

# risk

# RX

Integro's Healthcare Update - Fourth Quarter 2006

**premier** edition



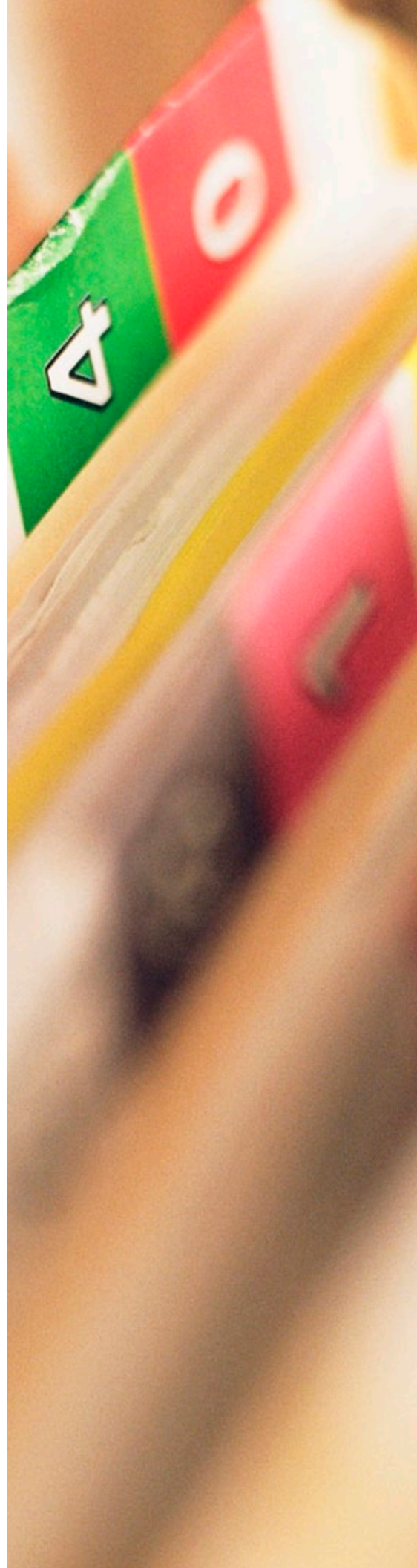
# premier edition

Welcome to the premier edition of Integro's quarterly healthcare update, *RiskRX*. This update exists to provide healthcare risk management and insurance professionals with relevant information regarding new, updated and developing issues within the healthcare industry. *RiskRX* will be electronically published quarterly.

Send letters to the editor, comments and contributions to Marleen Wolfe, Healthcare Project Administrator: [marleen.wolfe@integrogroupp.com](mailto:marleen.wolfe@integrogroupp.com)

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# safety in numbers

2006 JACHO Mid-Year National Patient Safety Goals

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), overseen by an expert panel including nurses, physicians, pharmacists, risk managers and other hands-on patient-safety professionals, has published a continuum of *National Patient Safety Goals* to promote specific improvements in patient safety.<sup>1</sup> The mid-year goals are released by JCAHO so that continuing accredited or certified organizations can identify the consistent goals and requirements of 2006-2007; recognize the new goals and requirements and retired goals and requirements of 2007; and assess compliance with the latest revised patient safety goals to not only improve patient safety in the prioritized areas, but also to maintain accreditation or certification.<sup>2</sup>

The following list includes the specific goals and requirements amended in 2006 and the goals and requirements effective January 2007 influencing each accreditation program—ambulatory care, assisted living facilities, home care organizations, hospitals, long-term care facilities and office based practices.

## 2007 JCAHO Guidelines:

**1 Improve the accuracy of patient identification.** The intent is to correctly identify the patient receiving the treatment or diagnosis and to match the service treatment to that individual; identifiers must be directly associated with the individual and medication, blood products or specimen tube.<sup>3</sup>

**2 Improve the effectiveness in communication among caregivers.** In most cited sentinel events, ineffective or problem communication is the essential cause. To reduce errors, communication must be timely, accurate, complete, unambiguous and understood by the recipient of the information.<sup>3</sup> The “hands off” policy, which requires that pertinent information be communicated during the transferring of service, improves accuracy in communicating a patient’s care, treatment and services, current condition and any anticipated changes.<sup>4</sup> Additionally, in 2007 a “read back,” which requires the receiver repeat medication or testing information provided, ensures that test results and medication orders are verified and fulfilled accurately.<sup>4</sup> Lastly, a standardized list of abbreviations, acronyms and symbols insures medications and treatments are accurately, efficiently communicated to the appropriate care provider.<sup>4</sup>

**3 Improve the safety of using medications.** When medications are a part of the patient’s treatment plan, appropriate clinical management ensures patient safety.<sup>3</sup> Developing standardized and redundant procedures reduces medication errors. These procedures include limiting the number of drug concentrations available in an organization; identifying, composing and reviewing a list of look-alike/sound-alike drugs; and labeling all medications, medication containers or other solutions on and off the sterile field.<sup>4</sup>

**6 Reduce risk of healthcare associated infections.** Compliance with the Center for Disease Control (CDC), current disease control and hand hygiene guidelines reduces the transmission of an infectious agent from staff to patient, which thereby decreases the incidence of healthcare associated infections.<sup>3</sup>

**7 Accurately and completely reconcile medication across a continuum of care.** Patient safety is compromised significantly by medication errors, particularly when a patient is being transitioned through the continuum of care.<sup>4</sup> JACHO requires organizations to develop a standard procedure for obtaining and documenting a patient’s evolution of medications, commencing upon admission.





The patient must also be involved in all medication reconciliation. The medication record and reconciliation is to be passed on to each new caregiver, including caregivers outside the organization.<sup>3</sup> Also, a complete medication continuum must be provided to the patient upon discharge.

**8 Reduce harm resulting from falls.** To reduce the risk of patient injury by falling, JACHO requires a healthcare provider to implement a fall risk reduction program. This program should reflect the organization's population being served, the service being provided, and the environment in which care is provided. The program should also assess patient risks and take appropriate precautions.<sup>3</sup>

**12 Encourage the active involvement of patients and their families.** To enhance a culture of safety, communication with patients and their families is key. Patients can share important information about clinical history, allergies, medication reactions and other key information to prevent adverse events and hazardous conditions. Thus, patients must be informed of the appropriate reporting procedures, and they must be encouraged to report any safety concerns.<sup>3</sup>

**R13 Prevent healthcare-associated pressure ulcers.** Pressure ulcers continue to be problematic in the healthcare industry, particularly in the senior care industry. Research suggests most ulcers can be prevented and halted (at stage one) if effectively identified.<sup>4</sup> Using clinical practice guidelines, assessing and reassessing a patient's risk of developing a pressure ulcer is paramount. Effective and immediate clinical management must occur when a pressure ulcer has begun.<sup>4</sup>

**15 Identify safety risks inherent in a patient population.** An organization must identify a patient's risk of suicide and other long-term risks associated with oxygen therapy (e.g., in the case of a home fire).<sup>4</sup> **RX**

<sup>1</sup> Joint Commission Resources Publication. *Joint Commission Perspective on Patient Safety*, (retrieved July 16, 2006). [Http://www.theschwartzcenter.org/JCAHO%20Implementing%20Rounds.pdf](http://www.theschwartzcenter.org/JCAHO%20Implementing%20Rounds.pdf)

<sup>2</sup> Legacy Emanuel Hospital & Health Care. *About the Goals*, (retrieved July 15, 2006). [Http://www.legacyhealth.org/body.cfm?id=1146](http://www.legacyhealth.org/body.cfm?id=1146)

<sup>3</sup> Joint Commission. *National Patient and Safety Goals*, (retrieved July 13, 2006). [Http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/](http://www.jointcommission.org/PatientSafety/NationalPatientSafetyGoals/)

<sup>4</sup> Joint Commission. *National 2006 Patient and Safety Goals, Implementation Expectations*, (retrieved July 13, 2006). [Http://www.jcaho.org/NR/rdonlyres/DDE15942-8A19-4674-9F3B-C6AE2477072A/0/06\\_NPSG\\_IE.pdf](http://www.jcaho.org/NR/rdonlyres/DDE15942-8A19-4674-9F3B-C6AE2477072A/0/06_NPSG_IE.pdf)

# consent & sensibility

CMS Guidelines Help  
Hospitals Service  
Medicare Patients with  
Informed Consent

The Centers for Medicare and Medicaid Services (CMS) administers the state and federally funded Medicaid program for groups of lower- to middle-class income individuals, providing healthcare to parents, children and the blind or otherwise disabled. The program pays for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs. CMS has set out the organizational, staffing, staffing responsibilities and procedures for facilities that provide Medicare treatment, as well as the informed consent requirements for all medical procedures and treatments, *see 42 CFR § 482.51 (b)(2)*.

The following summary explains CMS's informed consent form interpretive requirements, released in January 2005. The requirements mandate that hospitals receive a properly executed form prior to surgical intervention (i.e., an operation).

In defining a properly executed informed consent form, these regulations now specify that the form contain:

1. the name of the patient and/or the patient's legal guardian if appropriate;
2. the name of the hospital;
3. an explanation of the nature and purpose of the proposed procedure(s);
4. the name of the practitioner(s) performing the procedure(s) or important aspects of the procedure(s)—practitioner(s) other than the primary surgeon performing surgical procedure(s) must be included, even when performed under the primary surgeon's supervision. Practitioners who must abide by the CMS requirements include medical doctors, doctors of osteopathy, dentists, oral surgeons, podiatrists, registered nurse first assignments, nurse practitioners, surgical physicians, surgical assistance physicians, surgical technicians, etc.;
5. the name(s) of the specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon/practitioner. Significant



- 6. the risk consequences of the procedure(s) and the risks and consequences if no treatment is rendered;
- 7. alternative procedures and treatments;
- 8. updates of any surgeon(s) or assistant(s) that have been scheduled to participate as late as the day of surgery;
- 9. the signature of the patient or legal guardian;
- 10. the date and time when consent is made;
- 11. a statement that the procedure was explained to the patient;

- 12. the signature of a professional person witnessing consent;
- 13. the signature of the person who explained the procedure to the patient or guardian.

### Criticism of CMS Guidance

CMS has been criticized because of their “burdensome” interpretive requirements of 2005. According to CMS, its guidelines were not imposed to burden hospitals and physicians nor to hinder them from providing care by: (1) limiting the witnesses to a small group of physicians or registered nurses; (2) requiring an exhaustive list of the name(s) of every physician, even those with a minor role, involved in a patient’s care; and (3) informing a patient of every imaginable risk that could occur during surgery.<sup>1</sup>

However, CMS claims to be “anticipating a revision” of their guidelines. This revision is expected to provide additional clarifications and practical leniency on the requirements.<sup>2</sup> In the meantime, hospitals must weigh the risk of experiencing negative medical survey outcomes against the risk of increased exposure to liability as they evaluate their existing surgery consent forms.<sup>3</sup> **RX**

<sup>1</sup> Krivla, Kelly, *Legal Services Bulletin*. *Informed Consent: CMS Interpretive Guidelines*, (retrieved July 2006) Feb. 2006. [http://www.oahhs.org/issues/legal\\_services\\_bulletin\\_informed\\_consent.htm](http://www.oahhs.org/issues/legal_services_bulletin_informed_consent.htm)

<sup>2</sup> Stephan, David & Colman, Rachel. *CMS revises Guidance on Hospital Grievance Policies Effective*, (retrieved July 2006) September, 19 2005. <http://www.bccb.com/publications/Detail.aspx?id=93ebb344-44aa-47f6-b38e-00d28458da90>

<sup>3</sup> Hancock, Daniel, Johnson & Nagel PC. *CMS Creates Special Informed Consent Form Requirements*, (retrieved July 2006) March 7, 2005. [http://www.hdjn.com/pdfs/Client\\_Advisory%20-%20Informed%20Consent%20Requirement.pdf](http://www.hdjn.com/pdfs/Client_Advisory%20-%20Informed%20Consent%20Requirement.pdf)



# The Captive Audience

Best  
Practice  
Leadership  
for Healthcare  
Captive Board Members

A captive's success is determined by the structure, management and implementation of captive strategies and solutions which may be accomplished by an efficient, knowledgeable, and productive board. Every healthcare captive operates differently because of various facts unique to the organization, including size, location, business sophistication, the part of the health care continuum industry it services, its status as a private or public foundation, and the nature of its tax exemption status.<sup>1</sup> However, there are significant business practices that healthcare captive boards can embrace to facilitate its captive operations. Consider some common and unique "best board business practices" from legal, financial and board perspectives.

## The Duties of Directors and Officers

Although directors and officers should not be held accountable for the profitability of an organization, their ability to affect an organization's success lies in their capacity to account for all the responsibilities expected of them.<sup>2</sup> Directors and officers should exercise reasonable care in performing their leadership duties. In the for-profit environment, they have three clear duties:

1. To avoid personal and financial conflicts of interest;
2. To disclose material facts detrimental to the company's directors, regulators, creditors, stockholders, bondholders and potential investors;

3. To uphold their responsibilities, actively participate as a fiduciary, trustee, manager, investor, meeting facilitator and delegate who exercises knowledge, care, skill and prudence, honesty, objectivity, good faith and diligence, all while acting within the appropriate scope of authority to promote the best interests of the captive.<sup>2</sup>

Directors and officers may include independent directors, representatives of the parent company, trustees and insured representatives, all of whom must be aware of their obligations to the captive, as opposed to the parent owner and principal named insured.<sup>3</sup> They must assume full responsibility to work as one unit in establishing the captive's operating procedures and policies through team planning, monitoring and recommendations from committees, staff leadership and executive director oversight.<sup>2</sup> The directors and officers should represent a variety of disciplines to foster learning and form educated, responsible decisions on behalf of the captive. The captive's insured community may include physicians, employees and third party affiliations if applicable.<sup>3</sup>

### Meaningful Board Meetings

Regularly scheduled board meetings increase awareness of board member roles, independent responsibilities and functions.<sup>3</sup> Frequent board meetings efficiently provide information about captive policies and procedures, ethical guidelines and data relevant to the captive's financial, organizational and technical status.<sup>3</sup> If appropriately prepared in advance, meeting agendas should accomplish two objectives:

1. Segment educational opportunities, in an effort to keep all board members knowledgeable of the business practice;
2. Define question, answer and discussion time to resolve any discrepancies or address lingering issues.<sup>3</sup>

Ideally, prior to the meeting, staff and consultants should distribute the agenda and include all materials and business to be discussed. Minutes must be maintained to memorialize the key historical milestones for the captive company; include the material of discussion, dissents and rationales for decisions. This same team member should distribute the minutes among the other members soon after the meeting.<sup>3</sup>

### Mission and Leadership

An organization's strategy needs to begin with defining its mission—why the board was established and how the captive's

board supports the mission/vision/plan of the parent.<sup>3</sup> Focusing on a mission is the simplest way to define specific strategies needed to attain crucial goals (e.g., a leadership role to promote a collaborative alliance with voluntary physicians).<sup>4</sup> A focused mission creates a disciplined organization, and it prevents the organization from splintering with respect to its core mission.<sup>5</sup> A well-defined mission also serves as a constant reminder to look outside the organization for measures of success and best practices for health care captives. For example, looking at demographics for critical changes is a technique to focus and educate a board on current professional liability insurance issues so the board can generate innovative ideas to promote quality and safety for the institution and the captive.

### Stewardship

It is the duty of the board to take good care of the captive's resources. In doing so, the board should take a long-term view of the captive's operations and financial performance, establishing funding policy and premiums accordingly, and initiating changes where appropriate.<sup>4</sup> When parent companies experience financial difficulty, a captive's board must develop strategic plans to help rejuvenate its parent (e.g., provide innovative risk management solutions; enhance satisfaction levels; assure financial stability through growth, organizational efficiency, and cost effectiveness).



## Operations

The captive board must see that business and operations within the captive run smoothly and, if not, the board must promptly take the necessary action to protect the organization and assure regulatory compliance.<sup>6</sup> Thus, providing captive members with a policies and procedures manual and an explanation of the ethical code, are ways to ensure uniform expectations, practices and performance.<sup>3</sup>

A captive board should also commit to an active, informed and independent oversight audit process. At the very least, a board member or a committee chairperson should supervise and evaluate the performance of management, directors and independent advisors. This person should also perform periodic checks on the financial, structural and institutional makeup of the captive (e.g., assuring that the captive accomplishes risk identification, investment strategy, supervision, annual reviews of financials and group performance, and internal controls of the captive).<sup>6</sup> **RX**

<sup>1</sup> Regis Coccia, *Managing Editor and Business Insurance, Arts and Science Plus Medical Symposium*, (retrieved July, 2006) March 2003. <http://www.plusweb.org/Downloads/Events/RCoccia-ART&Science.ppt#647,6,The Actuarial Perspective>

<sup>2</sup> *Integro Insurance Brokerage Firm. Best Practices Healthcare Captive Board*, (retrieved July, 2006) June 27, 2006. *Healthcare Practice Audio-Conference*.

<sup>3</sup> *Honigman, Miller, Schwartz & Cohn, LLP. Top Five Characteristics of Effective Captive Boards*, (retrieved July, 2006) June 27, 2006. *Healthcare Practice Audio Conference*.

<sup>4</sup> *Towers Perrin: Corporate Governance, Vermont Captive Insurance Association*, (retrieved July, 2006). August 2004. <http://www.captive.com/service/kwplc/CaptiveGovernanceVCIA2004.pdf>

<sup>5</sup> *Harvard's Business Review, of August of 1989 & Dermott Will & Emery's Best Practices: Nonprofit Corporate Governance*, (retrieved July, 2006) 2004. <http://www.mwe.com/info/news/wp0604a.pdf>

<sup>6</sup> *Chubb Group of Insurance Companies. Sarbanes-Oxley Act; Pro-active Governance Check List*, (retrieved July 2006). *Healthcare Practice Audio-Conference*

# Ask *the* Risk Pros

**Q:** Are multi-year deals good deals in the soft market?

**A:** In the hard market of the mid-1990s, financial officers and healthcare risk management professionals became interested in multi-year deals for two main reasons: profitable premium rates and ease of administration.

**Stable, Profitable Premium Rates:** At that time, professional liability insurance premiums were expected to continue their steep rise, following seven years of deteriorating rates and an increase in the frequency and severity of medical malpractice claims. The primary and excess professional liability [medical malpractice] marketplace was described as being in a hard cycle. Likewise, pressure on department budgets helped motivate risk managers to lock in prices over a multi-year period, allowing them to stabilize fluctuations in their cost of risk.

**Administrative Ease:** In the mid 1990s, multi-year deals also promised administrative ease. Typically, risk managers must complete and process multiple applications and insurance policies each annual renewal period. With downsizing efforts, some healthcare organizations cut into risk management time and staff compliments, so in the hard market, these multi-year "deals" were viewed as a strategic option for buyers.

In a soft market, the administrative benefit of a multi-year insurance program remains intact, but premium rates typically suffer.

## Multi-year Policies: Pros and Cons

### Pros

- Long term underwriter relationships dictated by the policy parameters (e.g. multiple years).
- Budget cycle certainty; the cost of the coverage should remain stable.
- Budget relief; travel expenditures and visits with underwriters may not be necessary (Domestic, London/ European and Bermuda).
- Minimal effort for insured(s) and placing broker/agent; a renewal submission should not be necessary year to year.

### Cons

- Multi-year deals are designed to guarantee rates for policyholders. Typically these programs are not designed to address year after year terms and conditions, rate deflation (softening market) and material changes in exposure(s).
- May limit access to more competitive rates or markets which develop (or enter the market as new capacity).
- Minimizes emphasis at the healthcare organization on developing an annual risk profile, as a submission may not be necessary.
- May inhibit other competitive markets to provide quotes since a multi-year program is in place. **RX**



## Bird Flu Hybrids

### New CDC Experiment Studies Pandemic Probabilities and Genetic Properties of H5N1

Significant genetic changes in the H5N1 bird flu virus would, likely, be needed to create a strain that could cause a pandemic, a new study by researchers at the Centers for Disease Control and Prevention (CDCP) suggests. The experiment was designed to mirror the phenomenon that occurs in nature when two flu viruses combine to form a new virus, a process that led to the 1957 and

1968 pandemics. In the study, genes from a common human flu virus were added to genes from a 1997 H5N1 virus to create new hybrid viruses, which were tested in ferrets because their susceptibility to flu viruses is similar to that of humans. While the human viruses transmitted easily between the ferrets, the avian and hybrid viruses did not. Future CDCP studies will examine whether combining genes from the human flu virus with more recent H5N1 strains makes the new virus more easily transmittable. <sup>RX</sup>

# Calendar

## Events:

**October 29—November 1:** San Diego  
ASHRM Annual Conference

**November 2—3:** Phoenix, AZ  
Physician Insurance Association of America Legal Workshop

**November 28—30:** Grand Cayman  
IMAC Cayman Captive Conference

**December 6—9:** Charleston, SC  
South Carolina Captive Insurance Association Annual Meeting

## Conference Calls:

**November 15:** American Health Lawyers -  
*"Hot Topics in Healthcare Ethics"*

**November 14:** Integro Health Audio Conference Call - *"Risk Management Dashboards: Communicating Results"*



# A Grave Risk

When parents share beds with infants,  
the children may never wake up.

This summer, an infant less than one day old apparently suffocated after slipping between his sleeping parents in a shared bed at a California hospital. After a feeding around midnight, the newborn's parents, both minors, fell asleep together in a hospital bed with the baby on a pillow.


According to the hospital, it has a policy and practice of cautioning new parents against sleeping in the bed with an infant "because of the risk to the baby of accidental death." But the hospital could not confirm that the couple had been warned, citing patient confidentiality protocols.

This loss underscores the dangers of infant bed sharing. In a policy statement published last year, the American Academy of Pediatrics warned, "The evidence is growing that bed sharing, as practiced in the United States and other Western countries, is more hazardous than the infant sleeping on a separate sleep surface."

*The Journal of Pediatrics* recently reported increasing mortality rates for infants who suffocated on inappropriate sleep surfaces. The most conservative estimate showed the risk of suffocation increases by twenty-fold when infants sleep in adult beds instead of cribs.

According to Rangasamy Ramanathan, Director of the Newborn Intensive Care Unit at Los Angeles County USC Medical Center, most U.S. hospitals do not permit infants to sleep in the bed with their parents. Nevertheless, healthcare risk management professionals should develop a risk audit of practices in their clinical settings.


## Risk Management Tips for Maternal/Newborn Provider Settings

- Advise chair (OB and Pediatrics) and nursing staff of risk(s) inherent with bed sharing
- Convene a hospital-based task force to review recent cases of parent/child bed sharing
- Prepare a specific policy statement for the hospital
- Regularly review and update the current policy
- Promote risk management and policy with education for all staff members; parents and family
- Document education practices
- Develop and distribute patient education materials 



# Survey Says


## Hospitals Asked to Evaluate Staff Immunization Services

The Health Research and Educational Trust (HRET), in partnership with the American Hospital Association and Centers for Disease Control and Prevention, is surveying U.S. hospitals about their flu prevention and vaccination activities. The survey documents current practices to better understand the resources required for hospitals to provide flu vaccinations to staff. On July 18, HRET mailed the survey to a representative sample of 1,000 hospital CEOs who were asked to forward the survey to each hospital's head of infection control or occupational health for completion by August. 11. The cover letter notes, "Your participation will ensure that the experiences of your hospital and those like yours will be represented, as the results of this survey will inform national discussion around vaccinating healthcare workers for influenza." Survey responses are confidential, and hospitals that respond to the voluntary survey will receive a summary of the findings. Hospitals with questions about the study should contact HRET's Gretchen Torres or Samantha Hawkins at 800.242.4890, or [Gtorres@aha.org](mailto:Gtorres@aha.org) or [Hawkins@aha.org](mailto:Hawkins@aha.org). 

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## Measured Assurance

### HQA Announces New Standards for Care Quality

The Hospital Quality Alliance announced plans to add new quality information to the Hospital Compare website (<http://www.hospitalcompare.hhs.gov>). Between 2007 and 2009, hospitals will be asked to submit information about patient care experience; mortality rates for heart attacks, heart failure and pneumonia; and expanded information on surgical care, including steps to prevent blood clots, surgical site infections and post-surgical heart attacks and pneumonia. They also will be asked to submit information on pediatric asthma treatment, and on prevention of infections and other complications in intensive care and other critical care units. Some of the new quality measures are pending approval by the National Quality Forum, while others have already been endorsed. The American Hospital Association plans to send an advisory to members offering additional information on the new quality measures and their implementation. 

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To add a colleague or client to the *RiskRX* distribution list, to access the healthcare conference calls, or to update your contact information, please contact Marleen Wolfe.

If adding a new colleague to the distribution list, please include name, title, company, mailing address, phone and fax numbers, and email address.

We welcome your questions, suggestions and contributed articles.

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