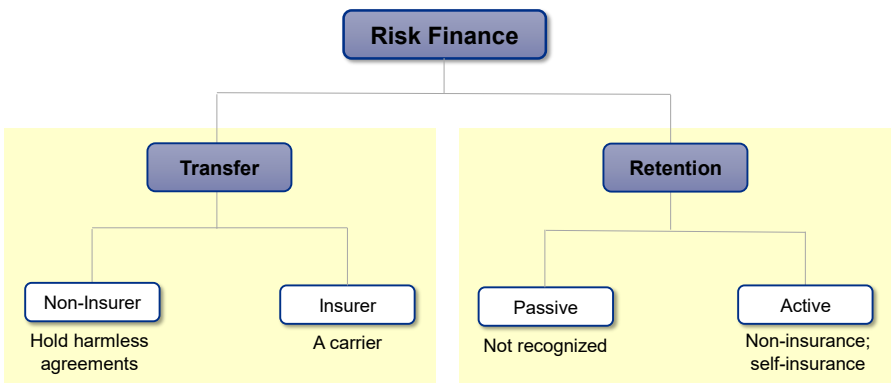
Risk Control Techniques

Risk Avoidance	• Never undertaking risk
Loss Prevention	• Reduce an organization's losses by lowering their frequency and reducing the possibility of a loss
Loss Reduction	• Reduce the severity of the losses that occur
Segregation	• Separation or duplication of loss exposure
Contractual or Non-Insurance Transfer	• As stated

RFPB p. 88-89

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Risk Financing Techniques



Fundamentals p. 47-49, 243-244
RFPB p. 88-90

Selecting & Implementing the Chosen Technique

Consider the following when deciding which technique(s) to implement:

- Organizational culture
- Implementation barriers
- Available resources
- Techniques/programs already in use

Fundamentals p. 50, 91-94, 161
RFPB p. 90-91

Evaluating & Monitoring the Chosen Technique

- Evaluate the chosen strategy
  - How will success or failure be determined?
- Establish a current baseline
- Set appropriate evaluative benchmarks for each risk
- Assign a responsible party to implement and monitor the strategy
- Monitor the external environment and evaluate emerging risk

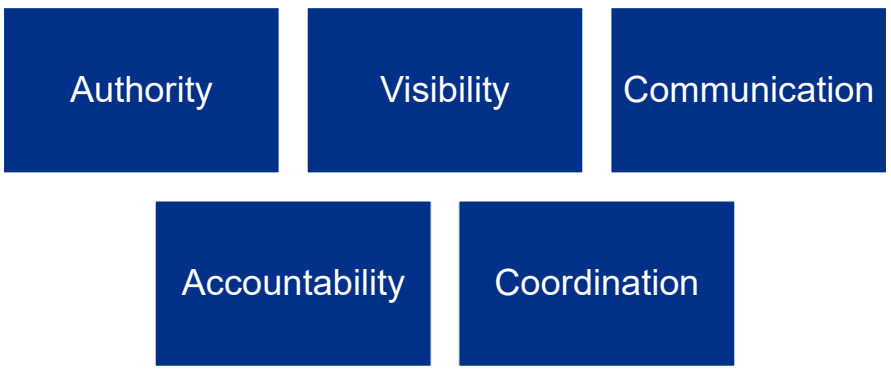
Fundamentals p. 50, 91-94, 161
RFPB p. 90-91

Risk Management Programs

- Risk Management program exist in a wide spectrum of settings
- Structure, and function vary widely
  - Organizational Culture/Philosophy
  - Type/Size/Location
  - Delivery Setting
  - Scope of services and activities
  - Available resources

Fundamentals p. 38-45, 50-57

Key Elements



Fundamentals p. 38-40

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Role of the Risk Manager

Required Skills

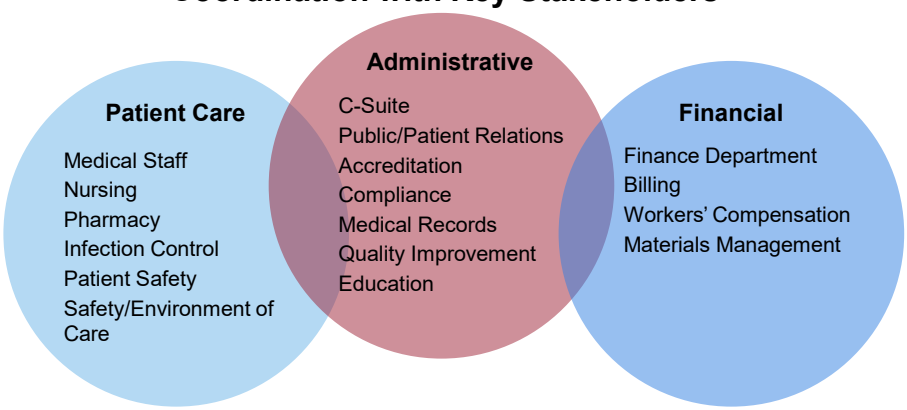
- An effective Risk Manager must be able to…
  - Communicate effectively
  - Negotiate
  - Remain objective/non-judgmental
  - Respect confidentiality
  - See the "big picture"
  - Maintain competence

Fundamentals p. 21-34, 63-66

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Key Relationships

Coordination with Key Stakeholders



Fundamentals p. 40-45

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Risk Management Program: Getting Started

Key components to consider

- Organizational commitment
  - Written statement/goals & objectives
  - Position descriptions/staffing resources
  - Policies & procedures

Fundamentals p. 58-59
RFPB p. 143-145
ERMPB p. 96

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Risk Management Program: Getting Started

Key components to consider

- Develop a risk management plan
  - Program description & objectives
  - Scope of program/components
  - Metrics
- Build a supportive Risk Management team

Fundamentals p. 58-59
RFPB p. 143-145
ERMPB p. 96

Policies and Procedures

- Establish standard of care
- Periodic review and update
- Consistent format
- Include dates of implementation and all revisions

Fundamentals p. 185, 363

Policies and Procedures

- Archive and retain outdated policies
- Must reflect reality
- Aligned with legal and regulatory requirements
- Ongoing in-service education

Fundamentals p. 185, 363

Policies and Procedures

Important Issues that Impact Liability Exposure:

- Informed consent
- Documentation
- Technology
- Privacy & confidentiality
- Disclosure & apology
- Acceptance of legal documents

Fundamentals p. 185, 363

Education

Key risk control activity

- General Risk Management education at orientation and annually thereafter
- Specific education developed to address issues as they arise

Fundamentals p. 101

Education

Issues that may require focused educational effort:

- Patterns of adverse events
- Changes in legal/regulatory environment
  - Patient rights
- New/emerging risks
  - Telemedicine
- High-risk or chronic problem areas
  - Informed consent
  - Documentation
  - End-of-life decision-making

Fundamentals p. 101

Addressing Organizational Exposures: Governance

- Governing Boards – Potential Liability
- Directors & Officers' Liability Prevention
  - Determination of potential areas of board liability exposure: discrimination, hazardous management, medical staff
  - Assessment of the degree of liability exposure in such areas: credentialing and privileging (physicians PL insurance limits and type of policy coverage; objective, non-arbitrary, etc.)

Addressing Organizational Exposures: Governance

- Governing Boards – Potential Liability
- Directors & Officers' Liability Prevention
  - Advertising liability: False advertising, copyright/trademark infringement
  - Implementation of corrective action to minimize liability exposure in high risk areas or activities: revise policies and procedures

Addressing Organizational Exposures: Crisis Management

When the "Worst" happens…

- Preparation
  - Solid plan
  - Role Delineation
- Education/Training

Addressing Organizational Exposures: Crisis Management

When the “Worst” happens…

- Early Recognition
- Communication
- Strong Response
- Managing the Media

Addressing Organizational Exposures: Credentialing & Privileging

- Accreditation & regulatory requirements
  - TJC & DNV
  - CMS Conditionals of Participation

Addressing Organizational Exposures: Credentialing & Privileging

- Patient Safety
  - Ensuring adequate training and continued competence
- Fiduciary & Legal Duty
  - Hospitals' ultimate responsibility

Addressing Organizational Exposures: Peer Review

- Historical perspective on outcomes
  - Providers have always policed themselves
- Hospital Peer Review Committees
  - Responsibility to adjudicate clinical competence
  - Recommendations relating to privileges made to governing board

Addressing Organizational Exposures: Peer Review

- Plaintiff's bar and discoverability
  - Demand for data created a negative impact
  - State statutes and protection vary widely
- Committee structure & reporting relationships key

Addressing Organizational Exposures: Workplace Violence

Addressing the issue:

- Identify gaps
  - Physical security
  - Staff & community education

Addressing Organizational Exposures: Workplace Violence

- Develop & test response algorithms
  - Clarify roles
  - Work collaboratively
    - Between departments
    - Community resources
    - Local law enforcement

Questions



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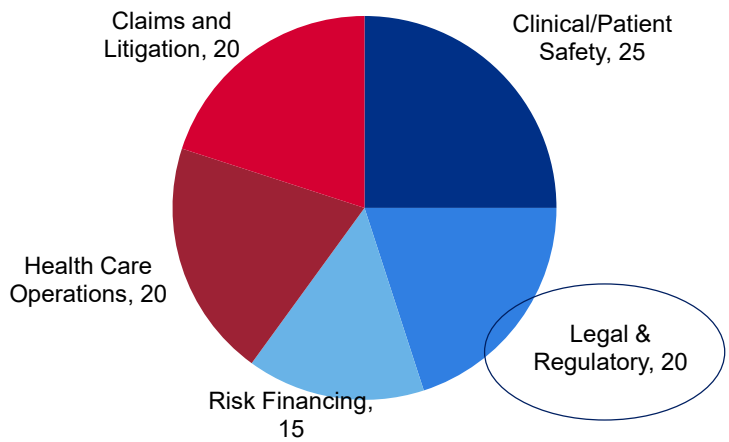
TAB 7 - Legal & Regulatory

Legal and Regulatory

ASHRM References Legend

ERMPB	Enterprise Risk Management Playbook
RFPB	Health Care Risk Financing Playbook
Fundamentals	Health Care Risk Management Fundamentals
OBPB	Obstetrical Risk Management Playbook
PSPB	Patient Safety Risk Management Playbook
POPB	Physician Office Risk Management Playbook
RCAPB	Root Cause Analysis Playbook

CPHRM Exam



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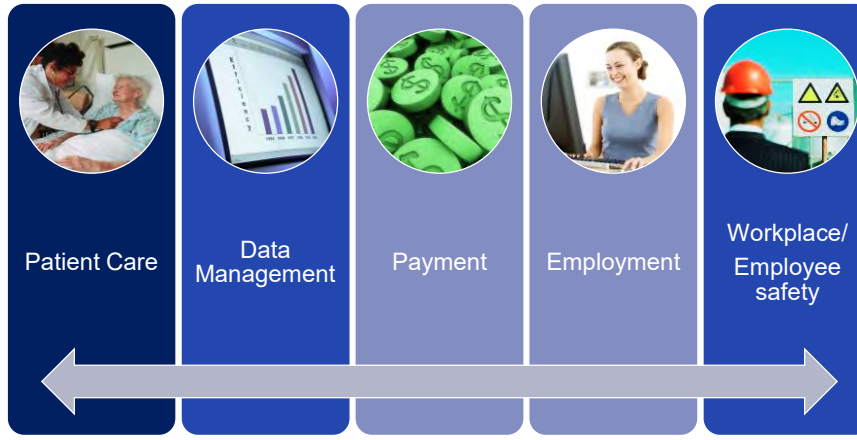
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Objectives

- Examine the value of ethics as a cornerstone in the delivery of health care
- Describe the informed consent process and its impact on patient care
- Summarize key regulations and laws that govern patient care, data management, payment, employment, and workplace safety in the health care environment
- Discuss accreditation, licensure and surveying bodies and the value of participating

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Statutes, Standards and Regulations



Fundamentals p. 171-217

4

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Types of Law

Statutory law	• Enacted by congress and approved by the president.
Administrative law	• Regulations and rules developed and implemented by a federal or state agency to provide direction for carrying out the purposes of the Acts it oversees.
Case law	• (Common law) Judicial interpretation of a statute or established court precedent.

Fundamentals p. 179-181

5

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Ethical Principles

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Ethical Issues

Created by the collision of:

- Law
- Medicine
- Biotechnology
- Business
- Philosophy
- Religion

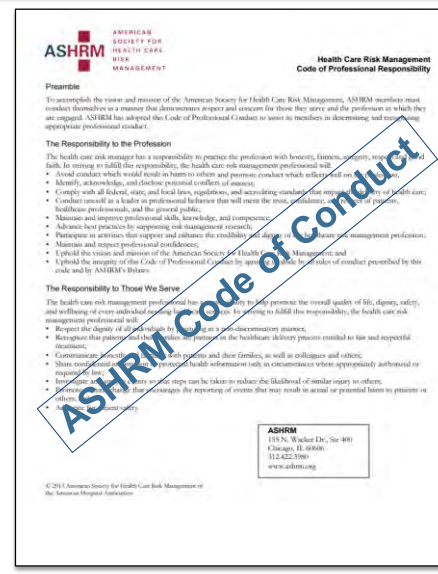


Fundamentals p. 210

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Ethics Basics

- Ethical principles and moral obligations
- Societal policy
- ASHRM Code of Professional Responsibility
- AMA's Principles of Medical Ethics (www.ama-assn.org)


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Health Care Risk Management
Code of Professional Responsibility

Preamble

The Responsibility to the Profession

The Responsibility to Those We Serve

ASHRM

ASHRM Code of Conduct

Fundamentals p. 66

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Ethical Principles

1 Autonomy

Ability to make decisions without undue influence

2 Beneficence

To do good and protect from harm

3 Non-maleficence

To avoid causing harm or prohibition against cruel treatment

4 Justice

Fairness and equal distribution of healthcare, non-discriminatory care

Fundamentals p. 210

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Moral Obligations

Obligations to patients include:

- Respect patient's privacy and protection of confidentiality
- Communicate honestly about all aspects of the patient's diagnosis, treatment and prognosis
- Determine whether patient is capable of sharing in decision-making
- Conduct an ethically valid process of informed consent



Fundamentals p. 173-177, 206-209

Ethical Issues in Patient Care

Advance Directives

Do-Not-Resuscitate (DNR) Orders

Research — *Belmont Report* | *Nuremburg Code* | *Declaration of Helsinki*

Institutional Review Boards (IRBs)

Informed Consent

Fundamentals p. 210

Patient Self-Determination Act

Elements of this act include:

- Provide written information to all adult patients on admission
- Document appropriately in the medical record
- Do not condition the provision of care on the execution of an advance directive
- Educate the staff and the community
- Comply with state law regarding patient rights



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Advance Directives

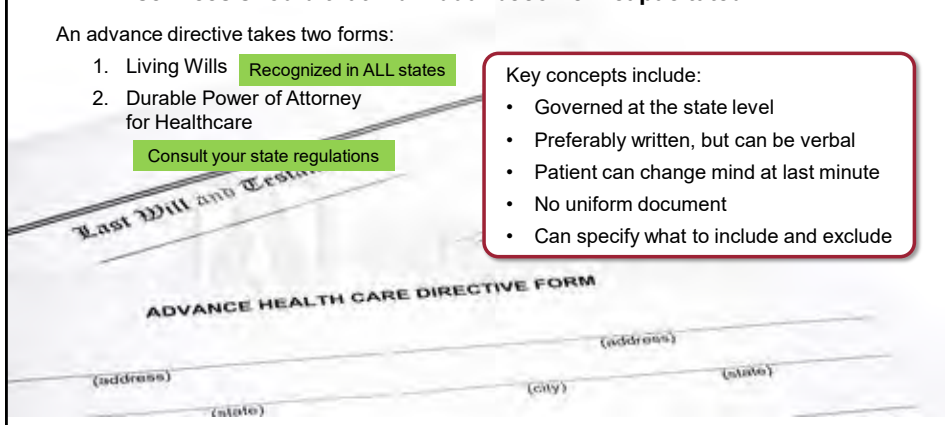
Legal document that outlines a person's wishes concerning healthcare services should that individual become incapacitated.

An advance directive takes two forms:

1. Living Wills — Recognized in ALL states
2. Durable Power of Attorney for Healthcare — Consult your state regulations

Key concepts include:

- Governed at the state level
- Preferably written, but can be verbal
- Patient can change mind at last minute
- No uniform document
- Can specify what to include and exclude



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Do Not Resuscitate

Key elements include:

- Governed at the state level
- Requires a physician order
- Documented in the medical record
- Requires clear policy and procedure
- Documented education of patient, family and staff
- Does not require advance directive
- May be rescinded for surgical interventions

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Which of the following is an example of advance medical directives?

A. Living will
B. Durable power of attorney for finances
C. Physician's do not resuscitate (DNR) order
D. Legal guardianship papers

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Patient Care

Withholding and Withdrawing Treatment

Life-sustaining treatment is any treatment that serves to prolong life without reversing the medical condition.

Needs to be addressed clearly in your facility's policy and procedures.

Examples of such treatment:

- Intubation
- Mechanical ventilation
- Renal dialysis
- Artificial nutrition and hydration
- Antibiotics
- Blood and blood products

17

Capacity

Patients must be able to understand their medical condition and consequences of decisions made in providing care.

There are several considerations:

- Normally determined by the physician
- Presumed unless there is reason to question
- May come and go; act as close to time of capacity as possible
- Normally not questioned as long as health care providers and patient's family agree
- Of age (varies by state and circumstances)

POPB p. 36

18

Surrogates of Patients

Definition: A surrogate is an individual legally authorized to make health care decisions on behalf of a patient who is unable to make or communicate decisions.

Examples of surrogates:

- Common law next-of-kin
- Durable power of attorney for health care



19

Non-Beneficial Medical Interventions

Definition: During palliative care, medical interventions can become non-beneficial when the burden of having the intervention outweighs its benefits, or the use of the medical intervention goes against patient's wishes.

Quality of life is defined by the **patient's** values.

Physicians do not have obligation to deliver care that will not have a reasonable chance of benefiting the patient.

Physicians are not required to violate their own ethical or religious beliefs.

Clinical staff may decline only for reasons of "conscience."

20

Health Care Disparity & Cultural Competency Measures

- The National Quality Forum endorsed 45 best practices to deliver culturally appropriate and patient-centered care.
- Issues addressed:
  - Promotion of equitable, high-quality, and compassionate care for all patient populations across health care delivery systems.
  - Communication
  - Community engagement
  - Workforce training

Fundamentals pp. 132, 154

21

Culturally Appropriate Care

The Joint Commission (TJC) set requirements to advance effective communication, cultural competence, and patient-centered care.

- Effective since January 1, 2011
- Incorporates diversity, language, culture, and health literacy into current standards

Requirements addressed:

- Effective communication
- Equitable treatment
- Accommodation of patient's cultural, religious, spiritual needs, and beliefs
- Non-discrimination in care
- Staff training in cultural sensitivity

Fundamentals pp. 76, 132, 154

22

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Ethics and the Law



Legal Decisions

Mandated by case law or statutes



Ethical Decisions

Best for the common good, exceeds what is required by law

Fundamentals p. 173

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Karen Ann Quinlan 70 NJ 10 (1976)

Case Name	Description	Issues	Outcomes
Karen Ann Quinlan 70 NJ 10 (1976)	• 21 year old collapsed at party after taking valium while drinking and dieting. • Doctors saved her. • She remained in coma for 10 years in New Jersey nursing home. • Family battled to remove life support equipment. Family won, equipment was removed and she remained alive for 10 years.	• Legal vs. common death • Patient's wishes • Right to Privacy	• Established Ethics Committees • Led to creation of Advanced Directives

24

Cruzan v. Director, Missouri Dept. of Health (1990)

Case Name	Description	Issues	Outcomes
Cruzan v. Director, Missouri Dept. of Health 497 U.S. 261 (1990)	• 25 year old Missouri female involved in car accident • In persistent vegetative state in skilled nursing facility (SNF) • Years later, parents wanted to withdraw nutrition & hydration • Nursing home demanded court order – case entered legal system • Trial court support parents; SNF appealed • Missouri Supreme Court overturned trial court- needed clear & convincing evidence • Went to Supreme Court- right to refuse treatment • Back to trial court • Family prevailed (after 10 years)	• 14th Amendment to U.S Constitution grants each person the right to refuse unwanted medical treatment- the principle of autonomy • "Clear & convincing' evidence (of wants/ don't wants) comes from the patient.	Developed Patient Self Determination Act (similar to Schiavo case)

25

Stamford Hosp. v. Vega (1995)

Case Name	Description	Issues	Outcomes
Stamford Hospital v. Vega (1995) 236 Conn. 646	• Patient was Jehovah Witness • Began hemorrhaging after delivering a baby and needed blood transfusion to save her life • She declined blood/blood products due to religious preferences • Court order was filed and granted • Was transfused against wishes and survived	Question of Interests Over Patient Refusal of Blood - 3 sets of interest: 1. Patient: • Common law right to self-determination • Federal right to self-determination • Constitutional right to exercise religious freedoms (federal and state) 2. Hospital: • Preserving patient's life • Protecting ethical integrity of the healthcare profession 3. State: • Preservation of life • Protection of an innocent third party • Prevention of suicide • Maintenance of the ethical integrity of medical profession	Theory of 'battery' resulted

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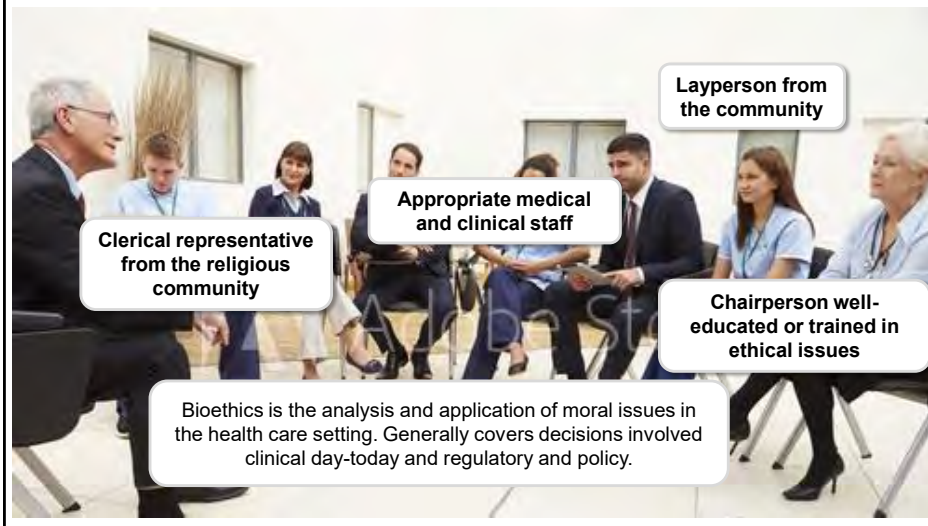
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Schlinder v. Schiavo (2005)

Case Name	Description	Issues	Outcomes
Schlinder v Schiavo (2005) FL	• Went into cardiac arrest secondary to electrolyte imbalance related to dieting strategy • Never regained consciousness • Remained on ventilator • Husband knew patient would not want to continue life sustaining measures • Husband entered a DNR order; SNF convinced him to remove it • Husband wanted to remove feeding tube- was opposed by parents • Parents desire to remove spouse as guardian • Life support was removed; expired due to dehydration • Case involved 14 appeals, numerous petitions	• Conflicting interests: • State • Parents – desire to remove spouse as guardian • Spouse – desire to support patient wishes	• Withdrawal of life support • Support of patient's wishes

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Ethics Committee



Fundamentals p. 66

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Ethics Committee & Risk Manager

The risk manager should:

- Develop an ethics consultation mechanism
- Act as a consultant on legal issues
- Serve as a facilitator
- Be a neutral party during discussions

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Ethics Committee Topics

Some of the more common topics that may be brought before an ethics committee include:

- Abortion and reproductive rights
- End-of-life or futile care
- Quality of life
- Surrogate decision-making
- Advance directives
- DNRs
- Medical resources
- Staff rights that conflict with patient wishes

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Ethics consultations and decision-making done systematically will help to ensure that ethical principles are met. Which of the following is an example of this approach?

a) Verification of the facts and assumptions of the participants
b) Documentation of the full conversation that was had to reach a decision
c) Unanimous agreement among the participants
d) Identification for the potential legal and ethical problems that may be involved

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Regulatory Oversight in Patient Care

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Informed Consent

- Introduction
  - Consent is a communication process, not merely the completion of a form
  - Consent is influenced by:
    - Federal law
    - State law
    - Case law
  - Failing to obtain consent may result in punitive damages and charges of unprofessional conduct

Fundamentals p. 173

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Informed Consent

- Risk Management Approach to Consent or Treatment
  - Policies and procedures
  - Risk identifiers
  - Education
    - Must recognize state-specific exceptions
  - “Family-focused” consent process is encouraged
  - Documentation

Fundamentals p. 178
POPB p. 32-33

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Informed Consent

6 basic elements	Disclosure of the nature and purpose of the test or treatment
	Description of the probable risks and benefits
	Explanation of risks and benefits of alternatives
	Risks and benefits of foregoing the test or treatment
	Opportunity for questions and understandable answers
	Opportunity to make a decision free of coercion and undue influence

Fundamentals p. 174
OBPB p. 251-253
POPB p. 34-35

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Informed Consent

- Exceptions from the General Rules of Consent
  - Emergency treatment exception
  - Therapeutic privilege exception
  - Compulsory treatment situation

Fundamentals p. 175
POPB p. 36-37

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Informed Consent

Importance of an Informed Refusal of Care

- Patient or recognized decision-maker must have mental capacity
- Inform patient of consequences of refusal of proposed test or treatment
- Document discussion with patient or recognized decision-maker
- Patients and decision-makers have the right to withdraw consent

Fundamentals p. 176-177
OBPB p. 253-254
POPB p. 37-38

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Informed Consent

- Needs of Specific Patients in the Informed Consent Process
  - Preliminary screening to identify special patients
  - Patients who warrant special considerations
    - Minors
    - Mentally disabled or challenged persons
    - Patients undergoing testing or treatment for certain diseases such as HIV, blood transfusion, or breast cancer
    - Research patients – have a specific process and form that must be followed

Fundamentals p. 176-177
OBPB p. 254
POPB p. 37

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Informed Consent

- Results of a Breakdown in the Consent Process
  - Battery
  - Negligent consent
  - Misrepresentation or deceit
  - Breach of contract
  - Corporate liability

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Medicare Conditions of Participation Conditions for Coverage

(Also known as CoP, CfC)

Purpose: Provides minimum health and safety standards for providers and suppliers that they must meet for initial and continued Medicare and Medicaid certification.

Details: Rules apply to twenty different health care settings and categories of providers: hospitals, rural health facilities, outpatient service providers, nursing facilities, home health, critical access providers, etc.

Fundamentals p. 197-198

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CoPs for Hospitals

- Quality assessment and performance improvement
- Medical staff
- Nursing services*
- Physical environment
- Infection control*
- Surgical services
- Governing body
- Patient's rights*
- Medical record services
- Pharmaceutical services
- Radiological services
- Laboratory services
- Food and dietetic services
- Long-term care (LTC) services (swing beds)
- Psychiatric hospitals: special medical record and staff requirements

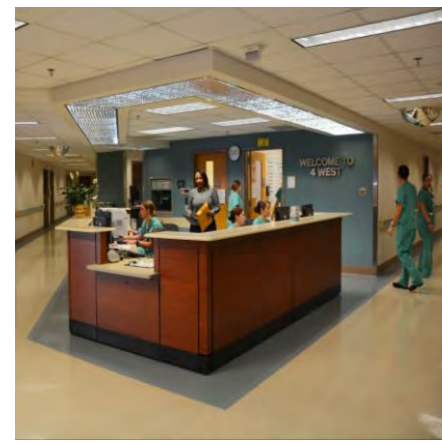
Fundamentals p. 182-183, 194-195, 197-198

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CoP: Nursing Services

Defines operational elements of a nursing service that includes the following mandates:

- Staffing and staff supervision
- Developing and implementing nursing care plans
- Staff competency assessment
- Medication administration
- Reporting blood transfusion reactions, adverse drug reactions, and medication errors



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CoP: Infection Control

Requirements include:

- Designating infection control officer
- Developing policies to address identifying and controlling infections and diseases
- Developing and maintaining a log system
- Delegating responsibility and accountability onto hospital CEO, medical staff, and director of nursing services for:
  - Ensuring hospital-wide QI and training to address issues identified by the infection control officer
  - Implementing corrective action plans in problem areas

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CoP: Surgical Services

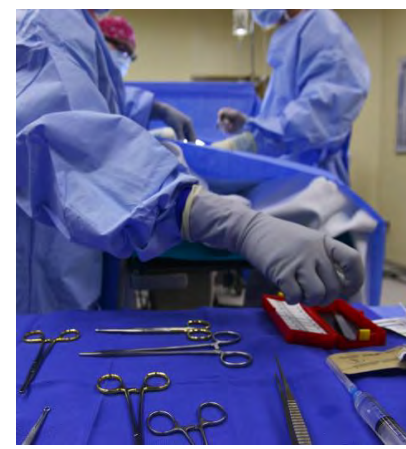
Surgical services must be well-organized and provided according to standards of practice.

Scope of the Services

- Staffing
- Duties of staff
- Surgical privileges

Delivery of Service

- Medical history and physical examination
- Informed consent form for the operation
- Post-operative care
- Operating room register
- Operative report



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CoP: Patient's Rights

Notice of Rights

Informing patients of their rights in advance of furnishing or discontinuing care

Privacy and Safety

The right to personal privacy and care in a safe environment

Complaint and Grievance Process

Informing patients of their right to complain and how to do so

Confidentiality of Medical Records

Patient's rights to privacy of electronic medical records and access to own records

Exercise of Rights

Advise patients of rights in participating, making informed decisions, being informed of health status, and advanced directives

Restraint or seclusion

Defining restraint, conditions when it can be used, monitoring of any restraint and seclusion, reporting of any resulting deaths

POPB p. 235-236

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CoP: Complaint & Grievances

- Standards are set by Medicare that hospitals must follow to manage complaints and grievances.
- Standards must ensure:
  - Families are informed of rights to present complaints and the mechanism to do so; by issuing a complaint it does not compromise patient's future access to care
  - Analysis of complaints and appropriate action is taken to correct the issues
  - A response is sent to each patient/family which addresses the complaint

Fundamentals p. 198-199

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Medicare & Hospital-Acquired Conditions

Deficit Reduction Act of 2005

Purpose: Since October 1, 2008, Medicare will not pay hospitals at a higher rate for increased costs of care that result in patient harm caused by a Hospital-Acquired Condition (HAC).

Enacted due to: High cost and high volume of HACs

Higher Medicare Severity Diagnosis Related Group (MS-DRG) = reimbursement

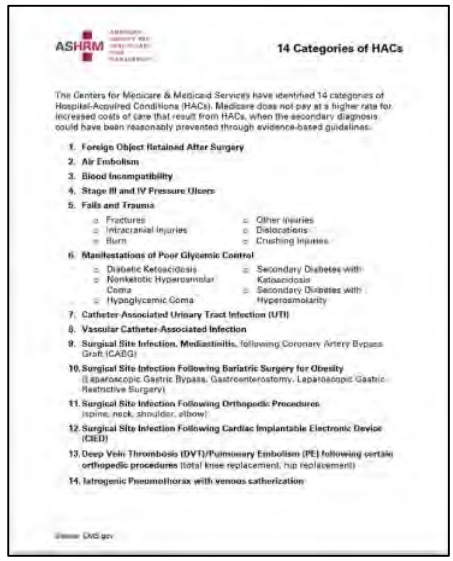
Harm could be avoided through evidence-based medicine

Fundamentals p. 189

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CMS HACs



ASHRM

14 Categories of HACs

The Centers for Medicare & Medicaid Services have identified 14 categories of Hospital-Acquired Conditions (HACs). Medicare does not pay at a higher rate for increased costs of care that result from HACs, when the secondary diagnosis could have been reasonably prevented through evidence-based guidelines:

1. **Foreign Object Retained After Surgery**
2. **Air Embolism**
3. **Blood Incompatibility**
4. **Stage III and IV Pressure Ulcers**
5. **Falls and Trauma**
   - a. Fractures
   - b. Intracranial Injuries
   - c. Burn
   - d. Other Injuries
   - e. Dislocations
   - f. Crushing Injuries
6. **Manifestations of Poor Glycemic Control**
   - a. Diabetic Ketoacidosis
   - b. Nonketotic Hyperosmolar Coma
   - c. Hypoglycemic Coma
   - d. Secondary Diabetes with Ketoacidosis
   - e. Secondary Diabetes with Hyperosmolarity
7. **Catheter-Associated Urinary Tract Infection (UTI)**
8. **Vascular Catheter-Associated Infection**
9. **Surgical Site Infection, Mediastinitis,** following Coronary Artery Bypass Graft (CABG)
10. **Surgical Site Infection Following Bariatric Surgery for Obesity** (Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery)
11. **Surgical Site Infection Following Orthopedic Procedures** (spine, neck, shoulder, elbow)
12. **Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)**
13. **Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following certain orthopedic procedures** (total knee replacement, hip replacement)
14. **Iatrogenic Pneumothorax with venous catherization**

It's important to document conditions that were present on admission (POA).

Intent is to improve quality of care and to protect the public from problematic providers.

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National Practitioner Data Bank (NPDB)



Clearinghouse for reporting and disclosure of certain final "adverse actions" taken against health care practitioners, suppliers, and other providers in an effort to combat fraud and abuse.

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What Does NPDB Track?

The National Practitioner Data Bank contains:

- Civil judgments against health care providers, suppliers, or practitioners related to care delivery
- Federal or State criminal convictions
- Actions by Federal or State agencies responsible for profe_ licensing and certification
- Exclusions of health care providers, suppliers, or practitioners from participation in Federal or State health care programs
- Any other adjudicated actions against health care providers, suppliers, or practitioners

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NPDB Requirements

Reporting Requirements

- Payments on behalf of specified licensed practitioners, report within **30 days**.
- Healthcare entities: Actions taken which adversely affect privileges of physicians and dentists or membership on the staff, report within **15 days** to board of medical examiners.
- Disciplinary actions taken by State medical and dental boards, licensing board reports within **30 days**.

NPDB Requirements

Hospital Obligations

- Request practitioner information from NPDB for new hires and for all practitioners every 2 years minimum.
- Privileges may be suspended or restricted for 14 days to investigate if professional peer review action is needed.
- Summarily suspend privileges subsequent to notice and hearing, if not doing so could cause harm to an individual.

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NPDB Requirements

Failure to Report Key Points

- Failure to report indemnity payments could result in up to a $11,000 fine.
- Hospitals that do not request practitioner information from NPDB are presumed to know whatever information would have obtained if they had asked.
- Failure to report a reportable adverse action waives the hospital's immunity protection from discovery for three years.

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Hospital Value-Based Purchasing Program (VBP)

- Three domains:
  - Clinical Process of Care (13 measures)
  - Patient Experience of Care (8 HCAHPS dimensions)
  - Outcome (3 mortality measures)
- Quality incentive program built on the Hospital Inpatient Quality Reporting (IQR) measure reporting infrastructure
- Designed to promote higher quality care for Medicare beneficiaries
- Rewards facilities with better patient outcomes, processes and experiences instead of just volume of services
- Funded by a 1.25% reduction from participating hospitals' base-operating Diagnosis-Related Group (DRG) payments in FY 2014

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Safe Medical Device Act of 1990

(Also known as SMDA or FDA device reporting law)

Purpose: Gather information regarding safety of medical devices, including reports about adverse incidents associated with their use.

Device: Any item used for diagnosis, treatment, or prevention of a disease, injury, illness or other condition, that is not a drug.

Reporting Requirement	To Whom	Timeframe
Unanticipated patient death	FDA + Vendor	Within 10 working days
Serious patient injury	Vendor (FDA if vendor unknown)	Within 10 working days

Submit annual FDA report by January 1st every year!

Fundamentals p. 81-82

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SMDA Reporting Requirements

Who Reports

- Hospitals
- Ambulatory surgical centers
- Outpatient diagnostic & treatment facilities
- Nursing homes
- Home care agencies
- Ambulance providers
- Rehab & psych facilities

Who is Exempt

- Physicians' offices
- Chiropractors
- Optometrists
- Nurse practitioners
- Employee health clinics
- Dentists
- Freestanding care units

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SMDA Reporting Requirements

Patient admitted for placement of bovine heart valve or orthopedic hardware.



First Post-Op Appointment

PROBLEM FOUND

Physician office not required to report.

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The risk manager has been notified of a death associated with an IV pump malfunction resulting in a fatal dose of a narcotic. The risk manager must:

a) Call the Food and Drug Administration
b) File a controlled substance report
c) Complete a SMDA report
d) Have the device checked by manufacturer

Fundamentals p. 81-82.

Recall Drivers

- Federal Agencies
  - FDA
  - OSHA
- Accreditation Requirements
  - The Joint Commission
    - Standard EC.02.01.01, EP 11
    - Standard MM.05.01.17, EPs 1-4
- Manufacturing trends – outsourcing of products
  - Product quality and safety outside full control of corporation

http://www.jointcommission.org

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Recall Challenges

- Develop standardized processes to receive and disseminate information about product recalls, notifications, and safety alerts to appropriate departments and individuals
  - Accountability – who is responsible?
  - Communication plan
  - Consider pharmaceuticals
  - Alerts Tracking mechanism
- Timely management of recall and replacement efforts
- Establish a claims processing mechanism

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Emergency Medical Treatment and Labor Act

(Also known as EMTALA)

Purpose: Congressional mandate for hospitals and providers to provide a "safety net" for persons seeking assessment and care for a possible clinical emergency at a Medicare-contracted hospital.

Why? To eliminate "patient dumping" of uninsured patients for no reason other than an inability to pay.



Fundamentals p. 201

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EMTALA Requirements

WHAT?	WHO?	WHEN?
Dedicated Emergency Department (DED) • Medical Screening Exam (MSE)	Qualified Medical Professional (QMP) • MD or APP must be written into Medical Staff Bylaws	Emergency Medical Condition (EMC) • Includes psychiatric illness, drug, alcohol intoxication

Hospital Requirements	Who's Included/Penalties
Stabilization Transfer: • No services/no capacity to manage patient • Patient refuses treatment • Benefits of transfer outweigh risks "250 yard" rule **Mandatory Reporting "suspected dumping" within 72 hours**	**Comes to the facility** • Walk-ins • Ambulance approach **Layman interpretation** **Sanctions for not reporting** • Termination of Medicare provider agreement • Civil monetary penalties up to $50,000 per violation (includes hospitals and physicians)

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EMTALA is triggered when:

a) The patient's physician office accepts an emergency patient
b) A patient is loaded into a hospital owned ambulance
c) The patient requests a county-wide ambulance for transportation
d) A patient presents within 300 yards from the main building

Fundamentals p. 202

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Regulations for Long-Term Care

(Also known as LTC laws or enforcement of residents' rights)

Purpose: Institution must meet certain requirements to participate as a skilled nursing facility (SNF) in the Medicare program, and as a nursing facility in the Medicaid program.

Details: Emphasizes residents' rights; promotes the dignity of residents; residents may file formal complaints about infraction of any right



Focus:

- Develop initiatives to continually improve, maintain overall level of patient care (focus on restraints, pressure ulcers, malnutrition)
- Published staffing requirements and plans
- Formal training, certification for nursing assistants

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Title III, Child & Elder Abuse Protections

Title	Purpose	Prohibitions
Title III: American Disabilities Act (ADA)	Nondiscrimination on basis of disability in public accommodations and commercial facilities	Prohibits private entities who provide public accommodations and services from denying goods, services and programs to people based on their disabilities
Child Abuse Reporting (CAPTA)	Protection of vulnerable populations	States have adopted provisions for the required reporting related to abuse and neglect
Adult Protective Services	Protection of the elderly and dependent adults	States have adopted provisions for the required reporting related to elder abuse and neglect

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HIPAA and Information Security

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Health Insurance Portability and Accountability Act

(Also known as HIPAA)

Purpose: Creates standards for use and dissemination of health care information.

Details: Privacy Rule regulates the use and disclosure of certain information held by "covered entities" and establishes regulations for the use and disclosure of Protected Health Information (PHI).



Disclosing PHI

- 18 HIPAA Identifiers
  - Name, contact information, SSN, date of birth, medical information, finger print, IP address, and so on.
- Release of PHI with authorization
  - Patient, outside treatment, payment, public benefit, incidental use, permission granted, identifiable information redacted
- Minimum Necessary Rule
  - Requesting only the 'minimum' amount of information needed to satisfy the request.

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HIPAA Obligations of Covered Entities

- Notify individuals of use of their Protected Health Information (PHI)
- Track PHI disclosures
- Appoint Privacy Officer to receive complaints, document policies, and educate staff
- Provide PHI to individual within 30 days of request
- Disclose PHI when mandated by law
- Take reasonable steps to ensure confidentiality of communication

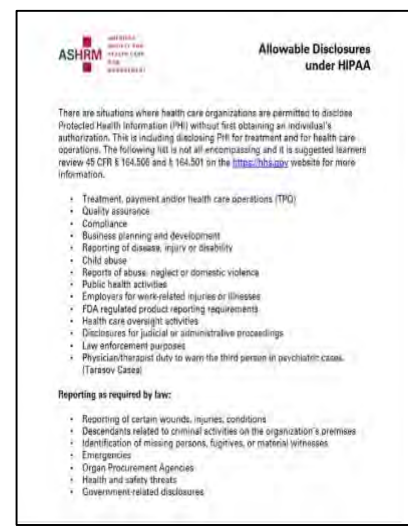
Fundamentals p. 206-209

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Allowable Disclosures under HIPAA

There are situations where health care organizations are permitted to disclose Protected Health Information without first obtaining an individual's authorization.

Learn more about HIPAA's permitted uses and disclosures.



Allowable Disclosures under HIPAA

There are situations where health care organizations are permitted to disclose Protected Health Information (PHI) without first obtaining an individual's authorization. This is including disclosing PHI for treatment and for health care operations. The following list is not all encompassing and it is suggested learners review 45 CFR § 164.506 and § 164.501 on the https://hhs.gov website for more information.

- Treatment, payment and/or health care operations (TPO)
- Quality assurance
- Compliance
- Business planning and development
- Reporting of disease, injury or disability
- Child abuse
- Reports of abuse, neglect or domestic violence
- Public health activities
- Employers for work-related injuries or illnesses
- FDA regulated product reporting requirements
- Health care oversight activities
- Disclosures for judicial or administrative proceedings
- Law enforcement purposes
- Physician/therapist duty to warn the third person in psychiatric cases. (Tarasov Cases)

Reporting as required by law:

- Reporting of certain wounds, injuries, conditions
- Descendants related to criminal activities on the organization's premises
- Identification of missing persons, fugitives, or material witnesses
- Emergencies
- Organ Procurement Agencies
- Health and safety threats
- Government-related disclosures

HIPAA Security Rule

Strictly limited to electronic protected health information or ePHI. Safeguards must be enacted under the following three areas:

1 

Administrative

- Vulnerability Assessments, plan to close gaps

2 

Physical

- Protect from intrusion
- Access controls
- Workstation security measures
- Device and media controls

3 

Technical

- Authentication for those seeking access
- Audit controls
- Policies & procedures

HIPAA

- A covered entity may disclose PHI without authorization for 4 purposes; to facilitate treatment, to obtain payment for services, for purposes of an organizations internal health care operations and as may be mandated by law.
- A covered entity may disclose PHI if such entity has obtained authorization from the individual
- When a covered entity discloses any PHI, it must disclose only the minimum necessary information required to achieve its purpose.
- The Privacy Rule gives individuals the right to request that a covered entity correct any inaccurate PHI.

Fundamentals p. 208, 342

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Data Management

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Data Management

- Purpose of the Medical Record
  - Primary communication medium for planning, coordinating, and orchestrating patient care
  - Primary basis for reimbursement
  - Legal document
  - Defense against negligence claims
  - Basis for many other important activities

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Data Management

Documentation

- Federal and state statutes
- Professional practice standards
- Specific health care facility protocols
- Third party payers
- Accrediting organizations

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The rules that govern documentation come from which of the following sources?

A. The hospital's CEO
B. State and federal statutes
C. Individual hospital unit managers
D. Insurance brokers

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Data Management

- HIPAA Regulations
  - Release of Personal Health Information
    - Must adhere to HIPAA rules and state statutes
- New variations of old concerns introduced by new information technologies
- Electronic Patient Records
  - Confidentiality and security issues
  - Accessibility and durability
  - Accuracy and evidentiary concerns
- Social media

Fundamentals p. 206-209, 303-304

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Data Management

- Security
- Risk Manager's Role
  - Monitor to assess quality of documentation
  - Communicate regularly with the Health Information Services/Health Information Management Committee
  - Educate the clinical staff
  - Work closely with privacy officer

Fundamentals p. 158-164, 189

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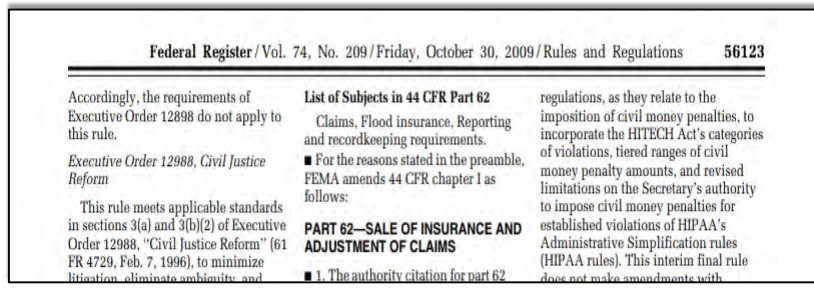
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Health Information Technology for Economic and Clinical Health Act

(Also known as HITECH)

Purpose: Promotes and advances the adoption of Health Information Technology (HIT).

Details: Intended to provide rapid, efficient and secure coordination of care and sharing of information among hospitals, physicians, long term care facilities, home health agencies, and all other authorized users.



Federal Register / Vol. 74, No. 209 / Friday, October 30, 2009 / Rules and Regulations 56123

Accordingly, the requirements of Executive Order 12898 do not apply to this rule.

Executive Order 12988, Civil Justice Reform

This rule meets applicable standards in sections 3(a) and 3(b)(2) of Executive Order 12988, "Civil Justice Reform" (61 FR 4729, Feb. 7, 1996), to minimize litigation, eliminate ambiguity, and

List of Subjects in 44 CFR Part 62

Claims, Flood insurance, Reporting and recordkeeping requirements.

■ For the reasons stated in the preamble, FEMA amends 44 CFR chapter I as follows:

PART 62—SALE OF INSURANCE AND ADJUSTMENT OF CLAIMS

■ 1. The authority citation for part 62

regulations, as they relate to the imposition of civil money penalties, to incorporate the HITECH Act's categories of violations, tiered ranges of civil money penalty amounts, and revised limitations on the Secretary's authority to impose civil money penalties for established violations of HIPAA's Administrative Simplification rules (HIPAA rules). This interim final rule does not make amendments with

Fundamentals pp. 342-343

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Breach Notification Rule

§

A "breach" is defined as "the unauthorized acquisition, access, use, or disclosure of [PHI] which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would reasonably have been able to retain such information."

§

Creates the right of individuals to be notified by the "covered entity" (CE) within sixty days if there is a breach of their Protected Health Information.

Fundamentals p. 209, 342

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Breach Notification Requirements

How must you notify affected parties?	
	Under special circumstances post on covered entity's home page, place notice in major print or announce on broadcast media.
	If felt to be urgent due to the possibility of "imminent misuse", notice given by telephone or other method.
	Written notice to the individual or their next of kin.
	If breach affects more than 500 residents of a state or jurisdiction, notice must be provided to prominent media within that area and reported to the Office for Civil Rights.

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CMS Initiatives Related to Payment

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Recovery Audit Program

Purpose

- Identify and correct improper Medicare payments through the detection and collection of overpayments and underpayments made on claims of health care services provided to Medicare beneficiaries.

Overview

- Claims submitted to Medicare are screened prior to payment and are generally paid without supporting medical records. Some claims may be paid inappropriately.

(Also known as RAC or Recovery Audit Contractor)

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What does a RAC do?

A recovery audit contractor (RAC):

- Reviews post-payment claims
- Detects and corrects past improper payments
- Obtains medical records on-site or by request
- Files claims for overpayment if a record request is not received **within 45 days**
- Cannot compromise or settle an overpayment claim
- Receives payment based on the amount they recover

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Medicare, Medicaid, and SCHIP Extension Act of 2007

(Also known as MMSEA)

Purpose: Requires that liability insurers (including self-insurers), no-fault insurers, and workers' compensation plans report specific information about Medicare beneficiaries.



What must be reported?

Identity of a Medicare beneficiary whose illness, injury, incident, or accident was at issue to enable an appropriate determination concerning coordination of benefits, including any applicable recovery claim.

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Underground and above ground storage tanks to store fuel oil are regulated by which Federal agency?

a) EPA
b) NFPA
c) OSHA
d) FDA

Fundamentals p. 106

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Employment

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Federal Statutes

- Fair Labor Standards Act (FLSA)
- Title VII of the Civil Rights Act of 1964
- Title I Americans with Disabilities Act (ADA)
- Age Discrimination in Employment Act (ADEA)
- Sections 1981 and 1983 of the Reconstruction Civil Rights Acts
- Family and Medical Leave Act of 1993 (FMLA)
- Equal Pay Act of 1963
- Uniformed Services Employment and Reemployment Rights Act
- "Whistle-blower" protection



Fundamentals p. 191-195, 359

88

Title VII of Civil Rights Act of 1964

(Also known as Anti-Discrimination Law)

Purpose:	**Prohibits not only intentional discrimination, but also practices that have the effect of discriminating against individuals because of their race, color, national origin, religion or sex.**
Details	**The law makes it illegal to harass an employee on account of the protected characteristics (race, color, religion, sex, national origin, age, or disability) or to retaliate against an employee who has complained about discrimination.**

Fundamentals p. 191-192

89

Anti-Harassment and Discrimination

Sexual Harassment
Any act that creates a "hostile work environment" is prohibited.

Hostile Work Environment
Intolerable work environment made by the frequency, severity, or pervasiveness of objectionable actions of a sexual nature, or hostility directed at people because of ethnicity, race, or age.

Pregnancy-Based Discrimination
Pregnancy, childbirth and related medical conditions must be treated as temporary conditions and may not be used to deny employment opportunities.

Fundamentals p. 191-195

90

Employment Discrimination and Disability

Sections 501 and 505 of the Rehabilitation Act of 1973

- Prohibits discrimination based on disability in the federal sector.

Title I of the Americans with Disabilities Act of 1990

- Prohibits discrimination based on disability in state and local governments and the private sector
- Requires reasonable accommodations to the applicant or employee

Sections 102 and 103 of the Civil Rights Act of 1991

- Permits jury trials and compensatory/punitive damage awards in intentional discrimination cases

91

Equal Employment Opportunity Commission

(Also known as EEOC)

Purpose: Responsible for receiving and investigating charges of discrimination filed by former, current, or prospective employees under Title VII, Americans with Disabilities Act (ADA), and Age Discrimination in Employment Act (ADEA).

Claims must be filed within 180 days of alleged action.

Negative Findings	Employee can bring civil action
Positive Findings	EEOC brings charges against organization

Fundamentals p. 41, 192

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Workplace Safety

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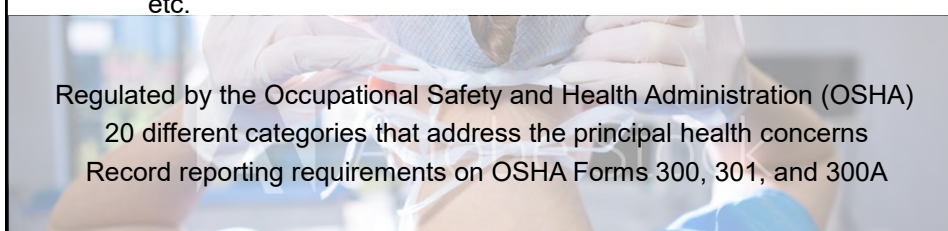
ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Occupational Safety and Health Act

(Also known as OSHA)

Purpose: To create workplace safety rules.

Details: Section 5(a)(1) establishes a federal requirement that employers provide a place of employment that is free from recognized hazards to personal safety and health, such as exposure to toxic chemicals, excessive noise levels, mechanical dangers, unsanitary conditions, heat or cold stress, etc.



Regulated by the Occupational Safety and Health Administration (OSHA)
20 different categories that address the principal health concerns
Record reporting requirements on OSHA Forms 300, 301, and 300A

Fundamentals p. 353

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Occupational and Environmental Risk Exposures

Environmental Issues
- Underground storage tanks
- Aboveground storage tanks
- Asbestos removal
- Disposal of hazardous waste
- On-site medical waste incinerators
- Clean Air Act
- Clean Water Act
- Toxic Substance Control Act



Environmental Issues in Acquisitions
- Inspection of the property
- Records review

POPB p. 118-127

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OSHA Required Protections

- Asbestos abatement
- Blood-borne pathogen control
- Sharps injury prevention programs
- Hepatitis B immunizations
- Infectious waste handling
- Radiation exposure safety
- Ergonomics in work place



Fundamentals p. 354

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Accreditation

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What is Accreditation?

- A reflection of compliance with established norms or standards
- A reflection or snapshot in time
- Viewed by the public and payer as a “Seal of Approval”
- For some payers a threshold for contracting

98

Voluntary Organizations

- The Joint Commission (TJC)
- Det Norske Veritas (DNV)
- National Committee for Quality Assurance (NCQA)
- American College of Radiology (ACR)

Fundamentals p. 150-151

Accreditation

Value of Participating

- Public demands it
- Participation makes good business sense
- Leads to improved patient care and safer environment
- Promotes good discipline
- Supports transparency

Fundamentals p. 150-151, 195-197

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Risk Management Implications

Liability Exposure

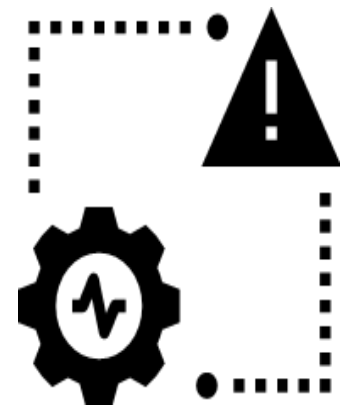
Ensuring standards of care are followed.

Non-Compliance

- Loss of certification for Medicare/Medicaid and private payer contracts.
- If CMS uncovers evidence of non-compliance, state and federal agencies may be notified.

Loss of Status

Reputational loss of the organization.



Fundamentals p. 195, 198, 241

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Regulatory Compliance Program

Purpose: Monitor and oversee health care organizations to ensure compliance with all current regulations and standards of health care oversight agencies.

CMS.gov
Centers for Medicare & Medicaid Services



The Joint Commission

Service Line or Department Specific

Examples include:

- College of American Pathologists (CAP)
- Mammography Quality Standards Act (MSQA)
- Clinical Laboratory Improvement Amendments (CLIA)
- Transplantation
- Oncology

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Regulatory Compliance Program

Purpose: Monitor and oversee health care organizations to ensure compliance with all current regulations and standards of health care oversight agencies.

- Serves as the on-site consulting resource.
  - Interprets and clarifies regulations and standards for hospital leaders and staff.
  - Educates staff on existing or newly released regulations, collaborates with multidisciplinary teams to ensure compliance.
  - Acts as a liaison for on-site visits from regulatory agencies, coordinating reporting requirements and mandated action plan submissions.
  - Provides support in developing corrective action plans for non-compliance concerns, can be the communicator to senior leadership.

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Key Collaborators

Collaboration among several areas are necessary for regulatory compliance:

- Internal Audit
- Patient Safety
- Clinical Leadership
- Operational Leadership
- Executive Leadership
- Government Relations
- Corporate Compliance
- Provider Relations/Medical Staff Office
- Regulatory & Accreditation



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Corporate Compliance

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Why Have a Corporate Compliance Program?

- Supports legal, regulatory, accreditation obligations
- Improve the quality and safety of care
- Demonstrates commitment to honesty and integrity in work practices
- Provide accurate view of employee and contractor behavior
- Identify and prevent criminal and unethical conduct
- Implement means for immediate, appropriate corrective action

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Fundamentals p. 57, 99

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Corporate Compliance Program Elements

What are the seven elements of corporate compliance?	
	Develop written P&Ps and standards that address risk assessments and Codes of Conduct.
	Designate a chief compliance officer to appoint oversight committee
	Provide routine education and training to employees at all levels, including onboarding of executive leaders and board members
	Implement lines of communication, including confidential complaint and reporting process
	Conduct internal audits to monitor compliance
	Enforce disciplinary action, including termination for specific offenses
	Investigate and resolve potential violations, involving health care risk management for patient safety issues

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Office of Inspector General (OIG)

Purpose: Protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.

What does the OIG do?

- ✓Oversight of programs funded through American Recovery and Reinvestment Act of 2009 (Recovery Act)
- ✓Develops annual work plans focused on gaps within health care systems
- ✓Focused investigations on individuals and organizations who knowingly and willfully execute schemes to defraud any HHS program
- ✓Facilitate communications with Federal, State, and local law enforcement

Fundamentals p. 242

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Questions



109

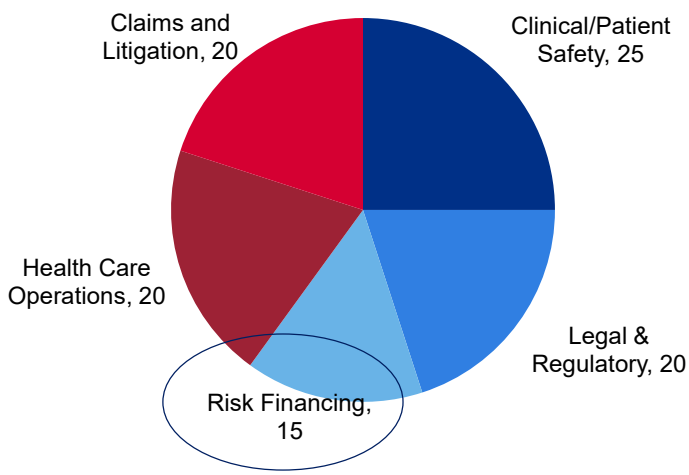
TAB 8 - Risk Financing

Risk Financing

ASHRM References Legend

ERMPB	Enterprise Risk Management Playbook
RFPB	Health Care Risk Financing Playbook
Fundamentals	Health Care Risk Management Fundamentals
OBPB	Obstetrical Risk Management Playbook
PSPB	Patient Safety Risk Management Playbook
POPB	Physician Office Risk Management Playbook
RCAPB	Root Cause Analysis Playbook

CPHRM Exam



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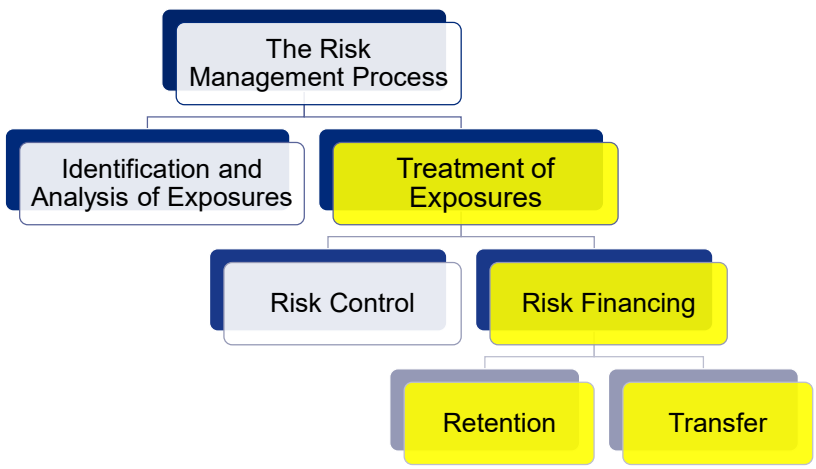
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Objectives

- Examine alternatives in risk financing techniques, such as retention and transfer
- Describe the types of insurance
- Explain the difference between claims-made and occurrence insurance

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Structure of the RM Process



Fundamentals pp. 45-48
RFPB pp. 87-91

4

Basics of Risk Financing

- Encompasses all ways of generating funds to pay for losses that risk control techniques do not entirely prevent
- Designed to obtain funds, at the least possible cost, to restore losses that strike the organization and assure post-loss financial resource availability

Fundamentals pp. 45-48
RFPB pp. 87-91

5

Distinction Between Risk Control and Risk Financing

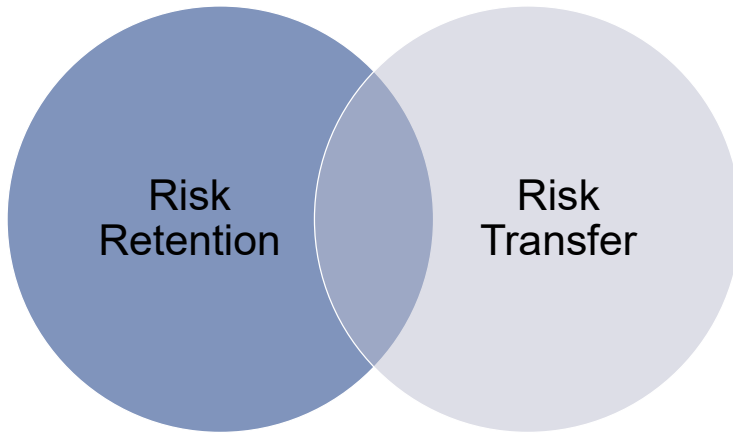
- An organization should apply at least one risk control and at least one risk financing technique to each of its significant loss exposures unless exposure avoidance is a practical and safe alternative
- One risk control technique often may be substituted for another; one risk financing technique often may be substituted for another

Fundamentals p. 13, 244
RFPB p. 59

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Risk Financing Techniques



Fundamentals pp. 48-49, 243-244, 249-256
RFPB p. 38-44

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Risk Retention Techniques

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Risk Retention

- Current expensing of losses
- Unfunded loss reserve
- Funded loss reserve
- Borrowed funds
- Self-insurance
  - Self-insurance trust
  - Affiliated, captive insurer

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Current expensing of losses
  - Charging off losses as current expenses without a fund or reserve; paying for losses out of available cash as they occur
  - Acceptable for losses that are small in nature and infrequent in occurrence
  - Example: deductible for automobile or property loss

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Unfunded loss reserve
  - An accounting entry that shows a potential liability, segregates a portion of surplus equal to booked value of retained losses
  - Examples
    - Uncollectible accounts
    - Loss of revenue for lost items (dentures, eye glasses, hearing aides, etc.)

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Funded loss reserve
  - Organization sets aside funds (cash, securities, or other liquid assets) for expected losses, i.e., “earmarked funds”
  - Examples
    - Reserve for taxes payable at the end of the month
    - Reserve to absorb the cost of defending claims

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Borrowed funds
  - An organization borrows to pay losses
  - Results in a reduction in its line of credit or ability to borrow for other purposes
  - Represents a depletion of its own resources to pay its losses and, in time, uses its own earnings to repay the loan

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Self-insurance trust
  - A funding vehicle that is a bank account administered by an independent third party (trustee)
  - The funds are designated for the sole and restricted purpose of paying losses

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

- Affiliated, captive insurer
  - A subsidiary to finance specified types of losses
  - Generally, the affiliated insurer and the insured "parent" organization are members of the same "economic family," negating any transfer of risk to an outside entity
  - Corporation for which the product is the payment of losses and the revenue is premium payments

Fundamentals pp. 243-256
RFPB pp. 38-44, 55-56, 79

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Risk Retention

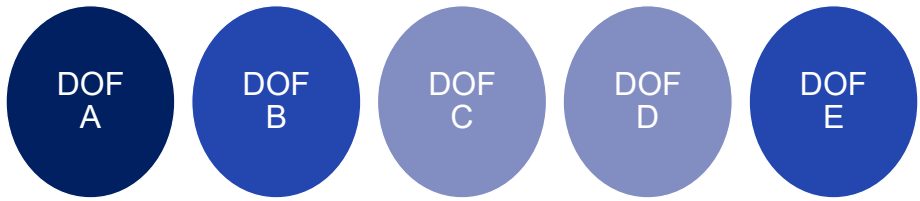
- Affiliated, captive insurer
  - Highly formalized type of retention
  - Types of captives
    - Single parent
    - Group captives
    - Rent-a-Captive

Fundamentals pp. 246-249
RFPB pp. 44, 55-56, 79

16

Single Parent Captive

- Daughters of Forgiveness



- All hospitals owned by same economic entity

Fundamentals p. 246
RFPB pp. 55-56, 79

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Group Captive

- Captive of Pediatric Hospitals



- Hospitals owned by all different economic entities

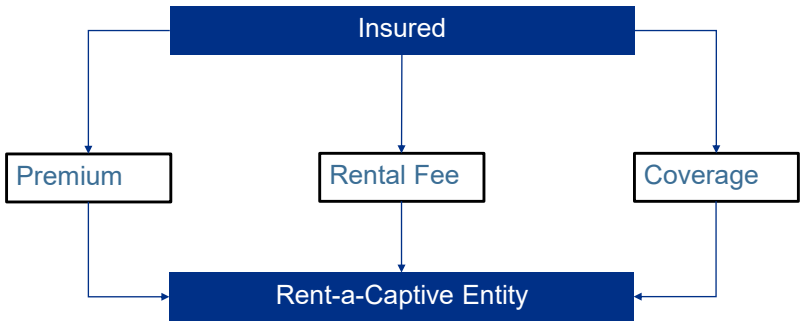
Fundamentals p. 246
RFPB p. 55-56, 79

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Rent-a-Captive

Rent-a-Captive Structure
(single insured)



Note: The rent-a-captive should be a standalone company or it could be a subsidiary of a commercial insurer. A rent-a-captive is normally fronted.

RFPB p. 56-57

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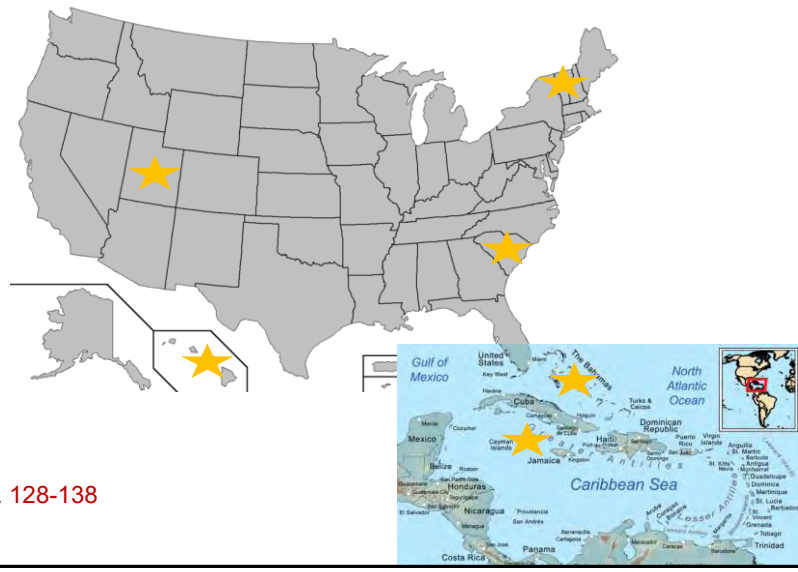
Which of the following is the definition of an affiliated captive insurer?

A. A funding vehicle that is a bank account administered by an independent third party.
B. Funds set aside (cash, securities or other liquid assets) for expected losses.
C. A closely held insurance company whose business is primarily supplied by and controlled by its owners and in which the original insureds are the principal beneficiaries.
D. A stock owned insurance company.

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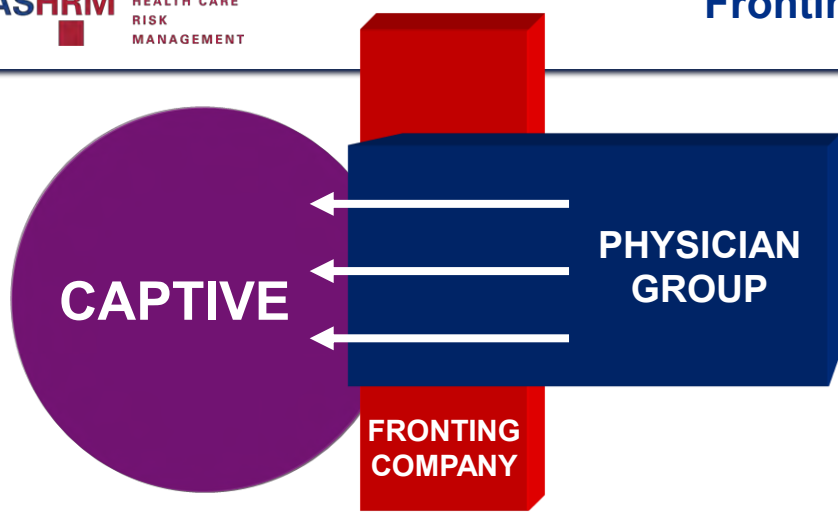
Domicile Selection



RFPB p. 128-138

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Fronting



Fronting Company is Mechanism by which Physician Group gets access to Captive

RFPB page 75

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Which of the following is a risk retention technique?

A. Noninsurance such as an indemnification clause
B. Risk purchasing group
C. Borrowed funds
D. Commercial insurance



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Which of the following is a generally acceptable planned strategies of funding payments for medical professional liability claims?

A. Cash on hand
B. Borrowed funds
C. Self-insurance trust
D. Unfunded loss reserve

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Risk Transfer

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Risk Transfer

- Definition: transmit an organization's risks to an outside party
- Funding the payment of losses from outside the organization after a specified loss
- Contract or provision of a contract
- Commitment to pay
- Organization can transfer the financial burden of losses but not necessarily the ultimate legal responsibility for losses

Fundamentals p. 243-256
RFPB p. 59-61

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Contract Review

Contract defined

- An agreement between two or more persons that creates an obligation to do or not do a particular thing

Fundamentals pp. 33, 258-259
RFPB pp. 13, 60, 114, 201

27

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Contract Review – Five Legal Essentials

- The parties to the contract are competent
- The contract represents mutual understanding between the parties
- There is consideration; a bargained-for exchange of legal value exists between the parties
- The contract is documented in writing if required for legal enforcement in the state
- The purpose or object of the contract is legal

Fundamentals pp. 33, 259
RFPB pp. 13, 60, 114, 201

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Contract Review

Contractual Risk Transfer

- Transferring or assuming financial risk
- Indemnification or hold harmless provisions

Liability Limitations

- Waiver of subrogation rights
- Insurance requirements
- Insurer solvency

Fundamentals pp. 33, 259
RFPB pp. 13, 60, 114, 201

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Contract Review

- Confidentiality Provisions
  - Compliance with HIPAA
  - Confidentiality and privacy issues
  - Negligent disclosure
  - Seek legal counsel for developing sample confidentiality provisions

Fundamentals, pp 206-209

30

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Contract Review

- Contract File Management
  - Reviewing or filing
  - Insurance certificates and endorsements
  - Tickler system
  - Policy and procedure development
  - Evergreen contracts



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Which of the following is an accurate statement related to contracts?

A. Represents a mutual agreement between the parties

B. Should address the obligations and consequences of breach of contract of one party only.

C. A contract can have a purpose that is illegal.

D. Documented in writing

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Risk Transfer

- Noninsurance
- Insurance
- Alternative risk financing technique
  - Risk retention group (RRG)

Fundamentals p. 47, 249-251
RFPB p. 57-60

33

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Risk Transfer

- Noninsurance
  - A contract under which one party, the transferee/indemnitor, agrees to pay money for specified types of losses for which, in the absence of the contract, the financial burden would fall on the transferor

Fundamentals p. 47
RFPB pp. 57-60

34

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Risk Transfer

- Noninsurance
  - Indemnity agreement - one party to a contract agrees to pay another if the latter suffers a specified type of loss
  - Hold harmless agreement - a commitment that one contracting party makes to another to hold the latter harmless from specified types of legal claims that may be brought against the latter because of activities covered by the contract

Fundamentals pp. 47-48, 244
RFPB p. 60

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Risk Transfer

- Insurance Definitions
  - Insurance is a system by which a risk is transferred to an insurance company, which reimburses the insured for covered losses and provides for sharing costs of losses among all insureds
  - A contractual relationship that exists when one party (the insurer), for a consideration (the premium), agrees to reimburse another party (the insured) for losses to a specified subject (the risk) caused by designated contingencies (hazards or perils)

Fundamentals p. 249-250
RFPB p. 59

36

Types of Insurance

- First party
- Third party/liability insurance
- Health and welfare insurance (social)
- Financial guarantees (surety/bonds)

Fundamentals pp. 270-288
RFPB p. 16-34, 43

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Types of Insurance

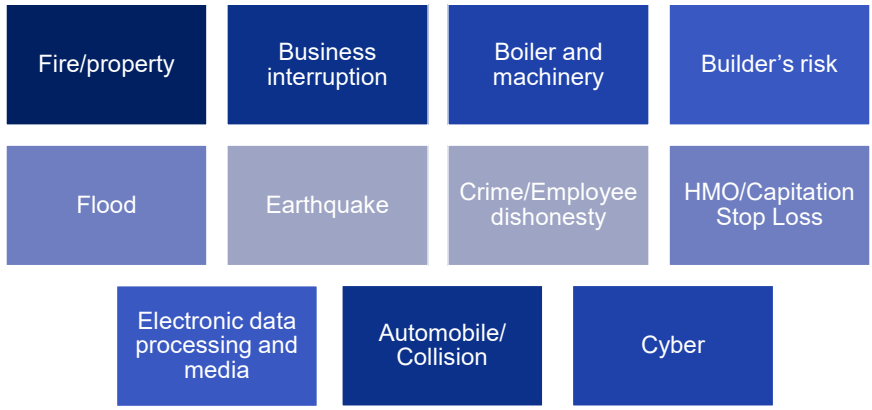
- First party
  - Provides coverage for the insured's own property or person so that the insured will be restored to the same financial position that he or she had prior to the loss

Fundamentals pp. 270-274
RFPB, p. 17-21, 43, 93-109

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First Party Insurance



Fundamentals pp. 270-274
RFPB, p. 17-21, 43, 93-109

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Types of Insurance

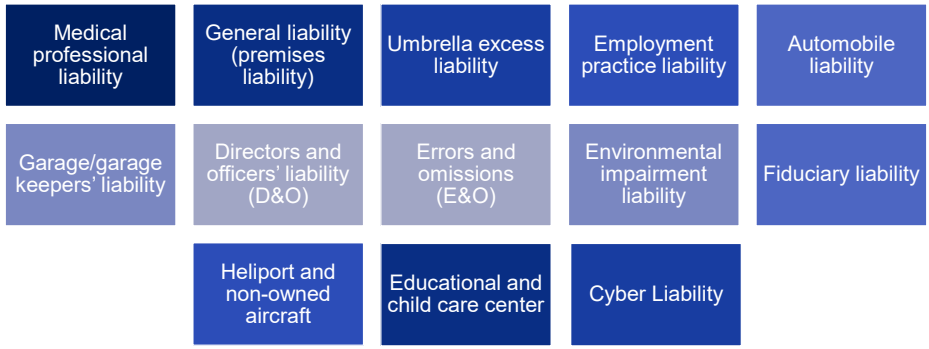
- Third Party Insurance
  - Synonym for liability insurance
  - Provides coverage to a party other than the insured to make that person whole for loss or injury covered by the insured
  - Involves three parties
    - One who is harmed
    - The insured who caused the harm or damage
    - The insurer

Fundamentals pp. 274-284
RFPB, p. 21-31, 43, 93-109, 113-114

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Third Party Insurance



Fundamentals pp. 274-284
RFPB, p. 21-31, 43, 93-109, 113-114

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Which of the following is an example of a first party insurance policy?

A. Automobile liability
B. Directors and officers liability (D&O)
C. Business interruption
D. Errors and omissions (E&O)

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Types of Insurance

- Health and Welfare Insurance/Social Benefits
  - Coverage intended to indemnify the employee by restoring his or her health and earnings to the level maintained prior to the loss
    - Workers' compensation
    - Health benefits
    - Long term disability
    - Short term disability
    - Dental
    - Vision
    - Life
    - Medicare Secondary Payer

Fundamentals p. 284-285
RFPB, p. 31-32, 43

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Types of Insurance

- Financial Guarantees (Surety/Bonds) – contract guaranteeing performance
  - Different from traditional concept of insurance in that assets are pledged for full amount of risk transferred
    - Contract bonds
    - Federal surety bonds
    - License and permit bonds
    - Public official bonds
    - Judicial bonds

Fundamentals p. 287-288
RFPB p. 16-17, 32, 43, 95

44

Alternative Method to Commercial Insurance for Risk Transfer

- Risk Retention Groups: an insurance company that provides liability coverage to its members and owners; members must be "similar or related entities" with respect to the liabilities to which they are exposed
  - Reciprocals
  - Purchasing groups

Fundamentals p. 249-251
RFPB p. 49-52



45

Risk transfer can be accomplished through noninsurance techniques, Which of the following is an example of a noninsurance technique?

A. Financial guarantees
B. Indemnification provision in a contract
C. Health and welfare insurance
D. Risk retention group

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Selecting Risk Financing Techniques

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Risk Financing Techniques

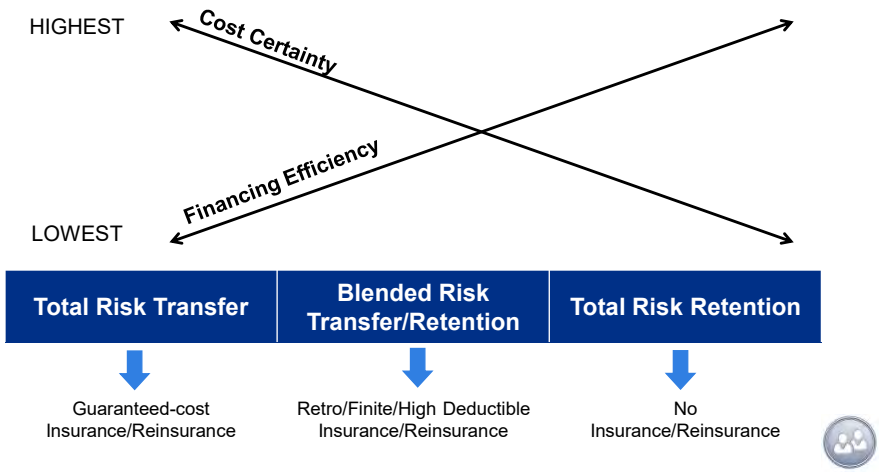
- Key variables to consider in selecting risk financing techniques
  - Size and type of organization
  - Financial strength and resources of the organization
  - Type of risk to be treated
  - Organization's risk-taking philosophy
  - Organization's goals and objectives
  - Effectiveness of the risk management and loss control program
  - Effect each technique has on the organization's long-run costs and, therefore, on its profitability

Fundamentals p. 251-256
RFPB p. 39-47, 83-91

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

Risk Financing Continuum
Retention v. Transfer



Fundamentals pp. 251-254
RFPB pp. 39-47

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ASHRM AMERICAN SOCIETY FOR HEALTH CARE RISK MANAGEMENT

The decision to transfer or retain risk will depend on many factors such as:

A. The financial stability of competing organizations
B. The type of risk to be treated
C. The number of years the organization's loss control program has been in place
D. The name and location of the organization's captive insurer

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Risk Financing Program Goals

- Identify short- and long-term financing goals in your risk financing program. These include:
  - Pay for negative financial consequences of an event
  - Maintain liquidity
  - Manage uncertainty
  - Comply with legal and regulatory requirements
  - Minimize the cost of risk
    - Cost of risk (COR) is the value of all risks faced by an enterprise in fulfilling its mission.

RFPB pp. 144-146

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A hospital insurance policy is expiring. The hospital has had no losses for this policy. Several insurance options have been provided. Which one do you select?

A. $130,000 premium with $10,000 deductible
B. $100,000 premium with $20,000 deductible
C. $95,000 premium with $25,000 deductible
D. $79,000 premium with $30,000 deductible

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Question Analysis

One Loss
- Item A – 130K +10K loss = 140K total cost of risk
- Item B – 100K + 20K loss = 120K total cost of risk
- Item C – 95K + 25K loss =120K total cost of risk
- Item D – 79K + 30K loss = 109K total cost of risk

Two Losses
- Item A – 130K +10K + 10K losses = 150K total cost of risk
- Item B – 100K + 20K + 20K losses = 140K total cost of risk
- Item C – 95K + 25K + 25K losses =145K total cost of risk
- Item D – 79K + 30K + 30K losses = 139K total cost of risk

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Question Analysis

Three Losses
- Item A – 130K +10K + 10K + 10K losses = 160K cost of risk
- Item B – 100K + 20K + 20K + 20K losses = 160K cost of risk
- Item C – 95K + 25K + 25K + 25K losses =170K cost of risk
- Item D – 79K + 30K + 30K + 30K losses = 169K cost of risk

- If your organization can withstand the financial implications of paying a $30,000 deductible for each potential loss, and the probability is low of having a loss, Item D is the best answer because it is the least expensive for up to two losses.

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Insurance: Basic Principles and Coverages

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Insurance Contract

- Insurance policy is a legal contract
  - Standard elements
    - Declarations page
    - Definitions
    - Insuring agreement
    - Conditions
    - Exclusions
  - Endorsements

Fundamentals pp. 256-260
RFPB pp. 13-14

Direct Insurance

- A contractual arrangement involving the purchase of insurance by an “insured” from an “insurer”
  - Primary insurance is the first layer of coverage, the layer that is prone to loss
  - Excess insurance sits over specific primary insurance to afford additional limits of liability

Fundamentals p. 259-260, 279
RFPB p. 26-27, 84-85

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Direct Insurance

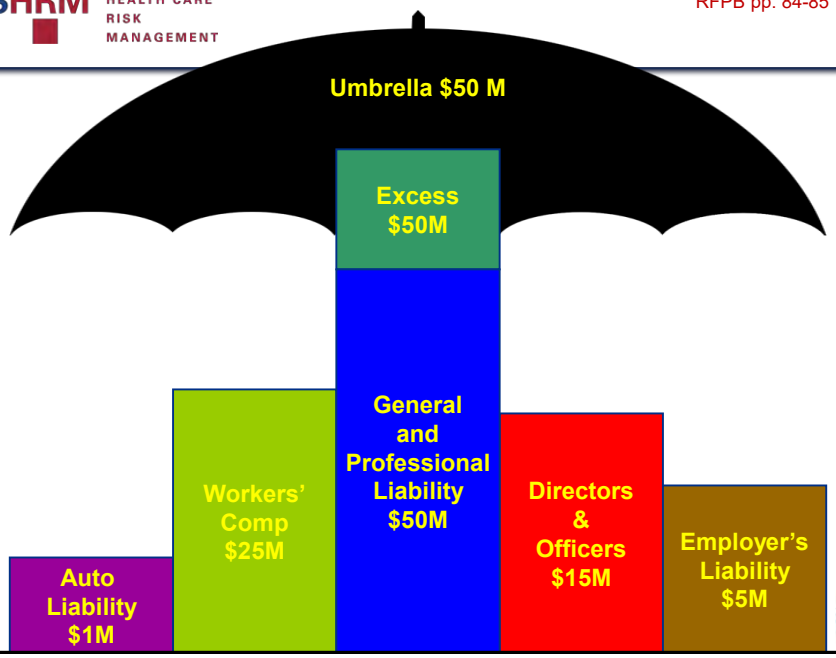
- Umbrella liability sits excess over several lines of liability coverage
  - Hospital professional liability
  - Commercial general liability
  - Employer’s liability
  - Automobile liability
  - Aircraft/heliport liability
- Always verify underlying limit warranties

Fundamentals p. 279
RFPB pp. 84-85

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Fundamentals p. 279
RFPB pp. 84-85



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An umbrella liability policy can sit excess over several lines of third party exposures. Which of the following would not be covered by an umbrella policy?

A. Directors and officers
B. Business interruption
C. Errors and omissions
D. Environmental impairment

RFPB p. 113-114, 118-119
Handbook v. 3 p. 245-249

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Reinsurance

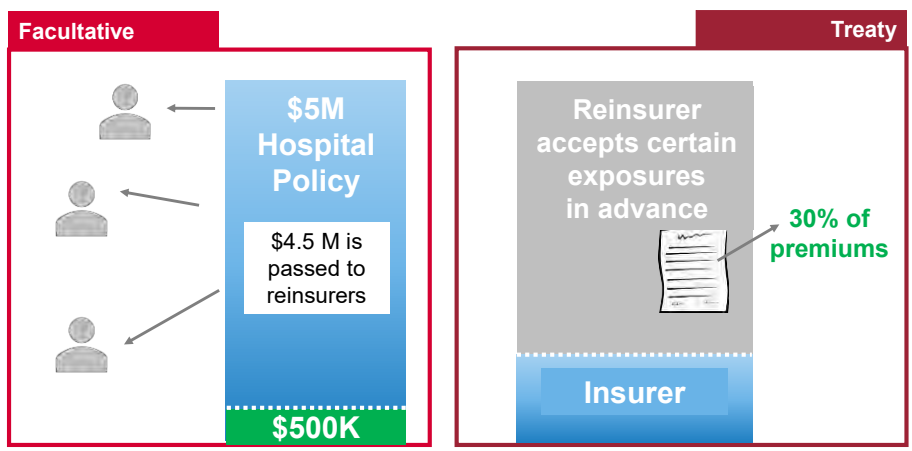
- A contractual arrangement involving the purchase of insurance by an “insurer” from “another insurer”
- Risk sharing reduces ultimate loss exposure to a more comfortable level
  - Stabilizing effect - smooths the ups and downs of fluctuating loss experience
  - Increases capacity
  - Catastrophic protection - protects against the adverse effects of large losses from natural forces or man-made disasters

Fundamentals p. 251-253
RFPB p. 111-112

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Reinsurance Types

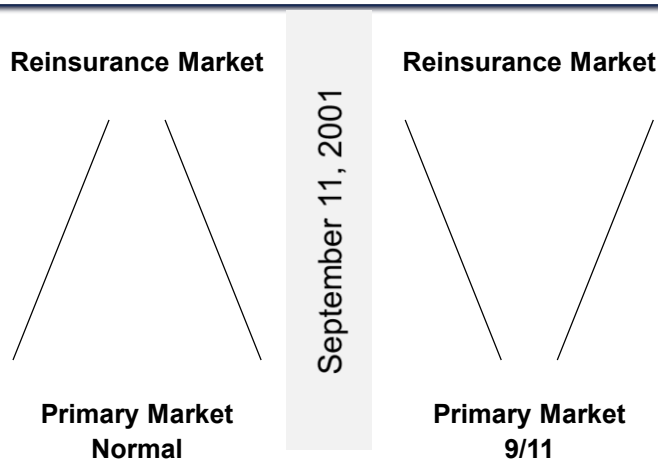


Fundamentals p. 251-253
RFPB p. 111-112

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Reinsurance



Fundamentals p. 251-253
RFPB p. 111-112

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Terms and Conditions of Limits of Liability

- Policy limit - represents the maximum amount the insurer will pay for losses
- Per occurrence – applies to a specific loss
- Aggregate – applies to all losses within a policy term
- Sub-limits – caps the most a policy will pay for a particular peril
- Defense costs – can be included within the policy limit or outside
- Deductibles or self-insured retentions (SIR) – may apply before the limits

RFPB p. 116-121
Fundamentals p. 269-270

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For the next three questions consider the following:

- The Rainbow Hospital has structured professional liability coverage with a combination of SIR and commercial insurance. The SIR limits are $2,000,000 per incident and $6,000,000 yearly aggregate. In addition to the SIR, the organization purchased excess coverage in the amounts of $10,000,000 per incident and $25,000,000 yearly aggregate.

- Assume that all the policies are written on a calendar year basis, all payouts are in the correct year, and the SIR fund and the commercial insurance carrier are financially solvent.

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If Rainbow Hospital has not had a claim paid during the year, what amount would be available for the first claim?

A. $2,000,000
B. $6,000,000
C. $10,000,000
D. $12,000,000

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If the first claim is settled for $5,500,000, how much will the commercial insurance company have to pay?

A. $0
B. $2,000,000
C. $3,500,000
D. $5,500,000

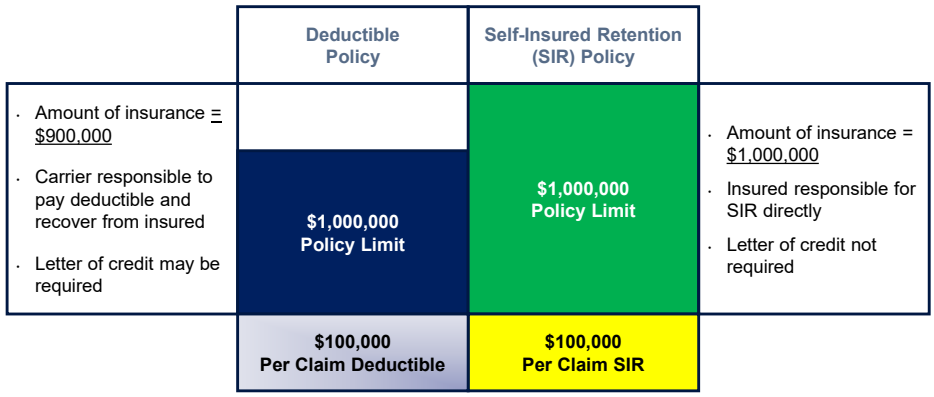
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If the above organization loses two additional $2,000,000 cases and then loses a case for $3,000,000, how much money from the SIR will be used to pay the fourth claim?

A. $0
B. $1,000,000
C. $2,000,000
D. $3,000,000

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Coverage Limits



Fundamentals p. 269-270
RFPB p. 116-119

69

Deductible v. Retention and the Effect on Limits

- Effects of a $100,000 Deductible and SIR on a $1,000,000 insurance policy
  - Deductible: Amount of insurance is $900,000, carrier will pay claim up to $1,000,000. The carrier will ask insured for $100,000 deductible. Letter of credit (LOC) may be required.
  - Self-Insured Retention (policy): Insurance available is for $1,000,000 making coverage/program limits $1,100,000, insured responsible for the SIR and usually pays before the carrier, generally no collateral required (LOC)

Fundamentals p. 269-270
RFPB p. 116-119

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A physician has a $2 million policy limit with a $100,000 per claim deductible. How much insurance does the insured have?

A. $2,100,000
B. $1,900,000
C. $1,800,000
D. Less than $1,800,000

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Insurance Coverage Forms/Triggers

Claims-Made Coverage

- Provides coverage for a claim that occurred after the inception or retroactive coverage date of the policy and is reported to the insurance company while the policy or any replacement policy is still in effect

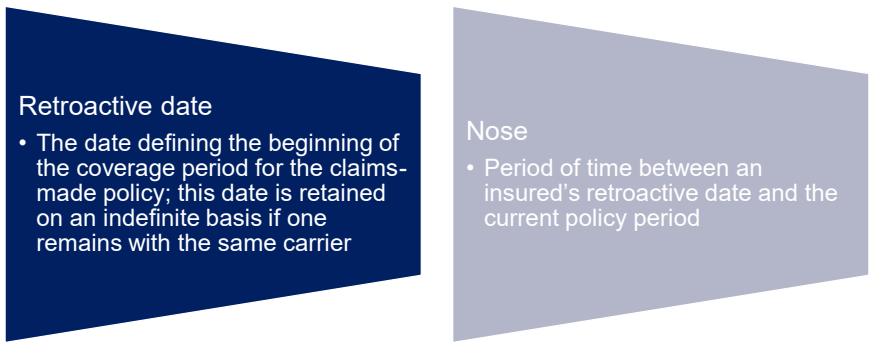
Occurrence Coverage

- Provides coverage for a claim that occurred during the policy period regardless of when the claim is reported to the insurance company

Fundamentals p. 267-268
RFPB – p. 34-38

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Claims-Made Coverage



Fundamentals p. 267-268
RFPB – p.37-38

73

Claims-Made Coverage

- Tail Coverage
  - Permits an insured to report claims that are made after a policy period has expired or has been canceled provided the wrongful act giving rise to the claim took place during the policy term
  - Provides coverage for a claim which occurred after the inception or retroactive coverage date of the policy and is reported to the insurance company while the policy or any replacement policy is still in effect

Fundamentals pp. 267-269
RFPB pp. 188-189

74

Claims-Made Coverage

- Changing Carriers
  - To change claims-made carriers, one can:
    - Maintain original retro date (nose coverage)
    - Buy an extended reporting endorsement (tail coverage) from existing carrier and establish a new retro date with the new carrier
    - The retro date will usually predate the effective date on the policy

Fundamentals p. 267-268

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Occurrence Coverage

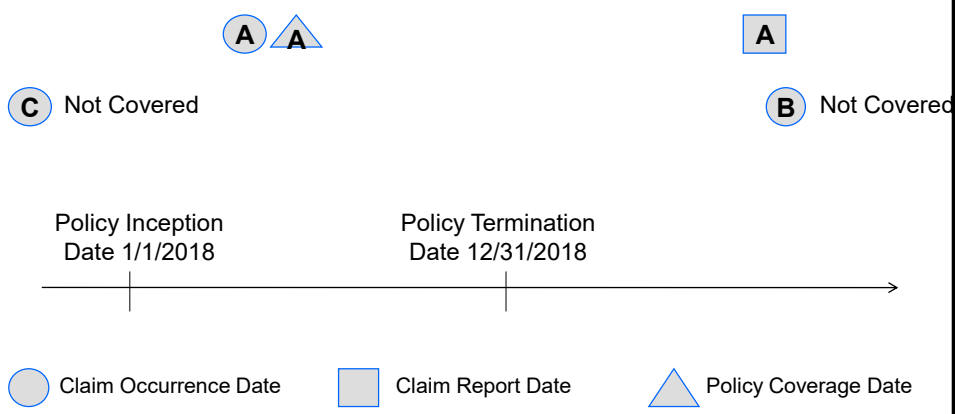
- Provides coverage of an insured for incidents that occur while the policy is in effect, regardless of when:
  - The incident is reported to the insurer
  - A claim is filed
- There is no need for an insured to obtain an additional policy endorsement or extension when it wishes to move to a new insurer

Fundamentals pp. 267-268
RFPB p. 119

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Occurrence Coverage Trigger

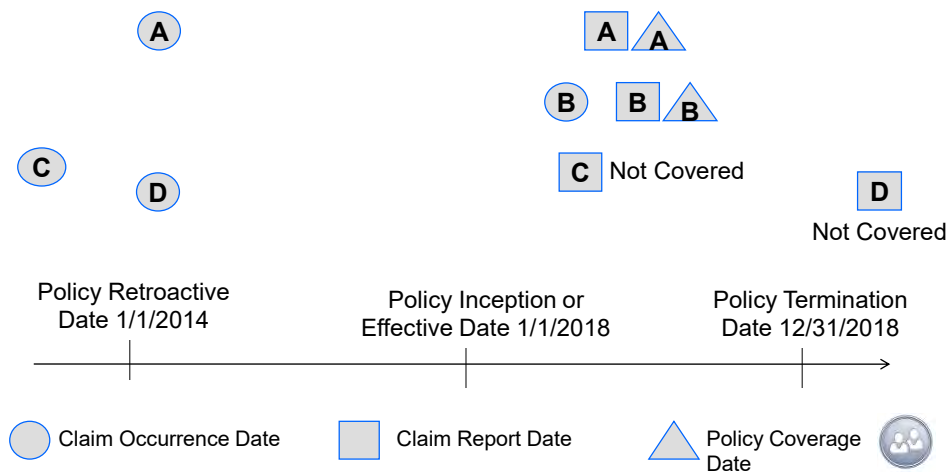


Fundamentals p. 267-268
RFPB pp. 119-121

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Claims-Made Coverage Trigger



Fundamentals p. 267-268
RFPB pp. 119-121

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Which of the following is an accurate statement about occurrence and claims-made insurance policies?

A. Invariably, an “occurrence” policy will cost less than a “claims-made” policy
B. Not all brokers and insurance carriers are able to offer “claims-made” coverage
C. Termination of “claims-made” coverage normally requires purchase of a “tail”
D. An “occurrence” policy always quotes higher deductibles than “claims-made”



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Insurance/Claims Scenario

- You are the risk manager for a small stand-alone hospital. You have responsibility for management of all medical professional liability claims.
- The following is a listing of insurance policies that have been purchased over the past 6 years.

Policy Period	Policy Type
1/1/2013 – 12/31/2013	CM/Retro date 1/1/2007-3 year tail purchased at policy expiration
1/1/2014 – 12/31/2014	Occurrence
1/1/2015 – 12/31/2015	Occurrence
1/1/2016 – 12/31/2016	Claims-Made/Retro date is 1/1/2016
1/1/2017 – 12/31/2017	Claims-Made/Carrier Change/Retro date is 1/1/2016
1/1/2018 – 12/31/2018	Claims-Made/Retro date is 1/1/2016

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Assumptions (1)

- Assumptions Made (1)
  - Policies purchased are adequate to cover all claims.
  - Statue of limitations is not a problem.
  - The hospital is the only insured and limits are not shared.
  - All carriers are solvent and capable of paying claims.
  - None of the claims were known at the time of their occurrence and were therefore not reported to the carrier.
- Questions (1)
  - Claim occurred on 7/7/2014 and is reported on 10/12/2015. Which policy would apply and why?
  - Claim occurred on 2/26/2015 and is reported on 9/17/2016. Which policy would apply and why?
  - Claim comes into your office on 3/3/2017 that occurred on 8/15/2013. Which policy would apply and why?
  - Claim is reported on 1/3/2018 and occurred on 6/23/2016. Which policy would apply and why?

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Assumptions (2)

- Assumptions Made (2)
  - Both the 2016 and 2017 claims made policies state that the insured has the affirmative duty to report all incidents or circumstances that could give rise to a claim.
  - In the 2016 policy, a claim for purposes of coverage is further described as being a written demand for compensation.
- Questions (2)
  - A lawsuit is filed and served in 2017 but the incident which gave rise to this claim occurred October 15, 2016. It was reported to the then current carrier as an incident on December 22, 2016. Which policy would apply and why?

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Insurance Regulations, Pricing, and Purchasing

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Regulation of Insurance

- Highly regulated industry
- Most regulations at the state level
- States give their insurance departments the power to:
  - License insurers and insurance company representatives
  - Monitor the financial condition and operations of insurance companies
  - Regulate rates
  - Approve policy forms
  - Take consumer complaints

Fundamentals, p. 260-261

84

Insurance Pricing

- Guaranteed Cost Programs
  - Guaranteed cost programs are also know as “fixed cost” or “first dollar” programs.
  - Few types of insurance in health care are purchased using this structure

RFPB pp. 55

85

Insurance Pricing

- Insurance Pricing: includes factors such as exposures, underwriting considerations, weighting/rating, and deductible considerations
  - Prospective rating
  - Loss exposure
  - Pure premium
  - Experience rating
  - Expense load
  - Risk Charge
  - Formula: Pure premium (losses + loss adjustment costs) + expense load + risk charge x experience credits or debits = guaranteed cost or first-dollar insurance premium

Fundamentals p. 45-46, 251-254
RFPB p. 55-56, 61-63, 151, 172

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- Retrospective Rating - Premiums are adjusted to reflect the current loss experience of the insured.



"Looks like the insurance rate has gone up again."

#68438012

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Sample Loss Run Report – Professional Liability (PL)

PL: Primary Group Practice

Insured Name:
Insured DBA:

Grand Totals:

Suffix Count: 91
Reserve – Initial: $3,281,546
HP Paid Loss: $3,347,987.50
HP Paid Expense ALAE: $1,212,644.26
HP Salvage/Subro: $0.00
Reserve – Current: $3,980,004
HP Incurred Loss ALAE: $8,540,635.76

Loss Ratio = $\frac{\text{Losses (paid losses + expenses + reserves)}}{\text{Paid premiums}}$

Paid Premiums = $5,685,037

RFPB p. 191-193

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Scenario – Calculating Loss

Loss Ratio = $\frac{\text{Losses (paid losses + expenses + reserves)}}{\text{Paid premiums}}$

Losses = $8,540,635

Paid Premiums = $5,685,037

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Guaranteed cost programs are also known as:

A. Deductible program
B. SIR program
C. Fixed cost program
D. Second dollar program

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Insurance Purchasing

- How much insurance should be purchased?
  - Appropriate policy limits
    - Limits historically purchased and loss history
    - Regulatory and legal climate
    - Exposures created by organization's business strategies
    - Benchmarking against similar organizations

Fundamentals pp. 262-265
RFPB pp. 84-85

91

Insurance Company Financial Security

- The financial stability of the insurance company is a consideration in the health care organization's decision to purchase insurance and must be carefully evaluated
- Rating Systems
  - A.M. Best
  - Other rating agencies (Standard & Poor's (S&P), Moody's, Fitch)
  - Two tiered rating system
    - Quantitative analysis
    - Qualitative analysis

Fundamentals, p. 261-262

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Cyclical Insurance Industry

- The insurance industry is cyclical
- Soft market: low premiums, flexible terms, and generous capacity
- Hard market: periods of escalating premiums, strict underwriting procedures and limited availability of coverage

Fundamentals, p. 265-267

93

Insurance Purchasing

- Most health care risk managers gain access to the commercial insurance market by using an insurance broker or independent agent

Agent

- Generally represents one or more insurance carriers

Broker

- Generally represents the purchaser

Fundamentals p. 256-257

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Request for Proposals (RFP)

- RFP Process – can be utilized for special projects, insurance broking, risk management consulting, outsourcing, etc.
- Types of proposal for insurance brokerage
  - Market Proposal
  - Conceptual Proposal

Fundamentals p. 257

Actuarial Applications

Actuarial Applications for Risk Financing

- Role of actuary
- Actuarial report
  - Purpose or scope
  - Distribution and use
  - Reliance and limitations
  - Summary and conclusions
  - Major assumptions
  - Exhibits and graphs



RFPB pp. 68-70, 169-177

97

The CFO requests the risk manager be involved in the feasibility study to analyze whether a captive insurance model makes financial and strategic sense for the organization. The risk manager should start this process with review of the organization's:

A. Current actuarial analysis
B. Timeline for captive development
C. Historical organizational loss data
D. Review of current commercial market

RFPB p. 68

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Risk Financing Scenario

- Facts
  - You are the risk manager for a local stand-alone hospital. You have responsibility for the purchase of all insurance coverage as well as the management of all self-insured programs and commercial insurance programs.
  - The HPL coverage is afforded by a combination of self-insurance and commercially placed insurance.
  - The SIR is $1,000,000 per incident and $2,000,000 yearly aggregate.
  - Excess coverage is placed above the SIR with limits of $5,000,000 per incident and $15,000,000 yearly aggregate.
  - Umbrella coverage is placed above the excess policy as well as other third party insurance policies with limits of $20,000,000 per incident and $20,000,000 annual aggregate limit.
- Assumptions
  - All policies are written on a yearly basis.
  - All payouts are in the correct year.
  - All the carriers are solvent.

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Risk Financing Scenario – Questions

1. What are the total limits available per incident and in the aggregate assuming the limits have not been eroded?
2. First claim payment is due for $1,200,000. Who paid and for how much?
3. Second claim payment is due for $2,700,000. Who paid and for how much?
4. Third claim payment is due for $6,000,000. Who paid and for how much?
5. What are the remaining available limits on the SIR and commercial policies?

100

Remaining Limits and Total Payouts After a Claim Payment – Example Problem Set-Up

	Limits (Available)	Paid	Remaining
SIR	$1,000,000/ $2,000,000		
Excess	$5,000,000/ $15,000,000		
Umbrella	$20,000,000/ $20,000,000		
Paid			

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Questions



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