risk RX

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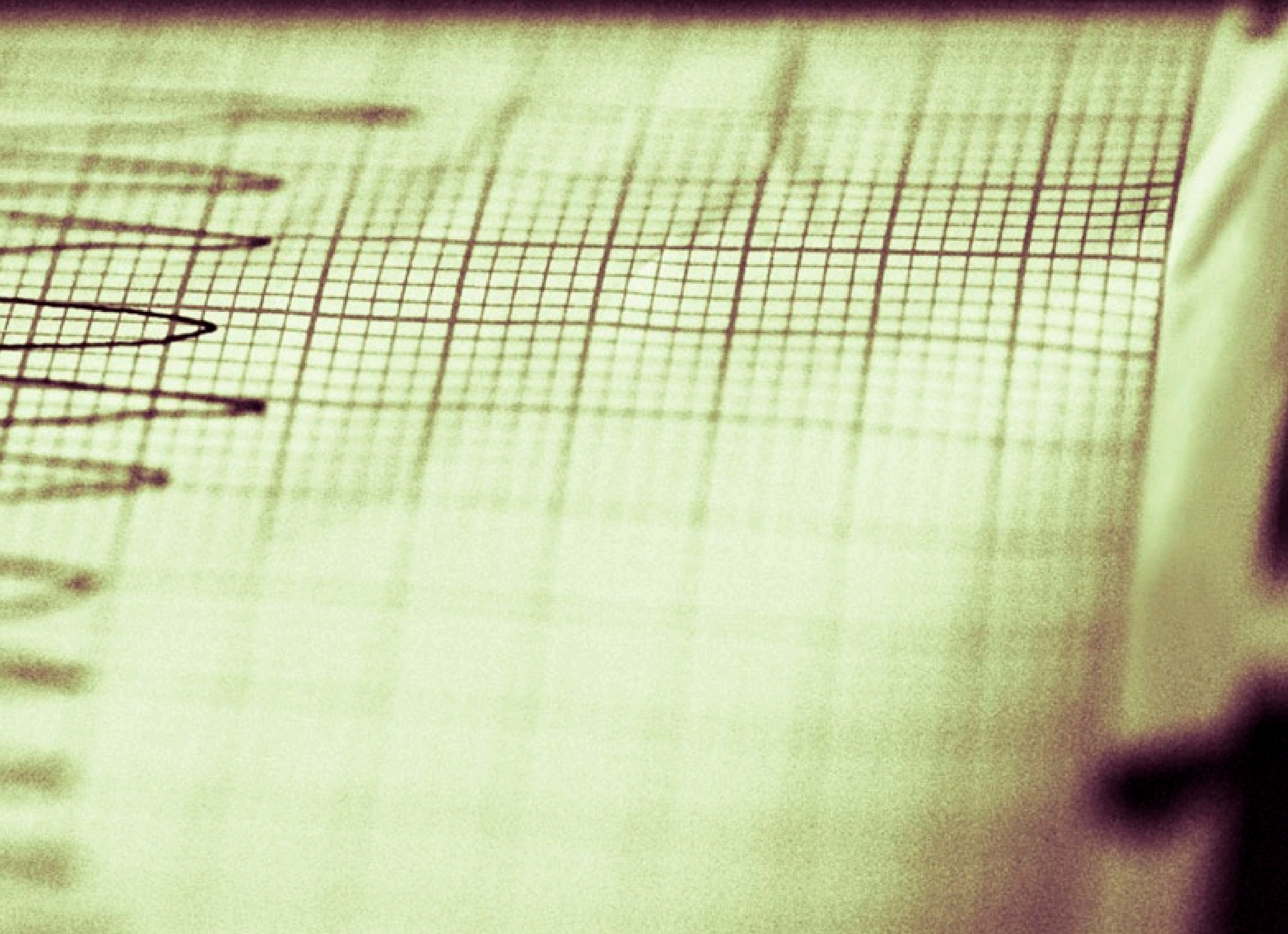

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RiskRX provides healthcare risk management and insurance professionals with relevant information regarding new, updated, and developing issues within the healthcare industry.

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Developing a Dashboard for your Risk Management Program

No department struggles with the adage "data rich, information poor" more than the risk management department of a health care organization. Risk management departments in hospitals, clinics, physician groups and other provider settings collect multiple data sets, yet face many challenges in making the data useful for their own department, and for leadership, boards, committees and front line users at the patient's bedside. The daily demands of a health care risk manager don't allow for constant focus on data analysis, data management and key metrics. Yet risk management programs cannot function or be successful without key performance indicators (KPIs) of current efforts and successes and future forecasts of performance. Many risk managers are faced with the question "what is the value proposition of risk management and loss prevention?" Using tools such as dashboards can help more effectively answer this question.

In healthcare, a dashboard is a commonly used management tool to gauge performance and progress toward clinical and operation goals. Dashboards can be designed and developed to address a wide range of objectives, from monitoring the viability of a risk management department's mission and objectives, to keeping a check on a department's ability to achieve service-level targets such as in incident investigations, setting reserves on claims or closing claims without payment.

Falling Short

Despite their recent popularity in health care, dashboards can be difficult to design and implement, and often fail to achieve their intended objectives. Common problems include misalignment of dashboard measurement with less important organizational goals, unrealistic or poorly defined risk management department objectives, and minimal leadership support for risk management effecting design, implementation and use in the organization.

The challenge within risk management is to design a dashboard that meets your organization's expectations. Broadly speaking, the keys to an effective dashboard initiative include: properly defining metrics; measuring appropriate thresholds; and identifying appropriate target audiences including operational and clinical committees, the risk management/patient safety committee and, in many instances, a captive insurance company board. Further, in designing metrics, they must be simple, manageable and sustainable. Risk managers would be well served to identify a dashboard champion in the organization who can assist in ongoing support of the initiative to create and populate this key management tool (*see Figure 1 for Risk Management/Claims Management Dashboard sample*).

Using a Dashboard to tell a Story

Measurement effectively drives improvement by providing a means of accountability to all areas of the provider organization[1]. Several key factors should be considered in developing measures that work:

- Measures must extend throughout the whole organization.
- Measures must complement the overall strategic plan of the organization, or the risk management program and the organization's error reduction initiatives.
- There must be consensus, with both administration and clinical leadership, on which measures to use and how to use them.
- Measures should be based on internal and external factors, benchmarks and best practices.
- Measures should empower employees to use the data efficiently.
- Ongoing review of the risk management program dashboard measures should be systematic, for management, clinicians and board members.

Why should Risk Managers invest in a Dashboard?

The reason so many risk management departments are designing and implementing performance dashboards is a practical one: the dashboard offers multiple benefits to everyone in an organization, including leadership, physicians, and professional nursing staff. These benefits include the platform to:

- Communicate the risk management and loss prevention strategy.
- Improve the visibility of error reduction efforts.
- Increase risk identification coordination.
- Increase motivation with a "usable" patient safety tool.
- Provide a consistent evidence-based tool to measure improvements.
- Reduce overall error costs including claims.
- Empower users.
- Deliver actionable information for all users including board members.

In short, performance dashboards deliver the right information to the right users at the right time. This, in turn, optimizes clinical decision making, enhances efficiency which improves care, and accelerates changes in policies, procedures and protocols that impact patient care and service.

Moving forward and not looking back

Like any new health care initiative, creating a dashboard for the risk management department can meet with failure if specific lessons are not considered. The success of the dashboard depends on thorough research as to what is important, how to measure it and how to display it. Risk managers should be aware of the following pitfalls:

- Information overload is the leading cause of failure. Too often risk managers will develop management reports that include multiple data sets and indicators. Managers become confused and are unable to use the data.
- Measures must be as current as possible. Performance data that is old is unlikely to be useful in healthcare and medicine. Current and timely data sets must be defined and collected. Historical data may be important but should not be the primary purpose of a dashboard KPI.
- Inconsistent definitions can bring a dashboard initiative to a screeching halt. One example in health care is the definition of a medical malpractice claim. Many experienced risk management professionals define a claim as a written demand, while some define it as an event that may lead to liability, while still others define it as an adverse event that is reportable to an insurance carrier. Definitions, even when inconsistent internally, must be agreed upon by the risk management department and users alike.
- Many risk management dashboards fail due to the selection of KPIs that are not important to leadership. It is very important that consensus be sought on all measures—measures that are sure to be on leadership's "radar screen."

Finally, investment in the design and roll-out of a dashboard cannot be a part-time initiative. To be successful, the dashboard must be simple in its design, the data current and visually appealing. An effective dashboard will help focus and inspire the entire health care team in managing risk and loss prevention.

[1] "Dashboards: Guiding the Way to Improved Hospital Performance," April 2004. *Executive Insights*. Healthcare Financial Management Association.

Figure 1 - Healthcare RM Program Dashboard

Measure	Threshold	Q1	Q2	Q3	Q4	Yr	Comments
Claims Management Program							
		%	%	%	%	%	
Assigned Claims Adjuster	within 1 day						
Assigned Counsel	within 7 days						
Investigation completed	within 14 days						
Investigation Report completed	within 30 days						
Reserve assigned (expense and indemnity)	within 45 days						
Diary Report completed	within 90 days						
Defense Strategy defined	within 120 days						
Known to Unknown	80%						
Closed without payment	70%						
Closed within reserve (ultimate)	90%						
Risk Management/Loss Prevention Program							
Number of Incident Reports within 24 hours	90%						
Number of Incident Reports reviewed within 48 hours	90%						
Number of major Incident Reports reported to Chief of Service/Administrative Director within 48 hours	90%						
Number of RCAs completed within 14 days	100%						
Number of SREs (Never Events) reviewed within 14 days with ultimate decision	100%						
Number of RM investigations completed and family advised within 48 hours	100%						
Number of "disclosures" performed that meet definition of event requiring disclosure	90%						
Loss Prevention Education Offerings: 2 per month = 24	24						
Loss Prevention Assessments per year	5						
Teaching Abstracts developed per year	5						
Patient Complaint Response within 7 days	100%						

the ABC's of PSO's

Patient Safety Proposed Regulation Aims to Improve Health Care Quality and Patient Safety

On February 12, 2008, the Agency for Healthcare Research and Quality (AHRQ) of the Department of Health and Human Services (HHS) issued a proposed regulation to implement certain provisions of the Patient Safety and Quality Improvement Act of 2005 (PSQIA), Pub. L. 109-41, 119 Stat. 424 (the Act), which was signed into law on July 29, 2005. The Act addresses the issues of improving patient safety and reducing the incidence of events that adversely affect patient safety, and it contemplates the establishment of a system for voluntary reporting of patient safety information to patient safety organizations (PSOs). As this is a proposed rule, HHS will take into consideration any comments that are received by April 14, 2008 in promulgating the final rule.

While it was a long-awaited piece of legislation by the time it was signed into law, the Act left several issues unanswered—namely how the PSOs would be established, who would be responsible for overseeing PSOs, how contracting with PSOs would work, and how the confidentiality and privilege protections would specifically apply to information collected for reporting to and analyzation by the PSOs. The proposed rule is intended to address and clarify these issues. Specifically, the proposed rule: (1) outlines the steps for the establishment and certification of PSOs, and (2) discusses in further detail the confidentiality and privilege protections that attach to patient safety work product (PSWP) that is collected for and by the PSOs. Several of the proposed provisions restate and clarify the requirements contained in the Act. Below we discuss the more significant provisions contained in the proposed rule.

Overview

The proposed rule permits various different types of entities to become PSOs—public, private, for-profit, and not-for-profit organizations. Entities that are listed as PSOs will not receive any sort of federal funding but will be permitted to offer individual and institutional providers the benefits of review and analysis of patient safety work product while being protected by the confidentiality and privilege protections contained in the regulations. The proposed rule discusses the process by which an entity becomes certified and is listed as a PSO, and how and in what form information would be collected and reported to PSOs. The PSOs aggregate and analyze the PSWP and report trends to the providers with which the PSO has agreements. The PSOs also provide guidance regarding how to eliminate or minimize the occurrence of such errors within their organizations. Thus, not only will PSOs serve to collect patient safety information, but PSOs may also assist providers in establishing effective strategies to improve patient safety as well as approaches for implementing such strategies.

Finally, as a way to encourage providers to undertake patient safety activities, the proposed rule, as in the Act, specifically provides for confidentiality and privilege protections for patient safety work product and provides for a civil money penalty of up to $10,000 to be imposed on persons who breach these provisions.

Definitions

The proposed rule includes several of the terms that were defined in the Act but also defines a few new terms. Understanding these terms is essential to fully comprehending what the proposed rule intends to achieve. (Visit Integro's Web site, ***www.integrogroup.com***, for a complete list of terms and definitions, which are included within the Act. The entire article is available in the Healthcare section, under "Services." In addition, you can obtain a copy by visiting us at the 2008 ASHRM convention, Booth 717.

Thus, not only will PSOs serve to collect patient safety information, but PSOs may also assist providers in establishing effective strategies to improve patient safety as well as approaches for implementing such strategies.

PSO Requirements and Agency Procedures for Certification and Listing of PSOs

While providers and PSOs are not required under the Act or the proposed rule to enter into formal contracts, AHRQ encourages such contractual arrangements because, in its view: (1) contracts offer providers greater certainty that a provider's claim to the statutory protections provided by the Act will be sustained, if challenged; (2) pursuant to such an arrangement, providers can require and receive assistance from PSOs to ensure that the statutory requirements are fully met; and (3) contracts can also give providers greater assurance that they will have access to the expertise of the PSO to provide feedback regarding their patient safety events.

In accordance with the Act, the proposed rule would establish an attestation-based process for initial and continued listing of an entity as a PSO. This includes an attestation-based approach for meeting the statutory requirement that each PSO, within 24 months of being listed and in each sequential 24-month period thereafter, must have bona fide contracts with one or more provider for the receipt and review of PSWP. AHRQ states that this approach is intended to encourage the rapid development of expertise in healthcare improvement.

Proposed section 3.102(a) (2) incorporates the statutory restriction that a health insurance issuer and a component of a health insurance issuer may not become a PSO. Additionally, public and private entities that conduct regulatory oversight of health care providers, including accreditation and licensure organizations, may not seek to be listed as PSOs.

In accordance with the Act, the proposed rule would require all entities seeking initial or continued listing as a PSO to meet fifteen general certification requirements: eight requirements that relate to patient safety activities (which entities would have to certify that they have policies and procedures to carry out at initial listing and at subsequent requests for continued listing), and another seven that govern their operation (which a PSO would have to meet upon listing and at subsequent requests for continued listing).

Minimum Contracts Requirement

Among the seven criteria that an entity must meet during its period of listing as a PSO is the minimum contracts requirement. The proposed rule attempts to clarify this statutory requirement

that a PSO must enter into bona fide contracts with more than one provider for the receipt and review of PSWPs within every 24-month period after the PSO's initial date of listing. The Act establishes four conditions that must be met for a PSO to be in compliance with this requirement. In the proposed rule, AHRQ proposes to clarify two of the four requirements: (1) the PSO must have contracts with more than one provider, and (2) the contract period must be for a "reasonable period of time."

The Act requires that in order to meet the minimum contracts requirement a PSO, among other things, must enter into a minimum of two contracts within each 24-month period that begins with its initial date of listing. The AHRQ confirms that while one contract with more than one provider would not meet this standard, two contracts with the same hospital system but with different facilities would meet the requirement, because the statutory requirement was intended to encourage PSOs to aggregate data from multiple providers. For example, one contract with a 50-hospital system would not meet this standard; however, two 25-hospital contracts with that same hospital system would meet this requirement.

In the proposed rule, AHRQ discusses but does not propose any clarification of the "reasonable period of time" requirement for PSO contracts. Instead, it proposed for purposes of discussion that such a standard could be time-based, task-based or a combination of both. AHRQ is seeking comments on the operational implication of these alternative approaches with the intention that provision in the final rule would provide certainty for contracting providers and PSOs as to whether this duration requirement has been met.

Additional Certifications for Component Organizations

In addition to the fifteen general certifications required above, the Act and the proposed rule require that component organizations meet three additional requirements in addition in order to be listed as PSOs. The three additional certifications address the entity's independent operation and separateness from the larger organization or enterprise of which it is a part; the entity would certify to: (1) the secure maintenance of documents and information separate from the rest of the organization(s) or enterprise of which it is a part, (2) the avoidance of unauthorized disclosure to the organization(s) or enterprise of which it is a part, and (3) the absence of a conflict between its mission and the rest of the organization(s) or enterprise of which it is a part. The proposed rule contains specific requirements that would ensure that such component PSOs will implement the type of safeguards for patient safety work product that the three additional statutory certification requirements for component organizations are intended to provide.

AHRQ states that it initially considered, but ultimately did not propose, prohibiting a component PSO from contracting, subcontracting, or entering any agreement with any part of the organization(s) or enterprise of which it is a part for the performance of any work involving the use of patient safety work product. Instead, it proposes a limited exception, in proposed section 3.102(c), that would permit contracts between component PSOs and any part of the organization or enterprise of which it is a part to enter into contracts or subcontracts for the performance of work involving the use of patient safety work product only if such contracts or subcontracts can be carried out in a manner consistent with the statutory requirements. That is, while a component PSO could enter into such arrangements involving the use of PSWP with a unit of the organization or enterprise of which it is a part, the component PSO would maintain the PSWP and be responsible for its security, and the component PSO would remain responsible for ensuring that the contracting unit does not violate the prohibitions on unauthorized disclosures. The AHRQ invites comments on whether such a limited exception is necessary or appropriate, and, if so, the appropriateness of the restriction proposed.

Among the issues not addressed by the Act that the proposed rule attempts to clarify is the extent of appropriate security measures that an entity seeking listing as a component PSO must take in order to ensure separation of reported patient safety work product from the organization of which it is a part. The proposed rule addresses this issue in the sections outlining the additional certification requirements for component organizations. The proposed rule would not permit a component PSO to have a shared information system with the rest of the organization(s) or enterprise of which it is a part, since this might provide unauthorized access to PSWP. Further, the proposed rule provides that the workforce of the component PSO must not engage in the work of the rest of the organization(s) if the work could be informed or influenced by the individual's knowledge of identifiable PSWP—thus avoiding conflict of interest internally. There is one exception to this prohibition: a clinician, whose work for the rest of the organization is solely the provision of patient care, would be permitted to undertake work for the component PSO—as the AHRQ does not see any conflict if the patient care provided by the clinician is informed by the clinical insights that result from his/her work for the component PSO. The clinician, however, may not have any duties beyond patient care in order to fit within this exception.

Confidentiality and Privilege Protections

Generally, the privilege and confidentiality provisions contained in the proposed rule do not differ from those contained in the Act. As in the Act, the proposed rule provides that PSWP is privileged and generally shall not be admitted as evidence in federal, state, local, or tribal, civil, criminal, or administrative proceedings and shall not be subject to a subpoena or order, unless exceptions (which are enumerated in the proposed rule) to the privilege applies. Further, the proposed rule provides that PSWP is confidential and shall not be disclosed except as permitted in accordance with the disclosures described in the proposed rule. Under the proposed rule, PSWP may continue to be privileged and confidential even after disclosure in certain situations.

Nonidentification Standard

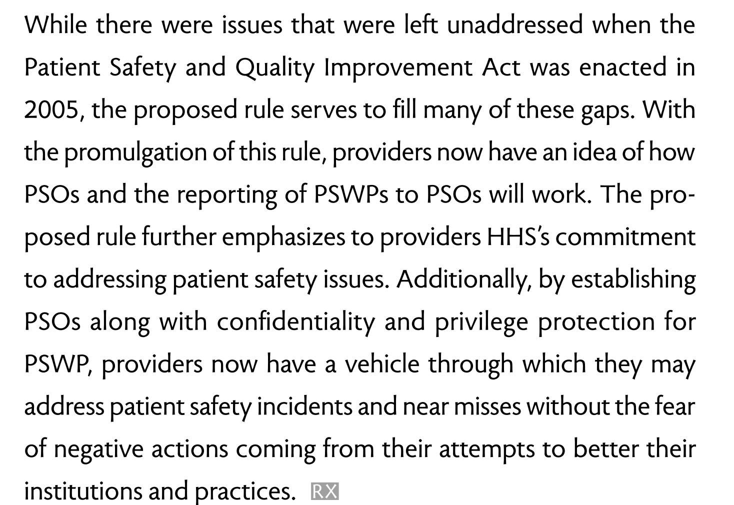
Proposed section 3.212 would establish the standard by which PSWP would be determined nonidentifiable. This determination is important because the standard for nonidentification effectively creates the boundary between what is PSWP-protected and what is not.

AHRQ proposes that the PSWP be contextually nonidentifiable in order to be considered nonidentifiable for the purposes of the proposed rule. The contextual nonidentification of providers and reports is intended to be similar to the standards for de-identification contained under the HIPAA Privacy Rule. The AHRQ proposes two methods by which such nonidentification can be accomplished: (1) a statistical method of nonidentification; and (2) a safe harbor process requiring the disclosing entity (a) to remove 15 specified categories of direct identifiers of providers or reports, and (b) to have no actual knowledge that the information to be disclosed could be used, along or in combination with other information that is reasonably available to the intended recipient, to identify the particular provider or reporter.

PSOs and HIPAA

The proposed rule cautions that the opportunity for a provider to report identifiable patient safety work product to a PSO does not relieve a provider that is a HIPAA-covered entity from its obligations under the HIPAA Privacy Rule. In fact, under the PSQIA, PSOs are deemed to be business associates of providers that are HIPAA-covered entities. Accordingly, such providers must enter into business associate agreements with the PSOs in accordance with their obligations under the HIPAA Privacy Rule. Such agreements may be entered into simultaneously as an agreement for the conduct of patient safety activities. In order to receive the protections of the PSQIA, however, a provider is not required to enter into a contract with a PSO.

Conclusion



While there were issues that were left unaddressed when the Patient Safety and Quality Improvement Act was enacted in 2005, the proposed rule serves to fill many of these gaps. With the promulgation of this rule, providers now have an idea of how PSOs and the reporting of PSWPs to PSOs will work. The proposed rule further emphasizes to providers HHS's commitment to addressing patient safety issues. Additionally, by establishing PSOs along with confidentiality and privilege protection for PSWP, providers now have a vehicle through which they may address patient safety incidents and near misses without the fear of negative actions coming from their attempts to better their institutions and practices. RX

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Ask the Risk Pros

Q: What are the hot topics these days when meeting with underwriters to discuss our health-care system and our risk management program?

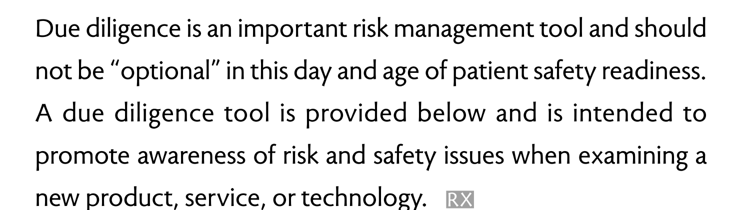
A: Our experience this renewal season with underwriters from the United States, Bermuda, London, and other foreign markets suggests that underwriting teams are interested in four major themes:

- Strategic – plans for growth, alliances, joint ventures and other key initiatives
- Financial and Operational – Update
  - Performance: positive/negative
  - Investments in technology leading to patient safety improvements
    - CPOE, bar coding, EMR, others
  - Turn around plans, if financials have taken a downturn
  - New leadership, if any
- Risk Management – Update
  - Loss prevention initiatives, including training and development
  - Statistics – use of a dashboard for the risk management program is commonplace today
  - Never events
    - How is the system responding to the new initiative?
    - Is there a policy/protocol in place or being developed?
    - How will never events be reported internally and externally?
    - Is the system concerned about increased liability?
- Claims Management – Update
  - Large losses, settlements and verdicts
  - Lessons learned from new or older cases – how does the system use the information?
  - Venue update on jury verdicts and settlement trends
  - Tort reform or challenges to key state/venue case law

Q: Our risk management program is relatively new in terms of staffing and updating policies and procedures. We are concerned about new technology or services being introduced in the delivery system without risk management involvement. Do you have any suggestions on how we can contribute?

A: We recommend that risk management be involved in the "front end" of the activities you have described. It is not unusual to hear that the risk manager is called after a new service, technology, or key protocol has been introduced, and there is a major event. Risk managers are often surprised by these calls and may be at a disadvantage if not involved when the new technology (as an example) is being considered.

Due diligence is an important risk management tool and should not be "optional" in this day and age of patient safety readiness. A due diligence tool is provided below and is intended to promote awareness of risk and safety issues when examining a new product, service, or technology. RX



Action Item or Step(s)	Yes	No	Resource – Internal Responsible Party	Comments, Guideline, Notes
New Service/Product Application filed in writing with Risk Manager (RM) Department ■ Application Form ■ Product or Service support materials, including brochures, from manufacturer ■ Business Case and Plan for implementation at hospital ■ Three references (external) for product or service with current email and telephone numbers				
New Service/Product sponsor identified in application				
Senior Advisor assigned				
Placed in calendar docket for review				
Notice sent to sponsor to prepare for administrative review				
Review team assigned and advise				
Financial Review				
Cost Benefit Analysis completed				
Cost of introduction and implementation completed in Business Plan				
Pro-Formas prepared				
Reimbursement (or private pay) methodologies prepared				
Cost of Training, if any				
Capital Equipment Request process completed, if applicable				
Budget, Cash Flow, Sample Balance Sheets and 3-year projections included for review				
Credentialing and Skill Competencies				
Staffing Plan with new hire vs. current hospital staff				
Training Plan				
Credentialing Plan for physicians and Allied Health (if applicable)				
Plans for competency based testing				
Clinical Guidelines appropriate?				
American College (ACOG) guidelines or position paper applicable				
Supporting literature (nursing, QA, RM, other) for competency based skill sets				

Action Item or Step(s)	Yes	No	Resource – Internal Responsible Party	Comments, Guideline, Notes
Consent, Patient Rights and Responsibilities				
Current Surgical Consent appropriate for new product or service				
If not, is new Consent Form and procedure required?				
New Consent Form and procedure completed				
Patient Education materials prepared and approved by necessary parties for new service or product				
New product or service presented to Patient Safety Committee				
Major risks, benefits and alternatives of new service or product identified				
Following Committees approved the "new" consent process: ■ Medical Records Review/New Form Committee ■ Medical Executive Committee ■ Risk Management Committee				
QI/Patient Safety				
Product or service reviewed for appropriate "indicator" tracking				
Literature search completed for QI or patient safety issues related to use of product or service				
Plans for monitoring and evaluation designed and appropriate				
Physician primarily responsible for new product or service familiar with need and process to perform "peer review"				
Clinical Research Protocols involved with new product or service? If so, has new product or service received approval from the Institutional Review Board at the Hospital?				
If Clinical Research Protocol, has process been designed and defined to advise participants of their limited rights in the research?				
Regulatory Oversight and Review				
Sentinel Event Alert database reviewed for information and warnings				

New Service or Product Risk Analysis - Healthcare

New Service or Product Risk Analysis - Healthcare

Action Item or Step(s)	Yes	No	Resource – Internal Responsible Party	Comments, Guideline, Notes
Other national and regional databases reviewed for "warning" information or "MedWatch" information: ▪ FDA ▪ CDC ▪ ECRI – Private Database ▪ Manufacturer's Database ▪ State Department of Health ▪ Other, as identified				
Other databases or information resources contacted				
Situational/Operational Analysis				
Supporting Market Trends				
Volume Estimates (with basis and research)				
Competitive Research ▪ Local Catchment area ▪ Regional ▪ National (to support growth opportunity)				
Target Market in area, region				
Marketing Plan, if needed, designed and ready for implementation				
Advertising program materials designed with Legal and Risk Management Review				
Campus Space Considerations: ▪ Care Delivery Space ▪ Staffing Space ▪ Storage (equipment)				
Information Technology needs				
Information Technology Officer aware of new product and service, and defined needs (with timeline and costs) to support approval				
Risk Management Review				
Risk Management (RM) involved with Due Diligence at outset of review process				
RM reviewed all business plans, program descriptions and data gathered to support new product or service				
Contracts (sample) reviewed by RM				
Literature search completed for "risks" of product or services				
Product Recall research conducted				

Action Item or Step(s)	Yes	No	Resource – Internal Responsible Party	Comments, Guideline, Notes
RM Consultants contacted for third party opinion or data: ▪ Underwriters ▪ Brokerage Consultants ▪ Insurance Consultants ▪ Defense Counsel ▪ Other local/regional risk management professionals				
Applicable RM standards or guidelines identified for product or service				
Medical malpractice trends (case law, claims review by Underwriter) identified for product or service				
Coverage determination for new product or service: approval sought from Broker or Underwriter				
Standing clinical / administrative Policies and Procedures prepared and reviewed for new product or service				
RM Education provided on risk and benefits to staff involved with new product or service				
Failure Mode and Effect Analysis performed on new product or service				
Other				
Applicable licenses, approvals, CONs, and other state or federal requirements met				
Goals and objectives of product or service				
Success Factors and target dates identified				
Job Descriptions completed, if applicable, with involvement of Human Resources				
Anti-Trust review completed				
Crisis Management Plan designed				

New Service or Product Risk Analysis - Healthcare

by the numbers

42 Percent of United States healthcare workforce who were vaccinated for the flu in 2007 (Source: CDC, 2008)

70 Percent of PL exposure that is "self-insured" in U.S. healthcare (Source: Conning Mid Year Report, 2008)

1 Rank of Integro in recent Business Insurance Reader's Choice Award

5 Percent of U.S. physicians representing more than 50% of medical malpractice payments through 2006 (Source: NPDB Annual Report, 2006)

1 Rank of largest verdict in the U.S. in 2007, which was medical malpractice (Source: Lawyers Weekly)

109 Verdict in millions of dollars. Largest verdict in the U.S. in 2007 (see above)

1.1 Millions of dollars – median medical malpractice award in 2006 (Source: Jury Verdict Research 2006, LRP Publications)

Events: Exhibitions, Conferences, and Meetings

22nd International Reinsurance Congress
October 15-16, 2008
Fairmont Hamilton Princess Hotel
Hamilton, Bermuda
www.reinsurancecongress.co.uk

Property Casualty Insurers Association of America
October 26-29, 2008
Westin Kierland Resort & Spa
Scottsdale, AZ
www.pciaa.net

Annual Bermuda Insurance Conference
November 12-13, 2008
Fairmont Hamilton Princess Hotel
Hamilton, Bermuda
www.pwc.com/bermuda

2008 World Captive Forum
November 17-19, 2008
Renaissance Esmeralda Resort & Spa
Palm Springs, CA
www.worldcaptiveforum.com

National Workers' Compensation and Disability Conference & Expo
November 19-21, 2008
Convention Center
Las Vegas, NV
www.wcconference.com

Cayman Captive Forum
December 2-4, 2008
The Ritz Carlton
Grand Cayman, Cayman Islands
www.caymancaptive.ky

20th Annual National Forum on Quality Improvement in Health Care
December 8-11, 2008
Gaylord Opryland Resort & Convention Center
Nashville, TN
www.ihi.org

Barton Certificate Program in Healthcare Risk Management
ASHRM - 2009 Modules
March 2-6, 2009, Chicago, IL
June 1-5, 2009, Austin, TX
www.ashrm.org/ashrm/education/modules.html

We are proud to be, speakers, sponsors and exhibitors at:

ASHRM: 2008 Annual Conference & Exhibition
October 2-4, 2008
Boston, MA

Cayman Captive Forum
December 2–4, 2008
Grand Cayman, Cayman Islands

In the Crosshairs: Boards are Asking, "What's My Risk Profile?"

The corporate scandals at Enron, WorldCom, and Tyco have, unfairly or not, led to a glaring spotlight being cast on all corporate boards, regardless of industry or size. Board members are being scrutinized as never before and may find themselves feeling as if they have a target on their backs.

Boards of medical groups, healthcare systems, long-term care organizations, surgical centers, and hospitals are hardly immune from this scrutiny. In fact, the spotlight now shining on the decisions made at an organization in the business of providing medical treatment raises the stakes even higher. This article highlights just some of the risks facing healthcare boards.

Peer Review and Credentialing

The boards of healthcare entities are ultimately responsible for the quality of patient care. Yet, patient care depends largely on the quality of physicians and staff. This extends board responsibility to the oversight of physician performance and discipline. These obligations often fall on the shoulders of lay people, who then rely on the technical knowledge of the medical staff to meet them.

Board responsibilities relative to patient care involve ongoing peer review (done by medical staff), and professional credentialing (granting or stripping a physician of medical privileges). Both responsibilities create the potential for claims from physicians alleging discrimination or impropriety in the credentialing process, or charging that they were wrongfully deprived of their right to practice medicine in that institution.

Credentialing claims may also come from patients who suffer injuries as a result of care received. Such claims would allege negligence on the part of the board in allowing the physician to become part of the medical staff, or to retain his or her position in light of medical practices falling beneath an appropriate standard of care.

Charity Care

Healthcare institutions benefiting from a non-profit status may now have the attention of taxing authorities. Governmental authorities have sought to remove hospitals' tax exempt status, claiming that the institutions have not provided enough charity care to their communities to warrant continued tax-free status. Should a healthcare institution lose its tax free status, the board could face claims from bondholders, who expected a tax exempt investment, but are now required to pay taxes on what has become a much less attractive investment. Investors may allege that the board misrepresented the tax exempt status of the institution, causing them to rely upon the board's statements to their detriment.

The IRS's interest in non-profits is reflected in its new 990 Form (these forms are public documents and may be used by regulators in their own investigations).

Network Privacy Risk

Healthcare boards may also face liability for failing to protect personal medical records and other information obtained during treatment, including financial data. Rather than dealing with protecting paper files, most medical and other patient information is now stored electronically with access from many sources inside and outside the institution. Along with the gains in efficiency through the use of electronic medical data comes the all-too-real potential for outsiders to wrongfully breach patient privacy.

If a hospital suffered such a breach, patients may claim the board failed to have the necessary protections in place. Thousands of current and former patients could file a class action suit, with potential damages estimated at $50 to $100 per record.

Employment

Due to their oversight responsibility over organizational functions, including human resources, boards may face claims arising from employment issues. Wrongful termination, racial or sexual harassment and other types of discrimination claims can pose significant risks to directors, especially if employees file the claims through a class action.

Actually, wage and hour issues have eclipsed discrimination in connection with employment claims, and few insurers offer coverage for it. Despite the fact that it is not a healthcare company, the recent verdict against Wal-Mart serves as an example

of the potential exposure from these types of claims. Wal-Mart got hit with a $6.5 million judgment for violating Minnesota wage and hour laws. The judgment could increase to $2 billion depending on the penalties imposed. Wal-Mart apparently required employees to work off the clock and denied rest and meal breaks to employees.

Unfair Competition-Restraint of Trade

Healthcare boards may face exposure from claims alleging violation of various statutes designed to promote fair trade and business competition. Claims that have been brought in recent years include nursing staff members alleging price fixing relative to their wages.

Many hospitals are involved with joint ventures and have interests in surgical centers or other outside medical specialty centers. Some physician groups are planning claims against boards, asserting that the operation of these facilities is being done in a manner that improperly impinges on a physician's ability to compete for medical business.

Mergers and Acquisitions

Just as in the public space, boards face potential liability in connection with any type of business transaction. Last year ranked as the second largest ever for dollars committed to the healthcare M&A market. Despite the slowdown in such transactions in today's economy, mergers and acquisitions still present a risk of claims arising from the business deal. In the event the transaction involves selling an individual hospital or other facility, entities acquiring these facilities often file claims, alleging that hospital management made various material misrepresentations during the course of the sales process.

Protecting Healthcare Boards

The risks facing healthcare boards continue to evolve. One manifestation of this is a reluctance to serve on a board at all. Statutory protections exist for boards to protect them from certain claims in some states. For example, Illinois law limits the liability of unpaid directors for damages stemming from "the exercise of judgment or discretion" in connection with their directorial duties. The statute, however, does not extend its protections to damages incurred through willful or wanton acts. This wording leaves an opening for claims. Directors may also be shielded from liability on the Federal level through the Volunteer Protection Act of 1997 that protects volunteers of IRS Code §501(c)(3) organizations from liability for damages, so long as they acted within the scope of their duties, in good faith, and without willful or wanton actions.

Beyond these statutory protections, with their qualified immunity that limits the protection to mainly negligence claims and not those that allege higher degrees of fault, healthcare entities typically purchase insurance that address some of the exposures facing boards. Coverages commonly purchased include:

- Directors' and Officers' Liability Insurance
- Medical Malpractice Insurance
- Network Security and Privacy Insurance

These types of insurance may address some or all claims made against a healthcare organization's board. Many times, however, claims originate from a variety of causes, some covered, some not. There may be particular causes of action that are specifically excluded by standard policies. As a result, it is imperative that boards work with their risk management staff and insurance broker to ensure their policies work together appropriately and provide the protection expected. Only then can board members of healthcare institutions take up their crucial responsibilities without fear of having a target on their backs. RX

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