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

The Risk Management Quarterly

Volume I - 2015

In This Issue

PRESIDENT'S MESSAGE

Dear Members,

Welcome to 2015! I'm hoping all had a peaceful and restful holiday season and everyone is energized to begin a new year.

Briefly looking back, we ended the 2014 year with a successful half day conference held at Mount Sinai Beth Israel. With a theme of technology, the Education Committee lined up three great speakers to discuss the ever growing area of medical and health related mobile apps and how healthcare organizations need to manage the associated risks of these applications by both patients and staff. AHRMNY would like to thank Mount Sinai Beth Israel for their hospitality and to our sponsors for their generous support.

Looking ahead, please be sure to save the date for our upcoming webinar on Thursday, February 12th. We are excited to have Dr. Joseph R. Masci, Director of Medicine at Elmhurst Hospital Medical Center to present "Epidemic and Pandemic Readiness: A Review of the Response to Ebola in the US". In additional, we are in the process of completing plans for our March Evening Networking Conference to be held at the Lighthouse International on March 18, 2015. We hope to see you there.

It is also the time of year in which our Nominations Committee will begin the process to fill the vacant positions for Board Officers and Directors. Stay tuned to future communications for a Call for Nominations.

In closing, I hope you enjoy this publication of the Risk Management Quarterly as the Publications Committee has been diligently working to provide you with a variety of topical and interesting information.

I look forward to seeing you at the March conference and best wishes for a wonderful 2015.

Gehan Soliman
President

EDITOR'S CORNER

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

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

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

Click here for the official ***RMQ*** Author Guidelines

Reminder:

Maximum article length 3,500 words

Photo requirements: (high resolution JPEGs – at least 300 dpi)

AHRMNY will not publish those articles promoting products or services

The information presented in
THE RISK MANAGEMENT QUARTERLY
is for educational purposes only

CALL FOR ARTICLE SUBMISSION

We are asking our readers to submit articles for future editions of the ***RMQ*** journal that focus on patient safety, environmental or staff safety, risk management, claims management, insurance issues and other relevant topics.

RMQ is published four times a year with a distribution of 300 copies per issue. Please forward any ideas or submissions for publication in the ***RMQ*** to "**Editors**", via email with attachments to: ahrmny@gmail.com.

The deadline for submission and consideration for the next journal is February 27, 2015.

INTRODUCING "MEMBER SPOTLIGHT"….

AHRMNY's *Risk Management Quarterly* is pleased to announce that we will feature a new *Member Spotlight* section in each edition (see page 15 for current member spotlight). This column provides members the opportunity to share professional accomplishments such as recently acquired education degrees or certificates; newly acquired professional designations such as the CPHRM, CPPS, etc.; an award or recognition received from their organization of employment; industry level recognition; facility/organization awards that the member was instrumental in facilitating the achievement of; projects such as IHI collaboratives, research projects; as well as promotions and job changes. Guidelines and Information Sheet for submissions to *Member Spotlight* is available in the Members Area section of the AHRMNY website. Please use your login and passcode to access these forms or you may email ahrmny@gmail.com to obtain copies.

SAVE THE DATE FOR THESE UPCOMING EVENTS IN 2015

Webinar – February 12, 2015
"Epidemic and Pandemic Readiness: A Review of the Response to Ebola in the United States"
Click link for more info and registration
https://attendee.gotowebinar.com/register/200000000029413789

Evening Networking Event – March 18, 2015
Program topics and registration details coming soon

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"JUST WHAT?" OPD MEET JUST CULTURE

By Karen J. Halpern, RN, BS, MSN, JD and
Lauren E. Sicard, RN, MSN, Esq.

Abstract: This article discusses the need for professional licensure disciplinary defense attorneys to educate the professional staff at the New York State Education Department Office of Professional Discipline about the philosophies of the *Just Culture* model and how those philosophies should impact their decisions regarding appropriate disciplinary penalties in cases involving unintentional medical error by the health care professional.

Introduction

In New York, the New York State Education Department's Office of the Professions is the agency that investigates and prosecutes all complaints concerning allegations of professional misconduct for all of the licensed professions. Professional misconduct is defined as "the failure of a licensed professional to meet the standards of practice".[1] Ultimately the New York State Board of Regents is responsible for the final disposition of all disciplinary matters involving the 50 professions that come under its jurisdiction.[2]

The disciplinary process is initiated by a complaint to the New York State Office of Professional Discipline [OPD]. The complaint can originate from many sources. Some of those sources may include a patient or family member, employer, co-worker or even through an anonymous source. All complaints to OPD are investigated. Being convicted of a crime, even a crime unrelated to the professional practice itself, will also trigger a professional discipline investigation.

The Professional Discipline Investigation Process

When an initial complaint is received, it is referred to an OPD investigator who gathers the documentation and information needed for the matter to be reviewed by a prosecutor and a member of the applicable board for the professional under investigation. That initial review will result in the licensee being advised that they are under investigation, and, further that they have an opportunity to attend an interview to put forth any information which they believe is helpful to their defense.

The licensee may elect not to participate in the interview with the OPD investigator. These authors believe that the interview is an excellent opportunity to present an explanation of the event under investigation, or present information regarding mitigating factors. Very often an investigation will be closed with a finding of insufficient evidence if the licensee makes a strong showing at the interview.

Representation at OPD

This article will comment upon a recent case involving a nurse under investigation at OPD which involved an unintentional medical error. When the error was identified, the nurse was transparent, honest and assumed full responsibility. The mistake was caused by human error. The nurse was willing to undergo re-education to improve her skill set and prevent future similar error. She had worked at the hospital for a number of years without any incidents or prior discipline. She had received excellent performance evaluations during her tenure at the hospital. Notwithstanding, she was notified by the hospital that she would be terminated from her position due to the error and would be reported to OPD. She opted to resign in lieu of termination. An OPD investigation ensued.

The nurse attended the OPD interview with counsel and was honest about the event. She fully explained the circumstances, including the fact that the incident involved unintentional human error. The nurse had completed several continuing education classes to remediate and re-educate herself in an effort to prevent a similar occurrence in the future.

Following the interview, her attorney was notified that the matter was screened by an OPD prosecutor with a member of the Board of Nursing and a determination was made that there was sufficient evidence to charge the nurse with professional misconduct. The suggested penalty was actual suspension of the RN license for a period of time, with a fine and probation.

During negotiations with the OPD prosecutor, the nurse's attorney argued that the error was unintentional, that the nurse was open and honest and was extremely receptive to remediation and re-education. Furthermore, her attorney argued that the *Just Culture* philosophy should be implemented and that the nurse should be supported not punished. To the surprise of her attorney, when *Just Culture* was mentioned, the prosecutor responded, "*Just what? I've never heard of Just Culture - are you making that up*?"

This was the perfect opportunity to explain the philosophies of the *Just Culture* model to the prosecutor and explain that support and remediation was the appropriate response rather than strict discipline. Strict discipline alone does nothing to improve and enhance the culture of safety nor does it improve patient outcomes.

Advocating for the use of the *Just Culture* model will often first require the disciplinary authorities, senior leadership and other health care decision makers to be educated in terms of its principals, benefits and application. The following summary describes the *Just Culture* philosophy including its history and the evidence based benefits which demonstrate improved patient outcomes.

What is Just Culture?

Traditionally, the culture in health care held practitioners accountable for all errors or mishaps that occurred with patients under their care. By contrast, a *Just Culture* philosophy recognizes that individual practitioners should not

be held accountable for system failings over which they have no control.[3] At the basis of the *Just Culture* model is the recognition that many individual errors represent predictable interactions between human operators and the systems in which they work. A *Just Culture* philosophy does not promote "no blame" as its primary governing principle although this is a common misconception. In fact, a *Just Culture* model does not tolerate conscious disregard of clear risks to patients or gross misconduct (e.g., falsifying a record, performing professional duties while intoxicated).[4] Additionally, application of a *Just Culture* model requires an environment where frontline personnel feel comfortable disclosing errors, including their own, while maintaining professional accountability.[5] In this way, the systems and circumstances contributing or causing an error can be addressed thereby preventing the error, and associated patient harm, from occurring again.

When was Just Culture developed?

Like so many patient safety initiatives in health care today, the development of a culture that treats mistakes justly has its roots in the aviation industry. As early as 1944, the increasing "criminalization" of the people involved with aviation accidents caused the industry to formally acknowledge accidents to be the result of an "undesirable chain of events".[6] To prevent the repetition of such events, the aviation industry recognized an effective investigation process and safety occurrence reporting system were both necessary, as opposed to a system based on finding blame.[7]

A *Just Culture* model is essentially comprised of two primary components: 1) A proactive/preventative approach to error through the use of a non-punitive reporting system designed to identify opportunities for improvement, and 2) A reactive approach to errors that seeks to establish whether the individual made the error due to a flawed system, human error, or behaviors described as at-risk, reckless, or intentional.

1) Just Culture – Transparent Event Reporting:

It is often said that those who do not learn from history are doomed to repeat it. This statement reflects the *Just Culture* objective, which is preventing the recurrence of mistakes and accidents by encouraging active and transparent reporting of occurrences, as well as full participation in an investigation for safety purposes instead of merely punishing those involved. Moreover, in 2000, Dr. Lucian Leape, a member of the Quality of Health Care in America Committee at the Institute of Medicine testified before the U.S Congress that "approaches that focus on punishing individuals instead of changing systems provides strong incentives for people to report only those errors they cannot hide. Thus, a punitive approach shuts off the information that is needed to identify faulty systems and create safer ones. In a punitive system, no one learns from their mistakes".[8]

Dr. James Reason, a noted psychologist in the field organizational culture is often quoted for stating a "*Just Culture* is an atmosphere of trust in which people are encouraged to provide safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior".[9] A *Just Culture* is one that learns and improves by openly identifying and examining its own weaknesses. Organizations that follow a *Just Culture* philosophy are as willing to expose areas of weakness, as they are to display areas of excellence. Of critical importance is the fact that caregivers feel that they are supported and safe when voicing concerns.[10] Individuals know, and are able to articulate, that they may speak safely on issues regarding their own actions or those in the environment around them.[11]

As an alternative to a punitive system, application of a *Just Culture* model, which has been widely used in the aviation industry, seeks to create an environment that encourages individuals to report mistakes so that precursors to errors can be better understood in order to fix the system issues. Transparency i.e. the free, uninhibited sharing of information, has been cited as one of the most important attributes of a culture of safety. In complex, tightly coupled systems like health care, transparency is a precondition to safety. Its absence inhibits learning from mistakes, distorts collegiality and erodes patient trust.

2) Just Culture – Accountability:

As previously stated a facility that embraces a *Just Culture* philosophy creates an atmosphere of trust in which people are encouraged to provide safety-related information, but in which they are also clear about where the line must be drawn between acceptable and unacceptable behavior. Therefore, accountability is essential to a successful *Just Culture* ideology. The components of accountability include the individual's understanding that they are to perform an action, a clear expectation what that action is, and the means by which they will be evaluated.[12] A *Just Culture* system involves the organization's development of a framework for consistent accountability, correction where accountability is poorly defined and individuals are clear what the rules are, or whether the rules are constantly changing.[13]

Determining when a health care provider warrants disciplinary sanction requires an understanding of the inter-relationship between human behavior, discipline and patient safety. There are various categories of behavior recognized by the different descriptions of Just Culture. The table below is an overview of the three behaviors and associated management strategies most frequently described in the various descriptions of Just Culture.[14]

Human Error	At-Risk Behavior	Reckless Behavior
Inadvertently doing other than what should have been done.	When a behavior choice is made that increases risk where risk is not recognized, or is mistakenly believed to be justified.	Action taken with a conscious disregard for a substantial and unjustifiable risk.
Manage by consoling the individual, then consider changes in processes, or procedures, training and design.	Manage with coaching and/or removing incentives for at-risk behavior and create incentives for healthy behavior. Teach situational awareness.	Manage with remedial or punitive action.

Conclusion of the OPD Case

The particular OPD case discussed above involved unintended human error that resulted in the parties appearing before a Board of Nursing representative at an Informal Settlement proceeding. At that time, the ANA Position Statement on Just Culture was presented and discussed.[15] The American Nursing Association (ANA) Position Statement specifically states:

> "The *Just Culture* concept establishes an organization-wide mindset that positively impacts the work environment and work outcomes in several ways. **The concept promotes a process where mistakes or errors do not result in automatic punishment, but rather a process to uncover the source of the error.** Errors that are not deliberate or malicious result in coaching, counseling, and education around the error, ultimately decreasing likelihood of a repeated error. Increased error reporting can lead to revisions in care delivery systems, creating safer environments for patients and individuals to receive services, and giving the nurses and other workers a sense of ownership in the process. The work environment improves as nurses and workers deliver services in safer, better functioning systems, **and the culture of the workplace is one that encourages quality and safety over immediate punishment and blame."** [Emphasis added]

The disciplinary authorities in this particular case were receptive to the defense arguments. Ultimately, a non-public discipline was negotiated and approved that did not include suspension or probation. The settlement consisted of a Violation Committee Statement which is not reported publically on the internet.

Summary

This brief case study is an example of how the education of decision makers regarding the *Just Culture* philosophy affected the final outcome and resolution of a nursing disciplinary matter that stemmed from an unintentional medical error. Eventually, once the disciplinary authorities were educated about the *Just culture* model of patient safety and the recognized theories of accountability, they were more willing to consider a less punitive action against the health care professional.

The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.

-Lucian Leape

Article references listed on page 28

About the Authors

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Karen J. Halpern, RN, BS, MSN, JD is a litigation attorney in private practice with an office in Melville New York. She is of counsel to the firm Lawrence, Worden, Rainis & Bard, PC. She is admitted to practice law in the New York State and Federal Courts. Her law practice for the past 25 years has been limited to medical malpractice defense litigation and professional licensure defense representing doctors, nurses and other health care professionals in disciplinary matters. She has lectured extensively on a variety of health law related topics including professional licensure defense and medical malpractice litigation. She is an ASHRM and AHRMNY member and sits of the AHRMNY Board of Directors. Karen also is a member of The American Association of Nurse Attorneys [TAANA] and sits on the national TAANA Board of Directors. Karen has held adjunct faculty positions at Adelphi University and Duquesne University in the Schools of Nursing, and SUNY Stony Brook in the Department of Preventive Medicine. Before becoming an attorney Karen was a Registered Nurse with over 12 years of experience as a Labor and Delivery Room Nurse. She holds a Bachelors of Science degree with a major in Nursing from SUNY Stony Brook, a Master of Science Degree in Nursing from Duquesne University and a Juris Doctor degree from Touro Law School.

Lauren E. Sicard, RN, MSN, Esq. is the Associate Director of Risk, Quality and Patient Safety at Affiliates Risk Management Services, Inc. She also provides risk management, quality, and patient safety services to other organizations in the New York metropolitan area. Lauren is admitted to practice law in New York and Massachusetts. Her professional focus involves developing risk management , quality and patient safety educational initiatives based on the lessons learned from medical malpractice claims, as well as several health care organizations. Prior to moving to New York, Lauren resided in New England where she worked for approximately 15 years as a Registered Nurse at the Brigham & Women's Hospital in Boston. In addition to her nursing and law degrees, she also holds a MSN in education, and a MFA in creative writing.

IN THE BEST INTEREST OF THE PATIENT
A VIEW FROM THE BENCH

F. Dana Winslow, J.S.C.
Supreme Court, State of New York, County of Nassau

For quality medical care, isn't the knowledge of what transpired with the diagnosis, care and treatment of a patient the Holy Grail, or the sought after goal of providing the best health care to the patient?

The perception of the need for considering the best interest of the patient is demonstrated in the creation of a lectureship entitled "Using Closed Medical Malpractice Cases to Promote Patient Safety" at the fifth annual Pegalis & Erickson, LLP lectureship at the New York Law School, attended by all segments of the medical and legal community. The dais and audience consisted of plaintiffs, defendants, risk management, insurance companies, doctors, and judges. One of the goals is to gather a copy of concluded medical malpractice tried cases, with appropriate deletion of names, and publishing them on a website that would be available for use by the medical-legal community. Such a process was thought to be of benefit to those involved, including risk managers, and, most particularly, consistent with the best interest of the patient.

There should be no disagreement among the various segments of the medical and legal community to the resounding "yes" that would emerge for such a proposition. However, the roar might become a whimper when the implementation of the actual procedures are considered.

The prevailing view from the doctors' and hospitals' perspective is that self-governance, with the opportunities afforded to confine the dissemination and the consideration of an adverse outcome to peer review, is best for the profession. Medical providers continue to subscribe to the proposition that the causes of an adverse outcome should be addressed from an in-house peer review of the events. The present conceptual belief is that the process allows for free discussion, within the confines of the medical community, without the fear of disclosure that would dampen discourse. The reason for such a procedure is to encourage more health providers to candidly discuss the salient care issues that occurred in the diagnosis and treatment of the particular patient and then to implement any necessary changes for future care of other patients. That approach certainly could have a positive benefit regarding care to those patients. Consideration of the facts of a like occurrence can favorably further treatment of future patients. However, it has a dampening effect on a doctor-patient relationship and leaves the patient unable to fill in the blanks concerning the care and treatment provided.

This author suggests that a practice be adopted that would allow the health provider to explain to the patient, at the earliest possible moment, any complication or less than satisfactory outcome of a procedure or course of treatment even if it means an acknowledgment that the health provider had, in some way, been responsible for the medical issues that have occurred. The declaration that the less than favorable outcome was a risk of the procedure, whether true or not, has become increasingly unsatisfactory to the patient and the family. Even so, such a declaration is frequently made known to the patient and his family for the first time during litigation and not at the time that would have been most helpful to them so they could have earlier determined not only what may have transpired, but understand what gave rise to the result that was less than satisfactory. The late delivery of this essential information may have deprived the patient, or the survivors, of an opportunity to address problems, and particularly the patient's problems, in a more satisfactory fashion. The concern, widely known and frequently cited, is that such candor may lead to an ultimate determination of legal liability by handing a prospective plaintiff self-incriminating admissions on a "silver platter". However, this failure to immediately address the problem in a candid and empathetic fashion clearly undermines the medical profession's credibility and esteem. Such an erosion, in turn, leads to a diminution of confidence in the reliability of the entire medical profession.

The most frequently asked question by the patient-family that arises is: "why didn't the doctor tell us what happened." That information is often heard for the first time during trial or discovery, rather than as it occurred, or as soon as the patient-family could be informed. In most instances, the physician, on a purely human basis, would prefer to see the affected patient tell the family what happened, but the physician has reservations, because of the perceived medical-legal implications.

In order for the doctors to speak openly to the patient-family, the physician must be afforded protections in any future litigation. The author suggests that any adverse statements made to the patient-family be excluded in future examination before trials or depositions, trials, and hearings. Taking a strong, and even strident position, for this proposed tenant is an important requisite. This response would be particularly significant if the best interest of the patient continues to be important in the context of avoiding further unanticipated adverse results.

For further consideration of the unanticipated results please note The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and AMA ethical code opinion 8.12 patient information. Additional publications, including IOM, point to the problem and some proposed resolutions.

To obtain this candor, an unanticipated bad result must be viewed from both the patient's perspective, as well as the physician's perspective. A forthright discussion may assist the medical community, which will avoid replicating an unsatisfactory result. The absence of such a discussion does little to provide the family with a psychological and inter-personal understanding of the occurrence or of the patient's needs.

It is not entirely without precedent and bears similarity to *People v Rosario*, 9 NY 286 (1961) codified in Criminal Procedure Law 240.45 and 240.44 with additional development in the federal system in *Jencks v. U.S.*, 353 U.S. 657, and the Jencks Act, 18 U.S.C.A. §3500. The *Rosario-Jencks* rule has a basic requirement that may be modified, namely that statements of the witnesses may be provided at or before the time of trial. The concept is that written or recorded materials be turned over to the adverse party. The difference between the author's suggestion and the previously described criminal law evolution is that the statement by the doctor be made at the earliest moment, but departs from *Rosario - Jencks*, by not allowing the plaintiff to use the candid explanation against the health-provider in the forums mentioned.

Why does it make a difference whether or not there is an explanation? The answer is self-evident. Candor for its own sake, could help avoid the patient proceeding with litigation or make the patient less interested in retribution and make settlement more easily achieved. There will be greater inclination to listen to advice rather than be led by emotion.

Both the plaintiff's and defendant's bar would share some of the same benefits if a candid dialogue were utilized. Both of the bars would more readily recognize conflicts and attempt to avoid them. Multiple defendants that had little to do with the case, but were considered necessary for discovery and, thus, included in the caption, would likely be eliminated earlier in the litigation. Due to the fear factor that some plaintiffs attorneys may have, namely that a potentially responsible health provider may slip through the screen, that may more properly be considered a fine mesh, would not preclude a cognizable claim against a health provider.

Frustrating a candid communication between the doctor and patient runs counter to the adage, "with knowledge comes change." It doesn't assist the patient or family if it is given too far from the adverse events. The benefit to the providers, and risk managers, is the avoidance of the courts to inform the patient of what has transpired in his or her case and to eliminate non-essential medical personnel from the claim. More frequently than not, our present procedures continue to be an enigma to the patient and with this change the doctor would be the first to provide an explanation before advice is given by family and friends.

On a philosophical note, Dante Alighieri's "Divine Comedy", (14th Century), provides:

> the darkest places in hell are reserved for those who maintain their neutrality in times of moral crisis.

Most of us have heard that refrain, particularly in the context of World War II and it may seem to be hyperbole in the context of our present considerations but not when we believe that what we want to do is are in the best interest of the patient. We are either frozen in place, something that this author would never suggest, or we are neutral in our consideration of the patient's welfare in the presence of the years of medical malpractice litigation. The time may be now that we keep pace with societal change as characterized by Benjamin Cardoza in The Growth of the Law.

About the Author

Justice Winslow was first elected to the Supreme Court, State of New York, Nassau County, in 1996. He has presided over numerous malpractice trials and is known to be an innovative Justice supporting, among other things, the practice of permitting questions from jurors to be posited to witnesses at trial. Justice Winslow has testified before Congress in connection with foreclosures in the aftermath of the 2008 financial crisis. Prior to sitting on the Supreme Court, Justice Winslow practiced law as part of a 40+ attorney firm for seven years, as well as at his own firm for nine years. He has also served as a Village Justice and in as a town attorney or county attorney for various municipalities. His community activities include founding and chairing Long Island Riding for the Handicapped, Inc. He also served as a special agent in Military Intelligence for the US Army from 1962 to 1965.

A COUNTERPOINT FROM THE RMQ PUBLICATIONS COMMITTEE

The Editorial Board appreciates the contribution of Justice Winslow, and article entitled "In The Best Interest of The Patient." However, we must make it clear that the views espoused in that article are those of Justice Winslow, and do not reflect the views of this publication. It is our opinion that, if anything, a complete privilege is necessary in all quality assurance to permit medical facilities unfettered and comprehensive review. The current system allows the jury to hear any statement given by a physician in the peer review process, and has chilled the process as a result.

Justice Winslow's article has high aspirations, and the Editorial Board wholly embraces the primary goal of having the most effective and thorough quality assurance process to ensure the best care of each and every patient under every conceivable scenario. However, the Editorial Board staunchly believes that, as Justice Winslow concedes, "the roar might become a whimper when the implementation of the actual procedures are considered."

All involved in hospital risk management and patient safety have made it their life's mission to create an environment where there are no such things as adverse events. However, due to the nature of the patients who present with comorbid conditions that require contradictory care and the emergent nature of many presentations, this is unfortunately impossible. Medicine is not an exact science and the human body is not a one dimensional raw material. A trite phrase comes to mind-hindsight is 20/20, but physicians and medical care providers are limited by being put into the situation of having to provide treatment in an unsure present.

Clearly, a paramount concern is what to do when an adverse event occurs. Justice Winslow advocates that an open commentary and frank discussion by the physicians involved in the event is the best medicine against future adverse events. However, there is a practical impasse that exists under any framework that renders the methodology proposed flawed, absent one of an absolute immunity.

We broached this subject with several major metropolitan area professionals who dedicate their lives to hospital risk management. Their opinion was unanimous, as stated by a major metropolitan area hospital risk manager, "Peer review has grown because it is confidential and the physicians are more willing to participate and learn from unexpected or unattended outcomes." Another professional stated, "It would provide a tremendous boon to our quality assurance if our physicians were granted an absolute privilege on all statements or admissions during the process."

Among those issues that one could see arising in such a scenario put forth by Justice Winslow are physicians being questioned at a deposition or at trial about a meeting with a family after a possible adverse event. While the physician may not be forced to divulge the nature of the conversation, the mere fact that the meeting took place without opportunity for an explanation (since that may be deemed as waiving the non-disclosure privilege), may well be interpreted by jurors as a tacit admission of wrongdoing. Indeed, time and again plaintiffs try to conflate the fact that physicians relay sorrow for a less-than-perfect medical result as an admission of guilt at trial. At the very least, the risk exists of the creation of a negative inference against the defendant in the mind of a juror.

A counterpoint from the RMQ Publishing Committee continued…

It is also conceivable that a physician could have an opinion as to what occurred at the time of the event and may believe that a mistake was made, yet, after analyzing the event and going through the quality assurance/peer review process, come to the conclusion that no mistakes were made and that the patient just suffered a known and accepted risk of the procedure or of the underlying disease process or that there were other outside factors that could not have been controlled or anticipated. However, when confronted at an examination before trial, or at trial itself, the practitioner would have to admit that the conversation and meeting with the family took place, even without disclosing the content the conversation, thereby leaving the inference open that some type of adverse event did occur, even though the content of said conversations would be privileged.

If our focus is really going to be on patient safety, what is really necessary to remedy these issues is a process that permits the free flow of information not only between patients and practitioners, but between practitioners and their peers. This currently does not exist in New York. Thus, instead of the method proposed, the Editorial Board advances the need for an expansion of the current quality assurance procedures in place in New York State to afford absolute privilege. This will open the door to the type of in-depth quality assurance review that will benefit medical results (if not costly medical malpractice litigation).

Hospitals in New York already have peer review mechanisms in place that address adverse outcomes and patient safety issues. In fact, in our experience, most adverse events that give rise to lawsuits are reviewed and used as teaching tools before the events ever become suits. Quality assurance committees review the events, determine if something was done wrong and, if there was a preventable bad outcome (even if nothing was done outside the standard of care), develop solutions to address the circumstances that gave rise to the outcome.

However, in New York, these peer review mechanisms always operate at a distinct disadvantage. Perhaps the most glaring problem with New York State Quality Assurance is the fact that the statements of providers are discoverable in a malpractice action. 45 states have a full, non-qualified privilege when it comes to the content and disclosure of quality assurance meetings. Yet, New York only has a qualified immunity as to the content of those proceedings. The system in place in New York actually frustrates quality assurance and patient safety by essentially discouraging those who could learn the most from the quality assurance lesson, *i.e.* the providers actually involved in the care, from making any statements, thus turning those actors into passive participants in the QA process. While the plaintiffs' bar may receive anecdotal advantage in medical malpractice litigation, future patients receive no such benefit as a full and complete quality assurance review was stymied out of physician fear that such statements will be discoverable litigation.

What is really needed to encourage patient safety is a mechanism which will actually encourage frank discussion by the participants involved, as opposed to one which inhibits. Thus, while patient safety is the utmost concern of all those involved, we believe that Justice Winslow's article is really more of an utopian band-aid exposing the limitations inherent in the current New York legal regime. Until such a time when those qualified immunities become full immunities, New York State will always be lagging behind, to a certain extent, in its patient safety and quality assurance programs.

In short, the Editorial Board could be best summed up in the following way. Good risk managers are wholly committed to patient safety and put the well-being of patients first. We have no interest in protecting 'bad apples' or participating in 'covering up' medical errors. We promote patient safety and proactive risk reduction. We encourage timely and honest discourse with families when unexpected or untoward events occur—this is what is ethically expected of healthcare providers. We advocate for robust informed consent discussions regarding procedures, treatment plans and medication management. We believe that providing patients with pertinent information up front about potential risks, benefits and alternatives to treatment reduces the opportunity for confusion, frustration and anger in those instances when outcomes do not meet expectations. We work collaboratively with our clinical staff to adopt evidence-based best practices. We seek to learn lessons from quality reviews, medical malpractice cases, media events and from our fellow risk, quality and patient safety professionals and strive to put systems based solutions in place that reduce variability in the delivery of care and prevent unfortunate events.

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Risky Business

"When Common Sense is Uncommon"

By Pamela Monastero, MBA

COMMON SENSE TIPS FOR STAFF:

This quarter's column explores the subject of pre-hospital care, ambulance call reports (ACRs) and hand-offs between ambulance teams and emergency department (ED) staff. In Spring 2012, we published an article by Jason D. Turken and Michael D. Levine titled *Pre-Hospital Electronic Health Records.*[1] Click link to download article http://ahrmny.com/images/downloads/Newsletters/pre_hospital_electronic_health_records_rmq_spring_2012.pdf The obvious concern, and the primary reason for AHRMNY's interest in this topic, was related to the hand-offs of paramedics to hospital ED staff--the timeliness and accuracy of pre-hospital information. The article also explored the various questions posed by use of electronic ACRs—seamlessness such as software compatibility, printer compatibility, encryption and HIPAA, among other issues. As stated by the authors, the New York City Fire Department's (FDNY) "intent was to develop an electronic pre-hospital care report to be used by ambulance crews in its Bureau of Emergency Medical Services (EMS)." The article indicated that ACRs were to be generated by hand held devices and transmitted to receiving hospitals prior to the EMS crew arrival. Very little literature specific to electronic pre-hospital care reporting was available at the time this article was originally published in the RMQ. One literature source quoted indicated that physicians continued to receive verbal reports from paramedics or third hand information from triage nurses. Obviously, any method of communication that is timely, concise, complete, accurate and facilitates the care of the patient is optimal, regardless of whether it is transmitted electronically, by hard copy or verbally. At AHRMNY, we would like to revisit this topic in 2015 and have prepared an opinion survey for our members and readership, which follows this column. We ask that you complete the survey by February 27, 2015. Click link to access online survey http://ahrmny.com/survey.php?id=6

Of interest and directly related to the communication that transpires between EMS and ED staff, the August 2014 edition of the Annals of Emergency Medicine (AEM)[2] published the results of a study involving patient hand-offs between EMS and ED staff. I encourage our members and readers to review this article and share it with their ED staff. The objective of the study was to evaluate EMS providers' perspectives to generate hypotheses to inform and improve the hand-off process. EMS providers were recruited from various national and regional conferences and 48 multi-state providers participated in the study.

It is well known that transitions of care, inclusive of patient handoffs, represent opportunities for medical errors and adverse events. According to The Joint Commission (TJC), an estimated 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off. [3] Root causes of ineffective transitions of care include communication—inclusive of lack of communication or hand-off, incomplete information, information obtained third-hand and timeliness of information, among other factors. Substandard hand-offs can result in delayed or inappropriate treatment, adverse events, omissions of care, increased length of stay, avoidable readmissions and other patient harm, not to mention the associated financial impact and potential media and medical malpractice issues. The TJC Transitions of Care portal contains valuable links, inclusive of the *Targeted Solutions Tool™ for Hand-off Communications*.

The AEM[2] article identified that the first transition of care (hand-off) likely occurs between the EMS team and the ED staff. The author's maintain that "EMS-to-ED hand-offs represent unique challenges, in part because participants have distinctive clinical duties and professional cultures and largely nonoverlapping sites of work that can lead to potential communication and teamwork gaps." The study revealed that the EMS participants surveyed indicated that although hand-offs are a central feature of their work, there are "no standard 5 points" in giving hand-off information, which can lead to improvisation when delivering verbal hand-offs. Participants also felt that "hand-offs occur quickly, normally within the first minute or so when ED stakeholders are engaged in the care of the patient." The perception is that the initial interaction, while essential, can become muddied when ED providers are very busy working with patients, especially with acutely ill and critical patients. Research questions and themes identified from the survey results are depicted in a detailed table (Table 2)[2] in the article and are as follows:

- Timing of the hand-off (there is a brief window of opportunity to convey essential information);
- Staff hierarchy (direct communication with the physicians was identified as being the most effective form of information exchange; EMS participants surveyed perceive themselves as being viewed as having low status and power in the ED setting and that ED staff did not understand their professional scope of practice, complicating EMS's work as patient advocates);
- Patient hierarchy (there is a higher level of information exchange on trauma patients vs. non-trauma patients and "frequent flyers);"

- Educational potential of the hand-off (EMS workers desired additional feedback about their patients' status and presumptive diagnoses during the hand-off so that EMS workers could improve their own clinical skills and capacity to advocate for patients);
- Role of standardization and technology (there is inconsistent use of out-of-hospital records at the time of hand-off and essential information can be missed; use of technology was inconsistent and often ineffective to support hand-offs; standardization could eliminate opportunities to convey important out-of-hospital information, including a description of environmental and interpersonal threats to health at home).[2]

The EMS participants surveyed "expressed a desire to relay critical information directly to the ED physicians and felt that this would lead to more robust and comprehensive hand-offs, inclusive of discussion of intangibles such as general diagnostic impression and assessment of acuity." They stressed that their communication with nurses was "problematic" and they "resented when nurses expressed little interest in hearing" what EMS had to say about the patients brought to the facility. Another interesting observation cited is that ED staff appears to be less interested in reports about non-trauma patients, even in those cases where clinical severity could be high. The EMS participants surveyed also expressed dismay regarding ED staff attitude about "frequent fliers," even when these patients appear quite ill. [2]

The EMS survey participants were also queried about the "role of technology in bridging gaps in hand-offs." The participants had the following comments: (a) electronic ACRs can be delayed from 24-28 hours due to lack of standardized or regulatory-mandated transmission time of these documents; (b) discrepancies were noted between what was verbally reported and what was documented on the ACR report; (c) discussion of whether ACRs (handwritten or electronic) are incorporated into hospital medical records. Regarding electronic records (ACRs or facility-based electronic medical records), the sense from some of the participants is that ED staff seem to prefer a hard copy or ACR form to memorialize the information given during the hand-off. [2]

Tips/Lessons Learned:

To improve hand-off communication between EMS and ED staff, the following was recommended by the survey participants:

1. EMS-to-ED physician (the provider who will be responsible for the patient's subsequent care) direct communication;
2. Interdisciplinary feedback on patients brought to the facility and transparency between ED staff and EMS to foster greater understanding and learning and shared understanding of scope of practice;
3. Standardize aspects of the hand-off beyond information contained in the verbal report. Utilization of technology that can close information gaps. [2]

One way that risk/quality/safety management professionals can obtain further insights into the EMS-to-ED hand-off and communication process is to have audits conducted for:

- Observing and documenting notes about crucial conversations and the exchange of information that takes place during the hand-offs. Take note of whether the discussion was robust and if the ED staff were actively listening and how EMS staff are viewed and treated by the ED staff and vice versa;
- Comparison of the hard copy ACR documentation (paper or electronic transmission) with your observations of the hand-off process, to determine whether hand-off information was timely, appropriate, accurate and complete and if information given verbally differs from any hard copy ACRs;
- If possible, conduct brief medical record reviews to correlate whether pertinent information from hand-offs by EMS (e.g. patient history, important social or environmental issues that can impact care, etc.) are incorporated into your facility's medical record and, possibly, the treatment plan;
- Determine whether the ACR becomes a permanent part of your facility's medical record and whether it is easily accessed by staff who may need to refer to it;
- Provide feedback to your ED team and, if appropriate, to EMS leaders and suggest recommendations for improvement as appropriate.

Article references listed on page 28

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Risk Management Quarterly Journal (RMQ), is designed to support both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. This column is based on the contributions of our constituent members, to whom we are grateful for sharing their experiences. We continue to encourage our members to submit their experiences anonymously for inclusion in this column. Please e-mail any suggestions to pamela.monastero@nychhc.org or mail to AHRMNY utilizing the RISKY BUSINESS form which can be found on our website at http://ahrmny.com/images/downloads/Newsletters/form_risky_business_form_7_2009.pdf. The form permits confidentiality.

AHRMNY SURVEY: "Pre-Hospital Electronic Health Records—Opinions on the New Ambulance Call Reports"

Dear Colleagues:

In the Spring 2012 edition of The Risk Management Quarterly, we published an article authored by Jason D. Turken, Esq. and Michael D. Levine, RN, called "Pre-Hospital Electronic Health Records" which outlined the New York City Fire Department's (FDNY) plan to develop an electronic ambulance call report (ACR)—Click link to read a copy of the article.

http://ahrmny.com/images/downloads/Newsletters/pre_hospital_electronic_health_records_rmq_spring_2012.pdf.

Now that electronic ACRs have been implemented in New York City, and elsewhere in the Tri-State area, we wanted to revisit this topic and are requesting that our readers and members provide feedback based on your experiences with electronic ACRs. Outlined below are questions and an area designated for additional comments. Please link to complete online survey by February 27, 2015.

http://ahrmny.com/survey.php?id=6

1. Does the ambulance team provide hard copy documentation/reports to your Emergency Department (ED) staff before leaving the premises?
   ☐ Yes ☐ No

2. Who does the ambulance team provide verbal communication to?
   ☐ ED Physician or PA ☐ ED Triage Nurse/Other RN
   2a. ☐ Other _____

3. If ACRs are faxed or electronically submitted to your facility, is there a significant lag time that could affect patient care?
   ☐ Yes ☐ No

   3a. If not, do ED staff obtain the necessary information from the ambulance crew prior to their departure from the ED?
   ☐ Yes ☐ No

4. Do you get telephone notification with information from dispatchers prior to ambulance arrival at your facility?
   ☐ Yes ☐ No

   4a. If so, do you receive a thorough report about the incoming patient?
   ☐ Yes ☐ No

   4b. Who receives the ambulance crew on arrival: _____

   4c. Do you have a formal process for ambulance check-in/check-out?
   ☐ Yes ☐ No

5. Are verbal discussions with dispatchers or ambulance crews documented by ED staff in the medical record?
   ☐ Yes ☐ No

   5a. Is information provided by the dispatcher or ambulance crew included in the ED History & Physical or other ED physician and/or nursing progress notes?
   ☐ Yes ☐ No

6. Does your facility have wireless printers that can be used by the ambulance team to print ACRs in real time from mobile devices?
   ☐ Yes ☐ No

7. Does your facility utilize an electronic medical record?
   ☐ Yes ☐ No

8. Please identify the following specifics about your hospital:
   8a. Hospital Size: # beds _____ # ED beds _____
   8b. Hospital Type: ☐ Urban ☐ Suburban ☐ Rural
   8c. Teaching Hospital: ☐ Yes ☐ No
   8d. Does ED have an ED residency program? ☐ Yes ☐ No

9. Please use this section to provide additional comments on the electronic ACR, hand-offs with ambulance crews and any additional insights and/or potential liability issues you may have:

INSURANCE MARKETPLACE UPDATE

MEDICAL PROFESSIONAL LIABILITY

By Robert Marshall

Overall Insurers who participated in the Medical Professional Liability Insurance Segment saw another good year in 2013 of continuing profits and improved policyholder surplus as underwriting margins remained profitable for eight consecutive years making the sector attractive to an overcapitalized Property and Casualty Insurance Marketplace. While the segment continued to operate profitably the rate environment remained significantly under pressure and competition remains intense. While severity of claims across the country appears to be slightly increasing, the frequency of medical malpractice claims on a relative basis appears to be either stable or slightly better than prior historical periods. There, however, remains significant deviation by geography. The run of financial success within this highly competitive-segment continues to attract insurer capital.

What's Happening In New York State?

In this article, we'll summarize what's happening in the following medical professional segments and what impact this has on the insurer and buyer community:

- Primary/Excess Hospital Professional/Reinsurance
- Physicians and Surgeons Medical Professional
- Reinsurance for Hospitals and Physicians

One of the biggest industry trends impacting the segment for buyers and insurers alike is the continuing trend of hospital mergers. This continuing trend is changing the landscape of hospitals in the United States and is creating huge single State and Multi-State conglomerates. The consolidations are being driven by many reasons, not the least of which is the Affordable Care Act. Here in New York the existing large financially successful hospitals are becoming even larger as non-profits such as North Shore-LIJ Health System, New York-Presbyterian Hospital, The Mt. Sinai Health System, and Montefiore Health System to name a few, acquire community hospitals and align themselves with physician groups at a feverish pace. And, several hospitals in New York have created their own health insurance companies in an effort to generate additional revenue streams and better control outcomes. In terms of medical malpractice risk exposures facing large health systems – they typically retain a large amount of this risk themselves through funding the risk on their balance sheet or through a single parent or group captive structure. As these large health systems become larger they typically can assume greater levels of medical malpractice risk exposure and rely less on transferring the risk to insurers and/or reinsurers. As a result, insurers are facing a reduced demand for coverage, in many cases, which has caused a super competitive marketplace for buyers.

We have experienced many transactions in 2014 which saw the acquiring hospital/healthcare provider reduce its medical malpractice costs by more than 50% in some cases by restructuring and consolidating programs.

Primary Hospital Professional Liability Segment

In New York State some hospitals continue to purchase a primary layer of insurance coverage (typically classified between $1M - $2M loss levels) through one of the licensed admitted insurers writing in New York. Hospitals typically located outside of downstate will continue to purchase primary layers due to their frequency and severity of losses being at thresholds where purchasing a primary layer of coverage is beneficial. Health care organizations who continue to purchase primary insurance programs will generally be attracted to the following:

- Premiums are competitive vs. the projected actuarial cost of self- insuring the loss layer;
- Primary insurers provide risk and claims services within the cost of the premiums;
- Allocated Loss Adjustment Expenses "ALAE" are typically offered outside of the aggregate limit of coverage provided;
- Voluntary Attending Discount "VAP"– Physicians can receive up to a 12% discount when the hospital and VAP's are insured with the same insurer; and
- Insolvency Protection through New York Legislation and NYS Guarantee Fund.

While commercial insurers outside of the licensed and admitted medical malpractice writers have risk appetites to compete for primary policies we typically find that, in many cases, they struggle to compete on a premium basis, and do not have the ability to match the VAP discount offered by the admitted insurers in the State.

Renewal Pricing Trends for Primary Layers of Coverage

Annual insurance renewals from the admitted and licensed primary insurers will be highly correlated to the institutions medical malpractice exposure change (Occupied Bed Equivalents); historical loss development within the loss layer; aggregate limit of liability provided; and claims made maturity. Without significant changes in either loss expectancy or exposure growth, hospitals should expect renewal premium ranges between -2% - +2%.

Excess Hospital Professional Liability Segment

The commercial excess insurance market (defined as limits above $1M - $2M per claim) is extremely competitive. The consolidating healthcare marketplace combined with a healthy market appetite in North America, Lloyd's and Bermuda creates great opportunity for buyers to improve terms and likely lower costs at renewals. Here providers in the New York marketplace find it no different than those around the country as leading commercial insurers and reinsurers such as Ace, AIG, Arch, AWAC, Berkley Medical, Berkshire Hathaway Specialty, CNA, Endurance, Iron Shore, Medical Protective, OneBeacon, Swiss Re, Zurich, Torus, and others compete aggressively. Buyers should continue to experience competitive conditions in 2014-2015 from a price, and structure perspective. In addition, Bermuda underwriting facilities such as AWAC, Endurance, Hiscox, Iron Shore, and XL to name a few will compete in this segment aggressively on a variety of different alternative risk financing programs, and several Lloyd's of London syndicates continue to maintain strong underwriting capabilities and appetites for excess healthcare programs.

Renewal Pricing Trends for Excess Layers of Coverage

Renewal premiums for excess programs will vary dramatically by institution but generally premiums are being negotiated at significantly improved terms and lower premiums at renewals. It is not uncommon for health care facilities with favorable loss experience to achieve 10% - 45% premium reductions. And, while most institutions are experiencing growth in their employed and contracted physicians, their loss experience and retention levels have kept the excess insurers free, in many cases, from excess payouts. Additionally, many institutions are reporting improved actuarial funding projections within retained risk layers as a result of prior year reserve releases which positively impact excess negotiations.

Similarly as with primary layered programs, the excess layer renewal policy premium and structure will be driven by changes in exposure, losses, claims-made maturity, limits, underlying limit amounts, and premium size.

Excess Hospital Reinsurance Segment

Institutions that purchase excess reinsurance contracts for their single or group captive program will also experience a similarly competitive marketplace as many of the excess underwriters also offer facultative reinsurance within the same underwriting facility. The advantage for a hospital to purchase reinsurance from the marketplace in lieu of excess insurance follows:

- Captive/hospital can structure favorable policy terms and conditions which is followed by reinsurer(s);
- Hospital can maintain greater control over claims adjudication process than standalone excess policy; and
- Ability to structure, in some cases, beneficial risk transfer arrangements that may not be available through standalone excess marketplace.

Renewal Pricing Trends for Excess Reinsurance

Facultative reinsurance placements are similar to the excess markets described above with ability to negotiate favorable terms.

Physician & Surgeons Medical Malpractice Segment

The admitted and licensed marketplace in New York is highly regulated- the largest admitted insurers in the State, Medical Liability Mutual, Physicians' Reciprocal Insurers and Hospitals Insurance Company all posted net profits in 2013 mirroring a national trend.

MLMIC, the largest writer of medical malpractice in the State of New York, paid out over $25m in policyholder dividends in 2013; paid another 5% in dividends in 2014 and just recently announced a special dividend payment of 7.5% to be paid to 2015 policyholders. This additional dividend is another example of continued profitability by insurers operating in this segment.

Additionally, the NYS Budget appropriated $127.4 million to the NYS Excess Medical Malpractice Pool for the 2014-2015 year. The Section 18 legislation provides physicians $1,000,000 of additional limit in excess of a primary $1,300,000 policy for no additional cost.

Renewal Pricing Trends for Physicians and Surgeons Medical Malpractice

The New York Superintendent of Financial Services approved a 2.1% rate increase effective July 1, 2014 for admitted carriers with rate deviations as follows:

General Surgery, including bariatric:	+5%
OBGYN:	-5%
Orthopedic Surgery	-5%
Cardiac and Vascular Surgery:	+5%
Emergency Medicine:	+5%
Neurology:	+5%
Anesthesiology:	-10%
Pediatrics:	-10%

While the admitted and licensed marketplace remains stable in 2014 there continues to be competition by Risk Retention Groups which offer potentially lower premiums than their admitted counterparts. Risk Retention Groups can set premiums without NYS approval.

Some of the more notable Risk Retention Groups active in the State are Medical Protective, Applied Medico Legal, and Oceanus to mention a few. There are some notable differences admitted from the marketplace:

- RRG's are not eligible for protection by the NYS Property/Casualty Insurance Security Fund in the event of insolvency;
- Physicians will not be eligible for the Section 18 Excess;
- RRG's may require capitalization and that money may not be returned if the policy is canceled; and
- Some hospitals are concerned with RRG's and granting of privileges for physicians who are insured through an RRG.

In addition to the commercial RRG's noted above there have been a number of risk retention groups formed by some of the larger multispecialty physician groups in the State. Below is a listing of some of the RRG's formed, to date, and their performance as reported in 2013:[ii]

Risk Retention Group	Physician Group	GWP-2013	Net Income-2013	# Insured's
Bedford Physicians RRG	Mount Kisco Medical Group & WESTMED	$17.2 million	$124.3k	490
Crystal Run Reciprocal RRG	Crystal Run Healthcare	$7.66 million	$930k	225
Physicians Proactive Protection, Inc. RRG	Advantage Care Physicians	$10.2 million	$3.2m	350
Oasis Reciprocal RRG	ENT & Allergy Associates	$3.8 million	$650k	65

Note: *All RRG's listed above have reported higher surplus from prior year results.*

Renewal Pricing Trends for Physicians and Surgeons Reinsurance Programs

RRG's typically purchase reinsurance programs to protect their balance sheet and help with unforeseen fluctuations in year over year claim payouts. The reinsurance marketplace for physician's medical malpractice is very competitive in the domestic, Bermuda and London marketplace. Reinsurers such as, Aspen, Beazley, Catlin, Hannover Re, Ironshore, Montpelier Re and Medical Protective are active. Medical Protective is now also selectively offering occurrence capacity on select reinsurance placements.

Reinsurance structures can vary dramatically on a risk by risk basis – most Bermuda and London facilities offer a multi-year swing rated/loss sensitive policy with minimum and maximum caps from a premium and limit perspective.

Renewal pricing will be highly influenced by actuarial loss projections within retained and reinsured layered programs; changes to exposures (increases and decreases to number of physicians and types of physicians insured), type of program structure (multiyear or single year contracts) and swing provisions negotiated within the reinsurance contracts.

Conclusion

The changing and consolidating healthcare provider and payor landscape is having dramatic impacts on medical professional liability insurer's premium growth opportunities and, as a result, will continue to put significant pressure on medical malpractice insurers top line prospects. Expect the market to remain extremely competitive in most sectors while 2015 trends continue to mirror 2014 trends. Watch for the potential for some consolidation with insurers/reinsurers landscape outside of the New York writers, and be careful of financial changes to insurer/reinsurers as the market continues to drive prices lower.

[ii] Risk Retention Group Directory and Guide 2014

member SPOTLIGHT

Jonathan D. Rubin, Esq., Partner
Kaufman Borgeest & Ryan, LLP

Speaking with Gregg Timmons, RN, MA, JD, CPHRM, regional healthcare manager for Casualty Risk Consulting—Healthcare and Marco L. Spadacenta, senior vice president, healthcare malpractice claims department with AIG Claims, Inc./Property Casualty, Jonathan L. Rubin, JD, senior partner with Kaufman, Borgeest & Ryan LLP (New York), presented at this year's ASHRM Conference in Anaheim and discussed in detail the provider's duty to warn third parties when a patient has expressed their intent to cause harm, describing the various legal obligations that can exist in different states. If there is any uncertainty, he said, providers must have good documentation for their actions or inaction. "When you hear something, write it down. Be specific. Identify the actions you have taken and the actions you plan to take," he said. Because state laws vary with regard to the duty to warn or protect, risk managers and providers must be aware of the particular provisions of their state. "This is ongoing and it isn't going away," Rubin said.

Lesli Giglio, RN, MPA, CPHRM
Director, Risk Management, Regulatory Affairs, Privacy/Patient Safety Officer–St. Francis Hospital

Lesli received a $40,000 grant from ASHRM for the Research project titled "Patient Participation in Error Prevention through the use of Patient Generated Safety Reports". The study will be conducted utilizing a Kiosk for a patient safety survey to be completed by patients and their families while they are in the hospital. She will be studying whether the use of technology engages patients and their families and whether this engagement and real time reporting of issues decrease patient incidents.

Jose L. Guzman, Jr., RN, MS, CPHRM
AVP, Healthcare Risk Management – Allied World Assurance Company

Jose earned the Certified Professional in Healthcare Risk Management (CPHRM) designation administered by the American Hospital Association. The CPHRM designation is the healthcare industry's premier certification for the risk management profession.

Jose L. Guzman, Jr., RN, MS, CPHRM - AVP, Healthcare Risk Management – Allied World Assurance Company
Ruth Nayko, RN, MBA, CPHRM, CPHQ, CPPS - Assistant Vice President– Allied World Assurance Company

Jose and Ruth were invited speakers at this year's ASHRM Annual Risk Management Conference held in Anaheim, California. Their program titled: "*Capacity and Decision Making in Hospital and Aging Service Environments: Risk Management Strategies and Toolkits to Implement"* was well received. Their program offered conference participants with an overview of the issues regarding assessment of *Capacity –vs- Competency*, dispelled myths regarding capacity, and defined clinical best practices to support how best to evaluate a patient's capacity for making healthcare decisions. ECRI's Patient Safety Institute provided a highlight of the program content in their November 2014 patient safety journal and emphasized key elements that were introduced by Jose and Ruth. The ECRI article also endorsed that risk managers should consider various strategies outlined in their program. At the end of their ASHRM presentation, risk managers were provided with a toolkit to take back to their organizations for future reference and for ongoing staff education.

Carolyn Reinach Wolf, Esq.
Executive Partner and Director, Mental Health Law Practice
Abrams Fensterman Fensterman Eisman Formato Ferrara & Wolf, LLP

Carolyn presented a session at the ASHRM National Conference on October 28, 2014 entitled, "Behavioral Health, Risk Management and Legal Implications of Workplace Violence". The session was attended by many and concluded with a wide variety of interest and questions and answers.

PRACTICAL TIPS...
THREE STEPS TO LIMITING LIABILITY TO FACILITY-ACQUIRED PRESSURE ULCERS

By Scott Buchholz, Esq. and Michael Wong, JD

The Braden scale is the most widely used measurement for determining a patient's risk of developing a pressure ulcer. However, a recent study analyzed the electronic health records of almost eight thousand patients, and found the Braden scale was not accurate in evaluating ICU patients.

Brenda Vermillion, DNP, RN was one of the researchers at Ohio State University Wexner Medical Center. In commenting on the study, she said:

> *The scale told us that every single patient in the ICU was at high risk for a pressure ulcer. But we knew that not every single patient went on to get an ulcer. Going by the score means that most ICU patients would either be under - or over treated for ulcer prevention – and neither is optimal.*

According to the US Department of Health & Human Services, more than 2.5 million people annually in the United States will develop pressure ulcers. Pressure ulcers have been defined by the National Pressure Ulcer Advisory Panel (NPUAP) in conjunction with the European Pressure Ulcer Advisory Panel (EPUAP) as a "localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear."

Research shows that pressure ulcers cost the US healthcare system more than $11 billion a year. More than 17,000 pressure ulcer-related lawsuits are filed annually. Of these, nearly 15,000 result in settlements or verdicts favoring the patient. The average settlement is $250,000. The largest single damage award is $312 million.

In the face of the possible inaccuracy in the Braden scale in evaluating ICU patients for pressure ulcers, what should clinicians do?

Because of the potentially high financial liability exposure, hospitals should consider these three key steps to minimize exposure and ensure that they are consistently applying standards for each and every patient under their care:

Step 1 - Observe Protocols

The Joint Commission recommends a pro-active approach:

- Take action to address any identified risks to the patient or resident for pressure ulcers, including the following:
  - Preventing injury to patients and residents by maintaining and improving tissue tolerance to pressure in order to prevent injury
  - Protecting against the adverse effects of external mechanical forces

Preventing injury means turning and repositioning patients every two hours. As stated by the Institute for Healthcare Improvement:

> *The aim of turning/repositioning the patient is to reduce or eliminate pressure, thereby maintaining circulation to areas of the body at risk for pressure ulcers. The literature does not suggest how often patients should be turned to prevent ischemia of soft tissue, but two hours in a single position is the maximum duration of time recommended for patients with normal circulatory capacity. Turning patients every two hours is a foundational element in most pressure ulcer prevention protocols. The turning, or repositioning, of the at-risk patient temporarily shifts or relieves the pressure on the susceptible areas, diminishing the risk of pressure ulcer development.*

As the IHI points out, successful hospitals have instituted "turn clocks". Hospitals may improve patient outcomes by using devices that can assist caregivers in making sure the turn protocol is observed.

Protecting against adverse effects includes using pressure-relieving surfaces:

> *Specialized support surfaces (such as mattresses, beds, and cushions) reduce or even relieve the pressure that the patient's body weight exerts on the skin and subcutaneous tissues.*

Step 2 - Ensure Documentation is Complete

If the hospital ever finds itself in a legal dispute over what it did or did not do to prevent pressure ulcers, what was not documented, was not done. As the consensus paper from the International Wound Care Advisory Panel states:

> *From the legal perspective the chart should note every time the patient was turned, his wound cleaned, the patient instructed on wound care, and so on. The notion that every such event can be accurately and fully documented removes the focus from patient care and puts it on creating perfect paperwork.*

Using "turn clocks" that have been automated to record these actions into the patient's records would relieve caregivers of the laborious task of documenting observation of turn protocols. As the International Wound Care Advisory Panel observes:

Documentation must be balanced with patient care. Good documentation must be comprehensive, consistent, concise, chronological, continuing and also reasonably complete. This means documenting regular skin assessments, pressure ulcer measurements, turning, the use of any special products such as a support mattress or devices and conversations with the patient or family relating to the pressure ulcer.

Step 3 – Communicate

Consider how you will communicate with patients and their families if the patient is at risk of a pressure ulcer or if the patient's skin deteriorates. Think about whether new processes are needed and, if so, what they will be. You may want to obtain or develop general informational materials for patients about the risks and potential consequences of pressure ulcers.

As well, ensure that patients and their families are given pressure ulcer information on admission, and that they are notified if skin conditions or risk of pressure ulcer changes.

Should a pressure ulcer develop upon admission and become a Stage 3 or Stage 4, here are some useful actions to take:

- Initiate the communication process as soon as possible after the development of this type of pressure ulcer
- Determine how much information the patient wants to know, or whether the patient prefers that someone else receive the information
- Speak in simple language, not medical jargon
- Be straightforward, truthful, concise and respectful
- Invite and answer all questions as honestly as possible
- Advise the patient how his or her care will be managed from now on
- Express empathy with the patient/family, sympathy for the pain and suffering
- Remain available to answer future questions
- Document meeting including those in attendance and next steps
- Plan to follow-up with the patient/family

Despite best efforts and practices, pressure ulcers can occur. Simply because a pressure ulcer occurs it does not necessarily mean a hospital and/or its staff is going to be held liable in a professional liability lawsuit. However, when a pressure does occur, it should be addressed with the patient and the family.

Conclusion

Preventing pressure ulcers not only provides better patient care, but also improves hospital risk management. Automating protocols that, for example remind staff to turn patients and document this into the patient's medical records, ensure care is provided and demonstrate that protocols have been observed. Moreover, if despite the observance of protocols, a patient develops pressure ulcers, communicating with the patient and his/her family can help improve patient satisfaction and minimize information-gathering lawsuits.

About the Authors

Scott D. Buchholz, Esq.

Michael Wong, JD

Scott Buchholz is a partner in the California law firm of Dummit, Buchholz & Trapp, having offices in San Diego, Los Angeles, Sacramento and within the Inland Empire. Mr. Buchholz's practice includes the representation of healthcare clients in their medical malpractice and other civil litigation. His clients include hospitals, physicians, pharmacies, ambulatory care centers, rehabilitation facilities and skilled nursing facilities as well as non-physician licensed personnel. He is the former president of the San Diego Association of Healthcare Risk Management and a Certified Professional in Healthcare Risk Management by the American Hospital Association.

He received his undergraduate degree from Bucknell University (1981), a graduate degree in economics from the Temple University School of Business Administration (1985) and a law degree from the Rutgers University School of Law (1984).

His firm was started in 1975 specifically to serve the legal needs of California acute care and specialty hospitals. The firm is privileged to handle a variety of litigation matters on behalf of 80+ in California, as well as allied health professionals.

Michael Wong is a recognized healthcare and patient safety expert. He has been at the forefront in driving practical solutions that reduce healthcare costs, decrease medical errors, and improve patient health outcomes

Wong is the driving force behind the Physician-Patient Alliance for Health & Safety (PPAHS), an advocacy group of physicians, patient advocates, and healthcare organizations. Supporters of and commenters for PPAHS include some of the most highly respected physicians and healthcare organizations, including The Joint Commission, Anesthesia Patient Safety Foundation, Anesthesia Quality Institute, Johns Hopkins School of Medicine, Harvard Medical School, Stanford University School of Medicine, and Cleveland Clinic.

A graduate of Johns Hopkins University and a former practicing attorney, Wong is on the editorial board of the Journal of Patient Compliance (JPC), the only peer reviewed journal devoted to helping patient's take their medication as physician recommended. Published in London, England, JPC looks into the ideal way in which patient compliance could be enhanced.

ALIGNING KEY HEALTHCARE ENTERPRISE RISK TO STRATEGIC INITIATIVES USING METRICS

By Ken Felton, RN, MS, CPHRM, DFASHRM

How many times have you heard; the only constant thing in life is change? Never has that statement been truer than in healthcare today. The Affordable Care Act has introduced even more volatility and uncertainty into an already increasingly challenging environment.

Hospitals in particular are subject to an extraordinary burden of government regulations and insurance requirements while under constant uncertainty about federal compensation, and tremendous pressure to improve quality and safety of care and control cost.[1]

Hospitals are among the most complex organizations to manage.[2] The complexity of the risks hospitals face has only increased with the current economic challenges.

Every year the American College of Healthcare Executives completes their annual survey of hospital CEO's to determine the top issues confronting hospitals. The number one issue for the past ten years in a row has been financial challenges. The remaining issues facing hospitals are listed in the following table:

Issue	2013	2012	2011
Financial challenges	2.4	2.5	2.5
Healthcare reform implementation	4.3	4.7	4.5
Governmental mandates	4.9	5.0	4.6
Patient safety and quality	4.9	4.4	4.6
Care for the uninsured	5.6	5.6	5.2
Patient satisfaction	5.9	5.6	5.6
Physician-hospital relations	6.0	5.8	5.3
Population health management	7.6	7.9	—
Technology	7.9	7.6	7.2
Personnel shortages	8.0	8.0	7.4
Creating an accountable care organization	8.6	8.6	8.4

The average rank given to each issue was used to place issues in order of concern to hospital CEOs, with the lowest numbers indicating the highest concerns.

The survey was confined to CEOs of community hospitals (nonfederal, short-term, nonspecialty hospitals).

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The following table of risks was identified from the past 5 completed Risk Assessment Probability and Impact Diagnostic (RAPID) healthcare enterprise risk management engagements.

Top 12 Risks Confronting Hospitals Identified through the Willis Risk Assessment Probability & Impact Diagnostic Enterprise Risk Management Process
• Regulatory / Compliance Issues • Competitor expansion / actions • Poor patient satisfaction / Patient complaints • Loss of / decrease in reimbursements • Growth in Medicaid / Medicare / underinsured populations • System / Network Failure and / or data security • Inadequate numbers of / growing demand for Primary Care Physicians • Infrastructure / Loss of Access to Critical Systems • Inability to drive patient populations / lives into the network • Negative patient outcomes • Inability to develop / maintain hospital-physician relationships • 'Brain drain'--loss of key individuals in high impact positions

The ultimate goal of an effective enterprise risk management process is to identify, assess, prioritize and develop performance improvement plans for those risks that could potentially threaten the achievement of organizational strategic or business objectives.

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The steps for dealing with emerging risks can and should fit seamlessly within an organization's existing risk management framework. This means setting time aside to have an open and analytical conversation about emerging risks at the highest level. This is particularly important when setting business objectives or at a time of organizational change. By adopting this kind of systematic approach when identifying, assessing, and responding to relevant emerging risks, the chances of being caught unawares will reduce dramatically.[5]

Enterprise risk management and a robust strategic planning process are essential to the achievement of the hospital's strategic objectives. To that end, management and the board of directors should analyze the links between various options and the risks they entail when entering into a strategic planning process (Smith, 2012).[6]

Lord Levine, the retired chairman of Lloyds of London once wrote: *Risk management is not simply about preparing for the worst. It's also about realizing your full potential. With a clear understanding of the risk they face, businesses can maximize their performance and drive forward their competitive advantage*.[7]

Having an understanding of game changing events will require a heightened state of awareness of the evolving conditions as well as an assessment of a risk's impact. An appreciation of its connection with other risk and its implications on organizational strategy and objectives will be essential to organizational endurance and the identification of future opportunities.

Effective enterprise risk management for an organization is to become proactive in the management of risk, rather than to be reactive. The ultimate goal is to become predictive in order to reduce the likelihood of surprises and place management and the board in a proactive state. Reacting to risk is more spontaneous and typically more disorganized. When reacting to risk, every loss will be more expensive than if the risk had been foreseen and controlled more proactively.

Albert Einstein once said: "Not everything that can be counted counts and not everything that counts can be counted." Key Risk Indicators however, are metrics that can provide timely information as early indicators of increasing exposure to emerging risks.

A goal of developing an effective set of KRIs is to identify relevant metrics that provide useful insights about potential risks that may have an impact on the achievement of the organization's objectives. Therefore, the selection and design of effective KRIs starts with a firm grasp of organizational objectives and risk-related events that might affect the achievement of those objectives.[8]

This strategic use of KRIs increases the likelihood that goals and objectives set by management are achieved due to the fact that risks and the related strategies are managed more proactively when relevant KRIs have been identified.[9]

When designed properly, reported timely, and measured reasonably, KRIs provide a predictive warning of potential issues that may adversely affect the business.[10] KRIs can be applied to any process that the business may determine has sufficient risk of failing or causing another process to fail, resulting in financial losses, non-monetary damages, or both. Businesses can use KRIs in all their operational processes to assist in predicting potential risk events.[11]

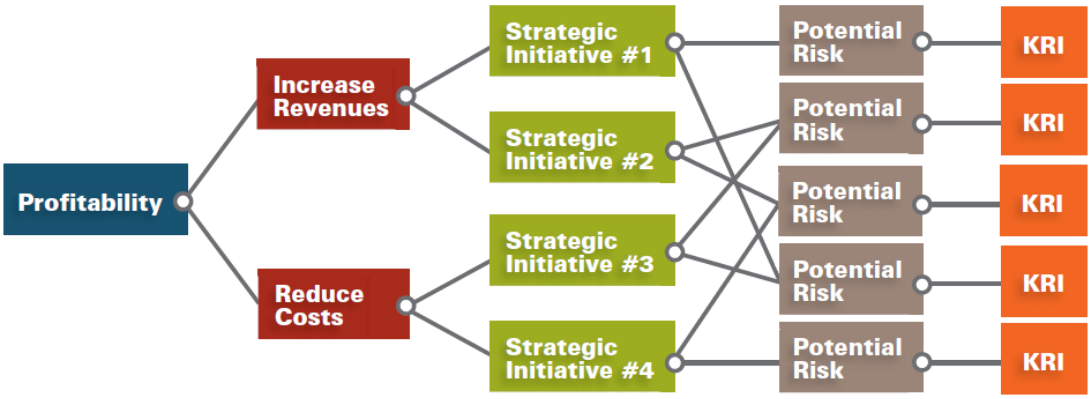
The use of Key Risk Indicators provides a number of significant benefits for the successful management of organizational risks. KRIs support the identification of underachieving aspects of the enterprise and with those areas of the organization that may require additional resources.

Effective KRIs should have the following qualities:

1. KRIs should be based on established standards
2. KRIs must be quantifiable (number, dollars, or percentages)
3. KRIs must be easily applied and understood by the end users
4. KRIs should validate or invalidate management decisions and actions

Mapping key risks to core strategic initiatives puts management in a position to begin identifying the most critical metrics that can serve as leading key risk indicators to help them oversee the execution of core strategic initiatives.[12]

Linking Objectives to Strategies to Risks To KRI's



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Linkage of top risks to core strategies helps to pinpoint the most relevant information that might serve as an effective leading indicator of an emerging risk.[14]

Utilizing an enterprise risk management focus for the identification, assessment, full articulation, prioritization, mitigation and communication of risk will be key to organizational endurance and the ability to capitalize on strategic opportunities. Mapping relevant risks to strategic initiatives and selecting effective Key Risk Indicators will be critical to the achievement of overall organizational objectives. As Lord Levene said, "With a clear understanding of the risks they face organizations can achieve their full potential maximize their performance and achieve a competitive advantage."

Who doesn't need a competitive advantage in the volatile, uncertain healthcare environment we are currently experiencing?

The most effective way of achieving a competitive advantage is in the development of practical performance improvement plans for the top 10 major risks identified in the articulation and prioritization process. Improvement planning captures the actions, deliverables, timelines, accountabilities and the measure of success to reduce the likelihood and/or impact of the risk. The improvement process provides a clear understanding of the strategies for improving the most relevant risks across the entire organization. The organization is now armed with a formalized plan to improve strategic decision making, resource allocation, maximize performance and achieve the overall organizational objectives.

Hospitals are now challenged more than ever before with significant internal and external changes which will require a more proactive enterprise risk management approach to address unforeseen and emerging risks. Now is the time to consider implementing a more dynamic enterprise risk management approach to ensure the greatest opportunity of success.

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About the Author

Ken Felton has more than 40 years of clinical and administrative healthcare management expertise in both private and public healthcare facilities. A licensed registered nurse, Ken began his career in the emergency department of Bon Secours Hospital, a large acute healthcare facility in Virginia. Ken's last position in the hospital setting was the System Risk Manager for the Connecticut Health System, a large 3 hospital tertiary care teaching system in central and northern Connecticut. Prior to joining Willis, he was the Healthcare Industry Practice leader for Webster Insurance, a regional broker in Connecticut. Prior to Webster, he was the Healthcare Industry Expert and Clinical Risk Manager for the healthcare division of Marsh in Hartford, Connecticut. Ken has also been named as a 2009, 2010 and 2014 Power Broker in Healthcare by the Risk and Insurance publication which recognizes brokers that deliver innovative and personalized solutions to meet their clients' needs.

Ken holds the designations of Distinguished Fellow and Certified Professional in Healthcare Risk Management in the American Society for Healthcare Risk Management. He is the Past President of the Connecticut Society for Healthcare Risk Management and an Associate member of the American College of Healthcare Executives. He is a former faculty member of the Bayer Pharmaceutical Risk Management Advisory Board. Ken is certified in Enterprise Risk Management by the Institute of Financial Consultants. Ken is a frequent speaker on numerous risk management topics at both national and state level.

REGULATORY UPDATE

SUNSHINE ACT UPDATE

By Zachary B. Cohen, Esq. and David E. Zabell, Esq.

Sunshine Act Update

On February 8, 2013, the Centers for Medicare and Medicaid Services ("CMS") issued its final rule (the "2013 Final Rule") regarding the Open Payments program, formerly known as the Physician Payment Sunshine Act (the "Act"). The 2013 Final Rule implemented certain regulations which set forth the reporting requirements under the Act (the "Regulations") as described in Section A below. As discussed in Section B below, due to numerous comments received by CMS subsequent to the publication of the 2013 Final Rule, on November 13, 2014, CMS issued another final rule (the "2014 Final Rule"), which removed an exemption to reporting payments made to physician speakers at accredited continuing medical education ("CME") programs.

A. The Act, Generally:

The purpose of the Act, generally speaking, is to make financial relationships among pharmaceutical companies, physicians, and teaching hospitals more transparent in an effort to limit any potentially improper and/or harmful financial influence on research, education, and/or clinical decision-making.

The Regulations, in general, have two main reporting components. The first component requires manufacturers of certain covered drugs, devices, biologicals, and medical supplies ("Manufacturers") to submit information about certain payments or other transfers of value made to physicians and teaching hospitals during the preceding year. The second component requires Manufacturers and certain group purchasing organization ("GPOs") to disclose any ownership or investment interests held by physicians or their immediate family members in the Manufacturers or GPOs.

The information required to be submitted by Manufacturers and GPOs includes, among other things, the name of the physician or teaching hospital, the amount and date of the payment(s) (or other transfers of value), and the nature of such payment(s). Some payments (and other transfers of value) are exempted under the Regulations and need not be reported. For instance, payments of less than $10, unless the aggregate amount given to a physician or teaching hospital exceeds $100 in a calendar year, are not reportable (such thresholds are adjusted every year based on increases in the consumer price index).

While the Regulations do not impose any reporting requirements on physicians or teaching hospitals themselves, it is important that both physicians and teaching hospitals monitor the disclosures made to CMS by Manufacturers and GPOs in order to ensure that the data reported is correct. The Regulations provide physicians and teaching hospitals a 45 day window to review and dispute information provided to CMS by the Manufactures and GPOs prior to publication by CMS. CMS requires Manufacturers and GPOs to submit such data by March 31 of each year, so physicians and teaching hospitals should be ready to review the data when it is made available for review. Physicians and teaching hospitals should, of course, keep and maintain accurate records of their dealings with manufacturers and GPOs.

B. The Final Rule:

The most significant change to the Regulations pursuant to the 2014 Final Rule was the elimination of the exemption to the reporting requirements of payments made to physician speakers at CME programs. Before the 2014 Final Rule, payments to speakers at accredited CME programs did not have to be reported by Manufacturers.

Despite the elimination of the CME exemption, payments to speakers at CME programs may still be excluded from reporting if the Manufacturer is unaware of the identity of the physician speakers receiving payment (i.e., so long as the Manufacturer does not require, instruct, direct, or otherwise cause a third party to provide the payment to a particular physician speaker). For example, if a Manufacturer directly pays a physician speaker, or conditions the sponsorship of a CME program on the participation of a specific physician, the payment is reportable. Furthermore, if a Manufacturer suggests a specific speaker or provides an identifiable set of suggested speakers, then any payment by the CME program coordinator to that physician speaker will be considered an indirect payment from the Manufacturer and must be reported. On the other hand, if a Manufacturer grants the CME program coordinator "full discretion" as to how the money furnished by the Manufacturer is spent, then those payments would not be reportable.

Further clarification from CMS as to the scope of non-reportable physician attendee subsidies (including, in particular, what exactly constitutes "full discretion" as referenced above) is required. CMS has signaled its intent to provide further guidance as to the intended impact of the 2014 Final Rule in the near future.

About the Authors

Zachary Cohen is an Associate at Garfunkel Wild, PC, which he joined in 2010. He is a member of the firm's Health Care and Health Information and Technology Groups, which advise clients on a host of business, regulatory and transactional matters.

Mr. Cohen received his B.A. from the University of Michigan and his J.D. from Georgetown University Law Center.

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RECENT CYBERSECURITY EXPOSURES PROVIDE IMPORTANT LESSONS

By Betsy D. Baydala, Esq.

Nearly half of all the data breaches in 2013 affected the medical/healthcare industry, accounting for 269 breaches (43.8%).[1] Personal identifying information contained in patient medical records has become one of the most valuable information on the black market. According to a recent Reuters' report, medical information is worth ten times more than a credit card number on the black market returning $10.00 per medical record.[2] Criminals mine for non-medical data in patient records – names, dates of birth, social security numbers, and addresses – to commit various forms of identity theft, such as filing false claims with health insurers, committing bank or credit card fraud, or buying medical equipment or drugs that can be resold for profit.

At a time when criminal hackers are focusing their efforts on attacking the healthcare industry, there has been a steady infusion of new technologies in the medical field. With new technologies revolutionizing the practice of medicine, healthcare providers must keep up with technology in a way that keeps patient information safe and providers financially stable for continuing care. Consequently, cybersecurity in the healthcare industry must be recognized as an important aspect of patient care and safety.

This article highlights the lessons learned from recent examples of cybersecurity vulnerabilities and exploitations that occurred in the healthcare industry. These recent examples also help frame a cybersecurity risk mitigation plan for healthcare providers.

Recent Examples

The Criminal Cyber Attack

In July 2014, Community Health Systems, Inc. ("Community Health"), a Tennessee-based hospital chain that operates 206 hospitals in 29 states, confirmed that its computer network was the target of an external, criminal cyber-attack in April and June 2014. During the cyber-attack, Community Health's security measures were bypassed and certain data was copied and transferred outside the organization. Specifically, the attack transferred patient names, addresses, birthdates, telephone numbers and social security numbers of approximately 4.5 million individuals who were referred to or received services from physician practice operations affiliated with Community Health. A forensic review identified the attacker as an "Advanced Persistent Threat" group originating from China who used highly sophisticated malware and technology to attack Community Health's systems.[3] This China-based group has a history of stealing medical-device blueprints, prescription-drug formulas, and other valuable intellectual property from large healthcare companies.[4]

Upon learning of the attack, Community Health worked closely with federal law enforcement authorities in connection with its investigation and possible prosecution of the attacker. Community Health also retained the computer security company Mandiant to conduct a thorough investigation of the incident and advise it on proper remediation efforts, including eradication of the malware from its systems. Community Health provided notification to the affected patients with an offer of identity theft protection services. Community Health has reported that it carries cyber/privacy liability insurance to protect it against certain losses related to this incident.

***Lesson Learned*:** If a healthcare provider suffers a cybersecurity breach, it will look to its insurance to determine whether it has any coverage to help mitigate the costs associated with the breach. However, traditional professional and commercial general liability insurance policies may not provide protection for security and privacy (cyber) incidents. With an ever-evolving range of risks, a number of insurance companies have developed specialized, stand-alone cyber insurance policies to help protect businesses and individuals from these risks. In this example, Community Health carried specialized cyber/privacy liability insurance to protect it against the cyber-attack, and has reported it does not believe this incident will have a material adverse effect on its business or financial results. Given the potential costs associated with a data breach – remediation expenses, regulatory inquiries, litigation, public relations costs and other liabilities – it is advantageous for each healthcare provider to review its insurance coverage and determine whether additional cyber protection is needed and financially feasible.

The Stolen Laptop

In June 2014, a Cedars-Sinai Medical Center ("Cedars-Sinai") employee laptop containing the medical records of more than 33,000 patients was stolen from the employee's home in California. Shortly after the theft, the hospital estimated the laptop contained at least 500 patient records. However, a data forensic analysis revealed that far more patients' records (33,136) were contained in the laptop. Included in these records were patient names and dates of birth, medical data, health insurance policies, and driver's license numbers. Social security numbers of approximately 1,500 patients were also contained in the laptop.

Although the stolen laptop was password-protected, it did not have additional encryption software that would have further protected the patients' data. Cedars-Sinai reported that the laptop's encryption software was mistakenly not reinstalled after a change to the computer's operating system. After the theft, Cedars-Sinai blocked the laptop's access to its computer network and started a process to confirm that all employee laptops were properly encrypted. Cedars-Sinai also notified state and federal officials of the stolen laptop, and sent letters to the patients whose records were in the laptop to inform them of the breach.[5]

Lessons Learned: In today's hyper-technical environment, there is virtually no reasonable excuse for sensitive data, such as personal health information ("PHI"), to be stored on an unencrypted laptop. It is imperative that health care providers ensure that laptops and other electronic devices storing PHI be encrypted. A cost-benefit analysis favors proactively spending money to properly secure electronic devices containing PHI, rather than reactively spending likely more money to recover from a theft/breach.

In the Cedars-Sinai case, there was no evidence that the laptop's medical records were accessed; however, because the laptop was not encrypted there was a legitimate concern that the information could be breached after the theft. The facts also suggest that at one point the laptop contained encryption software, but the software was inadvertently removed after a change to the operating system. Therefore, IT policies and procedures must be in place to verify that encryption software remains installed after system changes. This case also highlights the need for prompt and thorough forensic analysis following a breach. But for the forensic analysis, over 32,000 patients may not have been identified.

Dumped Medical Records

Parkview Health System, Inc. ("Parkview") is a nonprofit health care system providing community-based health care services to individuals in Indiana and Ohio. In September 2008, Parkview took custody of 5,000-8,000 patient medical records while assisting a retiring physician with the transition of her patients to new providers, and while considering the purchase of some of the physician's practice. On June 4, 2009, Parkview employees, with notice that the physician was not home, left 71 cardboard boxes of the patients' medical records unattended and accessible to unauthorized persons on the driveway of the physician's home. The driveway was within 20 feet of a public road and a short distance from a heavily trafficked public shopping area.

The U.S. Department of Health and Human Services' Office of Civil Rights ("OCR") opened an investigation after the retiring physician filed a complaint against Parkview alleging it had violated the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Privacy Rule when "dumping" these patients' records in her driveway. In June 2014, Parkview agreed to pay $800,000 to OCR to settle potential violations of the HIPAA Privacy Rule and to adopt a corrective action plan to address deficiencies in its HIPAA compliance program. As a covered entity under the HIPAA Privacy Rule, Parkview was required to appropriately and reasonably safeguard all PHI in its possession from the time it was acquired through to its disposition. As part of the corrective action plan, Parkview was required to revise its policies and procedures, train its staff and provide an implementation report to OCR.[6]

Lesson Learned: According to the OCR, it too often receives complaints of records being discarded or transferred in a manner that puts patient information at risk. A health care provider must review its own circumstances to determine what steps are reasonable to safeguard PHI during disposal, and to develop and implement policies and procedures to carry out those steps. At a minimum, health care providers must prohibit abandonment and/or disposal of PHI in dumpsters or other containers accessible to the public and other unauthorized persons. Examples of proper disposal of paper records are shredding, burning or pulverizing the records so PHI is rendered unreadable and indecipherable. For ePHI, electronic media should be cleared or purged, or the media device destroyed. Depending on the circumstances other methods of disposal may be appropriate. Any workforce member involved in disposing of PHI, or who supervises others who dispose of PHI, must be trained in proper disposal measures.[7]

Insider Theft: The Rogue Criminal Employee

In 2010, Emeline Lubin started working at Tufts Health Plan, a not-for-profit health maintenance organization based in Massachusetts. During her employment, Ms. Lubin stole personal identifying information, including names, dates of birth and social security numbers belonging to thousands of customers primarily over the age of 65. She then gave this information to two men involved in a scheme to steal Social Security benefits and collect fraudulent income tax refunds by using the stolen identities and filing false income tax returns. Ms. Lubin ultimately stole and disclosed the personal data of over 8,700 customers.

Lesson Learned: Prior to an offer of employment in the health care industry, a background check of a prospective employee should be performed. Once hired, employee training is mandatory under HIPAA and can serve as an effective measure in reducing the "insider misuse" of PHI and ePHI. Sufficient security safeguards must be implemented so that only those persons with authority to use PHI can access the information. In addition, a procedure must be in place whereby any employee or staff can immediately report unauthorized access, use or disclosure of PHI/ePHI, which can limit potentially criminal behavior. Periodic audit checks of an employee's use of PHI/ePHI may also help identify impermissible uses of such information.

Risk Mitigation

With the integration of technology and medicine, today's healthcare providers have a responsibility to understand the risks and vulnerabilities they face with respect to cybersecurity. For a hospital, this responsibility expands to members of the board of directors or board of trustees. Given the complexities of cybersecurity, risk mitigation cannot be delegated or isolated as an IT department issue.

1. Accountability

An effective cybersecurity plan starts with identifying person(s) responsible for developing and implementing the plan. By identifying person(s) responsible there is inherent accountability. In a large healthcare organization, this role may be given to the Chief Information Officer or Chief Information Security Officer. Designated person(s) should be responsible for handling the day-to-day activities to verify that proper actions are being taken and the cybersecurity plan moving forward. Even with the designation

of such person(s), key healthcare decision makers, such as the hospital board/trustees, should maintain oversight over the plan as an added layer of accountability and to maintain an understanding of the plan. Moreover, as the Tufts Health Plan employee insider case shows, accountability should be expected throughout all levels of the organization with an understanding that protecting patient privacy and security is critical to patient safety and safeguarding the organization from financial and reputational harm.

2. Identify Cybersecurity Risks

Before a cybersecurity plan can be developed, a healthcare provider must identify the scope of potential threats and vulnerabilities. In doing so, one must know where patient data is and how it is stored. It is important to understand that cybersecurity risks are not limited to the potential loss of PHI, but broadly encompass all assets and devices. Information networks containing financial data, patient data, personnel files and medical devices must be identified. To the extent financially feasible, a healthcare provider may consider hiring an independent consultant to audit its systems and identify the universe of possible threats and vulnerabilities.

3. Develop a Cybersecurity Risk Mitigation Plan

Once the scope of potential threats and vulnerabilities are identified, a healthcare provider can next determine the necessary security measures to implement in order to reduce and/or eliminate the risks identified. The likelihood of each threat and vulnerability should also be assessed, along with the potential impact (financial, patient safety, reputation) of each occurrence. It is imperative for healthcare providers to document all the actions taken and considered when developing the cybersecurity plan. If a breach occurs and the healthcare provider is investigated, a well-documented plan could provide a layer of protection against possible fines and litigation. In determining which security measures to implement, a useful framework to consider is the one released by the National Institute of Standards and Technology ("NIST") in February 2014 that is based on existing standards, guidelines, and practices used to reduce cyber risks to critical infrastructure.[9]

A thorough cybersecurity plan also contemplates and prepares for an inevitable breach and includes a breach response plan. A breach due to a criminal insider is an important possible breach that should not be forgotten when developing a response plan. The breach response plan should account for all required notifications, forensic analysis and remediation efforts. In the event of a breach or suspected breach, the breach response plan should be immediately triggered in order to reduce ongoing exposures and associated costs. Depending on the scale of the breach, public relations actions may also be indicated. A well-developed plan also provides for what types of incidents will trigger notification to upper management (e.g., the hospital board/trustees), how notification will be given, and how they will be kept apprised of the investigation, response and recovery, if applicable.

Finally, the cybersecurity plan cannot remain static. Periodic evaluations must be in place to ensure the plan is current and can adjust for other potential threats and vulnerabilities that may arise.

4. Assess Cybersecurity Insurance Needs

A cybersecurity breach can trigger numerous costs, including breach response/notifications, forensic analysis and remediation, as well as possible business interruption costs, regulatory fines and/or litigation fees. As a result, an important question for every healthcare provider to ask is whether and how adequately it is protected by its existing insurance coverage in the event it suffers a cybersecurity breach. Most, if not all, health care providers carry professional and commercial general liability insurance; however, reliance on traditional insurance policies likely will not provide adequate coverage in the event of a breach. Therefore, healthcare providers should consider purchasing cyber insurance to finance the risk from what experts believe will be an eventual breach. Market intelligence suggests that now is a worthwhile time to consider purchasing cyber coverage because this is a fast-growing insurance market with policies being purchased at a discount.

Conclusion

As the recent examples demonstrate, cybersecurity breaches in the healthcare industry can happen anywhere and in many different forms, from the mundane to the highly sophisticated hacker. It has been suggested that hospitals are one of the hardest network environments to secure given the primary focus on protecting and improving human life. However, the risk of a cybersecurity breach can be significantly reduced, if not eliminated, by implementing and committing to an effective cybersecurity risk mitigation plan.

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About the Author

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ASHRM 2014 Cocktail Reception

Anaheim's sunny and warm weather served as the perfect back drop for the AHRMNY Chapter Cocktail Reception at this year's ASHRM Conference. Surrounded by palm trees and tiki torches, approximately 50 of AHRMNY's members and friends gathered on the outdoor patio lanai at Roy's Restaurant to enjoy some Hawaiian fusion fare and drinks. Chapter President, Gehan Soliman, welcomed guests and in keeping with this conference theme of "Sharing in the Caring through Enterprise Risk Management" encouraged sharing of ideas and suggestions on how the NY Chapter can better serve the NY health care risk management community. After a long day of education and learning, the gathering at Roy's was a great way to end the day. The only things missing were the flower leis and grass skirts.













ANNUAL CONFERENCE SUMMARY
June 6, 2014
Lighthouse International – NYC

Gehan Soliman and the Education Committee did an outstanding job with the June Annual Conference attended by 130 members at the Lighthouse International. Throughout the day attendees were able to visit with our exhibitors, ELM Exchange, MAGNA Legal Services and Handicare. Our gracious sponsors included: Aaronson, Rappaport Feinstein & Deutsch, LLP; Kaufman, Borgeest & Ryan, LLP; Martin, Clearwater & Bell, LLP; McAloon & Friedman; MedPRO RRG; Wilson, Elser, Moskowitz Edelman & Dicker, LLP and Medical Liability Mutual Insurance Company (MLMIC). Our gracious contributors included ACE-Esis, Gabriele & Marano, Marsh and Physicians' Reciprocal Insurers (PRI).

The day began with our morning keynote speakers Colleen Canning, JD, CPHRM, Assistant Vice President, ACE Medical Risk and Richard D. Sem, CPP, CSC, President Sem Security Management who presented "Violence in Hospitals." The program provided insight as to how violence continues to be an emerging area of risk for healthcare facilities and their risk managers. To prevent and mitigate workplace violence, healthcare facilities must take an honest look at their culture and practices, create a prevention plan that addresses weaknesses and builds on available resources. 18 Million healthcare workers are at risk. The rate of workplace assaults overall is 2/10,000 overall but 8/10,000 for healthcare (AMA). Workplace violence is defined as "any act or threat of physical violence, harassment, intimidation or other threatening disruptive behavior that occurs in a work setting." Examples include threats, physical assaults, muggings and shootings. Perpetrators may include patients, employees (current and former), family members (of employee or patients), and outsiders such as drug seekers. One of the key lessons learned is that many organizations stated, "We never thought it would happen hear." Risk management's role includes establishing a zero tolerance policy, seek commitment from Senior leadership for financial and cultural support of zero tolerance, foster a duty to report incidents of violence and develop a comprehensive violence prevention program. Attendees were provided with a "Hospital Violence Prevention-Self-Assessment Tool" published by ACE Medical Risk Group.

There were two morning breakout sessions. "Using Simulation–Education to Improve Healthcare" was presented by Jared M. Kutzin, DNP, MS, MPH, RN, CPPS, Director, Simulation Center at Winthrop University Hospital and Robin Lynch, MSN, RN, Simulation Center Manager at New York – Presbyterian/Columbia Medical Center. The history of simulation was reviewed dating back to the first simulator, Mrs. Chase in 1911 that was a porcelain doll through more recent simulators such as SimMan which has pupils that react to light etc. Simulation is used for technical skills training such as laparoscopic training, IV therapy etc. as well as communication skills, breaking bad news and error disclosure. Attendees at this session had the opportunity to participate in three simulation exercises. This included a teamwork and communication building exercise; a rapid cycle deliberate practice for improving role and team performance in a code; and an obstetrical scenario with a simulator. The obstetrical scenario included a debriefing with a focus on TeamSTEPPs. In some hospitals the role of the patient safety nurse (PSN) has been created and this professional facilitates simulation training and real-time drills using birthing manikins, pelvic models and simulated patients to recreate routine and critical events. Research studies related to simulation was also discussed and studies have shown that students trained on the simulator perform as well as those trained on human subjects and members of an experimental team (simulation) showed a trend towards improvement in the quality of team behaviors. In the Consolidated Risk Insurance Company (CRICO) Risk Management Foundation (RMF) community, the hospitals and other organizations that sponsor the clinicians they insure have moved simulation-based training from pilot project, to incentive program, toward it becoming a requirement for privileging and credentialing. The other morning breakout session was titled, "Disclosure Communication" presented by Chris Stern Hyman, Esq., Mediator, Medical Mediation Group, LLC and Carol B. Liebman, Clinical Professor, Columbia Law School. The presenters define disclosure as:

- "Series of conversations following an adverse event, medical error, and unanticipated outcome.
- Conversation is a dialogue not a monologue.
- Empathy is expressed and an apology is offered if appropriate.
- Questions are encouraged and answered.
- Next meeting or follow-up is discussed.
- Contact information is given."

The presenters recommend listening for interests instead of positions and indicated that interests are the needs and concerns and motivating factors represented by the positions. They also recommend dealing with and responding to feelings. A helpful strategy is planning the disclosure conversation which the presenters stated includes:

- "What are patients/families likely to want to know?
- What are physician/nurse concerns about disclosure?
- Who should attend & speak
- When should conversation take place
- Sequence of the conversation"

Additionally, the presenters discussed statutes and standards requiring disclosure to patients which include Joint Commission Standards, states with patient notification statutes following adverse events, AMA Code of Medical Ethics and the American College of Physicians' Ethics Manual.

Following the morning breakout sessions, the annual business meeting was held during lunch. Francine Thomas, President 2013-2014 was commended for her accomplishments during her year of leadership. Election results were announced with acknowledgement of re-elected and new members to the AHRMNY Board. The new establishment of an Emeritus Board and appointed members was presented.

The afternoon keynote address, "Emerging Trends and the Future of Enterprise Risk Management" was presented by Hollis D. Meidl, Managing Director, National Healthcare Practice Leader, Marsh. Health Reform is changing organization risk profiles. System top risks include: regulatory compliance, physician strategy, payment risk, technology, capital performance, managed care/network risk and mergers/acquisitions. The RIMS Survey 2014 was discussed. It was noted that 59% of healthcare organizations responded that risk management has some impact on setting the business strategy in the organization, 30% responded that it has significant impact and 11% responded that risk management has no impact in setting the business strategy in their organization. A simple definition of enterprise risk management was provided stating it is a holistic approach to risk management that provides a framework for entity-wide risk identification, prioritization of key exposures, and development of operational responses to adverse events based on a foundation of ownership, accountability and transparency. Numerous Enterprise Risk Management (ERM) frameworks are available and can be found on "Google." Moving from risk specialization (limited focus on the linkage between enterprise-wide risks and strategies) to enterprise risk awareness involves adopting an ERM framework, assigning executive ownership of risk management and conducting routine risk assessments. Taking the program to the next level of risk management integration requires implementing a fully integrated ERM structure based on a framework, monitoring and reporting on risks throughout the enterprise and coordinating ERM activities. Building risk-reward optimization requires embedding risk management into strategic planning, monitoring risks with early warning risk indicators, linking risks to stakeholder value and driving sustainable performance.

There were two afternoon breakout sessions. "Healthcare Worker Safety: The "New" Safety Crisis" was presented by Grena Porto, RN, ARM, CPHRM, Vice President, Risk Management, ESIS ProClaim. The 1999 *IOM To Err Is Human* did not address worker safety. However, if we look at employee injuries in healthcare, we have "Déjà Vu All Over Again." The presenter indicated that healthcare is a leading sector in occupational injury and illness. Healthcare workers make up 11% of the workforce, but accounted for 21% of all workplace injuries and illness in 2011. Data from the ANA reveals that 52% of nurses complain of chronic back pain. Total annual cost of occupational injury and illness in the US is $250B (per UC Davis published Jan 2012). The point was made that if healthcare accounts for 21% of that, it amounts to $1B per week. Workers compensation premiums are effected by the Experience Modification (E Mod). Both good and bad years impact the experience mod for three (3) years. For example, a 2010 loss experience would raise premium rates for 2012, 2013 and 2014 even if an organization has good loss experience from 2011 through 2013. Patient and worker safety share organizational safety culture as their foundation but generally the current state is for risk management to have responsibilities linked to patient safety and human resources to have responsibilities linked to employee safety. There has to be improved coordination between employee safety and patient safety. The presenter recommends eliminate safety silos, look at causes of injury across all populations, look at workplace and work design, incorporate ergonomics and safety engineering principles into the design of the work and environment, apply culture of safety principles to worker safety and implement Voluntary Protection Program (VPP). Under the VPP framework, management, labor, and OSHA work cooperatively and proactively to prevent fatalities, injuries and illnesses. The average VPP worksite has a Days Away Restricted or Transferred (DART) case rate of 52% below the industry average which translates into reduced absenteeism, increase productivity, increased employee morale and decreased workers compensation costs. The attendees were encouraged to obtain their organization's share of savings of that $1 Billion per week spent in healthcare on worker injuries!

The other afternoon breakout session was "E-Discovery" by Guido Gabriele III, Esquire, Gabriele & Marano, LLP. The NY State Rule for Litigation Holds was discussed. The duty to preserve begins at the time litigation is reasonably anticipated. There are five (5) steps in a litigation hold policy:

1. Suspend records
2. Identify sources
3. Notify key players
4. Conduct a broad search
5. Preserve in native format

The importance of metadata was discussed as it reveals who accessed a record, which records were accessed, when it was accessed, whether it was modified, when it was modified or created, whether a portion was deleted and when and how long a record was viewed. Discoverable records include paper medical records and notes, electronic medical records, EMR Metadata, relevant personal email and documents, and relevant personal social media postings.

The annual conference concluded with a farewell toast and attendee networking.

Click here to view event photos

IN MEMORIAM

Guido Gabriele, Esq. – September 14, 2014
We mourn the loss of a valued member of our Risk Management Community

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[1] (New York's Professional Misconduct Enforcement System, 2014)
[2] (New York's Professional Misconduct Enforcement System, 2014)
[3] (Agency for Healthcare Research and Quality, 2014)
[4] (American Nurses Association, Congress on Nursing Practice and Economics, 2010)
[5] (Agency for Healthcare Research and Quality, 2014)
[6] (Trogeler, 2014)
[7] (Trogeler, 2014)
[8] (American Nurses Association, Congress on Nursing Practice and Economics, 2010)
[9] (American Nurses Association, Congress on Nursing Practice and Economics, 2010)
[10] (David Marx, 2001)
[11] (Allan S. Frankel, 2006)
[12] (Allan S. Frankel, 2006)
[13] (Allan S. Frankel, 2006)
[14] (American Nurses Association, Congress on Nursing Practice and Economics, 2010)
[15] (American Nurses Association, Congress on Nursing Practice and Economics, 2010)

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Resources:
Joint Commission Center for Transforming Healthcare, Hand-off Communications, www.jointcommission.org/toc.aspx
National Institute of General Medical Sciences, Office of Emergency Care Research, www.nigms.nih.gov/About/Overview/OECR/Pages/default.aspx

[1] Turken J.D., Levine M.D., Pre-Hospital Electronic Health Records, *The Risk Management Quarterly*, Spring 2012
[2] Meisel, Z.F., Shea, J.A., Peacock, N.J., et. al., Optimizing the Patient Handoff between EMS and the Emergency Department, *Annals of Emergency Medicine*, Aug 2014
[3] www.jointcommission.org

Aligning Key Healthcare Enterprise Risk to Strategic Initiatives Using Metrics.....18

[1] Setting the Record Straight o Time's Article "Bitter Pill", American Hospital Association, 2/28/13, pg. 3
[2] Ibid., pg.1
[3] American College of Healthcare Executives Announces Top Issues Confronting Hospitals: 2013, January 13, 2014.
[4] Beswick, Kelsey and Bloodworth, Jane: Housing Corporation "Risk Mapping – Dilemmas and Solutions"; Risk Management Topic Paper No. 4
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[8] Mark S. Beasley, Bruce C. Branson, Bonnie V. Hancock, Developing Key Risk Indicators to Strengthen Enterprise Risk Management, December 2010, pg. 2
[9] Ibid, pg. 5
[10] Kim, Ed, Pure Risk Training 101: Key Risk Indicators (KRIs) Practical Risk Analysis of Current Issues and Events in Finance, Economic, Geopolitics, and the Stock Market, March 23, 2008, pg. 1.
[11] Ibid.
[12] Mark S. Beasley, Bruce C. Branson, Bonnie V. Hancock, Developing Key Risk Indicators to Strengthen Enterprise Risk Management, December 2010, pg. 2
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[14] Kim, Ed, Pure Risk Training 101: Key Risk Indicators (KRIs) Practical Risk Analysis of Current Issues and Events in Finance, Economic, Geopolitics, and the Stock Market, March 23, 2008, pg. 1.
[15] Ibid.
[16] Mark S. Beasley, Bruce C. Branson, Bonnie V. Hancock, Developing Key Risk Indicators to Strengthen Enterprise Risk Management, December 2010, pg. 2

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[1] http://www.idtheftcenter.org/ITRC-Surveys-Studies/2013-data-breaches.html
[2] http://www.reuters.com/article/2014/09/24/us-cybersecurity-hospitals-idUSKCN0HJ21I20140924
[3] http://www.sec.gov/Archives/edgar/data/1108109/000119312514312504/d776541d8k.htm
[4] http://www.bloomberg.com/news/2014-08-18/why-would-chinese-hackers-steal-millions-of-medical-records-.html
[5] http://www.latimes.com/business/la-fi-cedars-data-breach-20141002-story.html
[6] http://www.hhs.gov/news/press/2014pres/06/20140623a.html
[7] For more information on the issue, OCR provides answers to frequently asked questions about disposal of PHI: http://www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf.
[8] http://www.justice.gov/usao/ma/news/2014/August/LubinEmelinepleaPR.html
[9] http://www.nist.gov/cyberframework/index.cfm

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