Nomination Questionnaire

Name:	**Bonnita Boone**
Date:	**4-20-18**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

I have been a valued member of board for some time and always participating on the fund raising committee and the educational committee. Introducing AHRMNY to Cyber in 2008 and 2010, ERM 2014 and Just Culture in 2009.
This year (2017) I had speakers address and update the group on CMS emergency preparedness and in June 2018 I am working with the committee, (we found a speaker) to discuss claims resolutions.
In 2009 and 2010 excess insurance markets made contributions for the first time to AHRMNY, Berkley Med, (ace), Chubb ,Endurance, Zurich, and Marsh in 2014.
It is important to me that we look beyond immediate issues in NYC and considers a broader space on National issues, (such as recent M&A and what to means to the healthcare industry).

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

Education and membership

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

I believe in the Strategic map: Development, Voice, Information and awareness.
I think we should partner with a teaching institution that promotes Risk management and offer a scholarship.
I started a networking group for women of color in insurance, (about 200 members) and one of initiatives is education, and sharing opportunies.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I can typically attend with enough notice unless I have a client conflict. My move to Chicago was to take care of my nephew. He is getting better and I hope to return soon. I am in New York once a month.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

No not since 2013

I have been honored by Business insurance, (2016) and the IICF (2017)

Nomination Questionnaire

Name:	Dylan Braverman
Date:	April 16, 2018

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

As President-Elect, I look forward to working with Tiffany. She is a dynamic leader, and I personally believe in her goals and vision. I look forward towards helping Tiffany implementing her goals and to further the great work of her predecessor, Lesli.

I look forward to working hard to ensuring that the educational opportunities offered by AHRMNY continue to be top notch and exciting for our members. I have access to a vast amount of excellent experts in litigation, risk management and health care, and plan on leaning on all of them to offer their expertise to our members.

I plan on continuing my work on implementing a charity event with a focus on a AHRMNY 10k. I strongly believe that the publicity for AHRMNY will be astounding, and that we will be able to serve a greater purpose by raising funds for an excellent cause.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

Education, Membership and the aforementioned Charity committee.

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

I have long been involved with AHRMNY as a Committee Member, Board Member and Officer. This organization boasts some of the most dedicated, hardworking and caring individuals in the industry. The American healthcare industry is in sore need of vision, and AHRMY is on the front line of insuring that New Yorkers receive access to the best healthcare in the worlds.

As a medical malpractice defense attorney, I see firsthand that awe-inspiring dedication of our medical professionals, and feel that any move towards not only ensuring that best care is provided, but that the public knows that we strive to provide the best care, is an extremely worthy endeavor.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I have a long history of making every meeting, educational event, ASRHRM conference and ASHRM Academy.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee
I have written a recent White Paper on medical malpractice in anticipation of Grand Rounds for CityMD. I have also written a Professional Liability White Paper for certain underwriters at Lloyd's of London. These are proprietary papers owned by the client (and not myself or my firm) and cannot be disclosed.

Nomination Questionnaire

Name:	**Michael Brendel**
Date:	**April 19, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?
I have been a part of the Fundraising Committee for a numbers of years and each year each year we have had an increase in sponsorships. I believe in my role as AVP for Sedgwick I have made many connections that can help in the future growth in fundraising for AHRMNY.
2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.
I would like to continue in my role as Co-Chair on the Fundraising Committee. Thus far in 2018, I helped raise $59,000 and in 2017, I helped raise $39,750 in sponsorships. I like being part of this committee as I work with a significant amount of defense firms in my position and have reached out to all for sponsorships.
3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.
My involvement has and will focus on AWARENESS. I believe I have been advocate to promote AHRMNY through my dealing with defense firms and my client contacts at Sedgwick.
4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.
I have had no issues in the past with my attendance at the above meetings.
5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee
Sorry, I have not.

Nomination Questionnaire

Name:	**Linda Foy**
Date:	**4/20/18**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?
I will continue to co- chair the publications committee if the President so desires, provide support to fund raising and regularly attend board meetings.
2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.
Publications Fundraising
3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.
Having been a risk management professional for over 30 years on both the healthcare and carrier sides I believe my role as co-chair of the Publications Committee supports our goals of development, voice, information and awareness.
4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.
I have historically attended all but 2 board meetings a year and expect that to continue
5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee
N/A

Nomination Questionnaire

Name:	**Dawn M. Giunta**
Date:	**April 20, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

With my legal expertise in medical malpractice in both the acute and long term care industries and my strong interest in risk management, I can help assist the AHRMNY Board with discussions and strategic planning pertaining to current trends in liability, patient safety, regulatory concerns, etc. I also bring a perspective focused on medical and legal concerns through the lens of case law. I am eager to get involved in providing AHRMNY members with educational opportunities.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

I am interested in being involved in several AHRMNY committees, with a specific interest in education and fundraising, as I see the importance of the organization in helping to strengthen the healthcare risk management community of New York by providing valuable resources and networking for all those in the field.

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

As AHRMNY moves forward with the Strategic Map focused on 1. development, 2. voice, 3. information and 4. awareness, I am passionate about helping our members develop themselves with leadership skills, advocacy tools and heightened awareness of industry trends in New York risk and patient safety. This also includes furthering our efforts to influence greater utilization of ERM practices and patient safety initiatives, while also helping to expand AHRMNY membership.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I am available to attend the required meetings and all events. My firm, Bartlett LLP, is willing to accommodate my schedule to see that I am available as needed.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

I am currently working on a risk management article focused on enterprise risk management assessment of the healthcare organization's fraud and abuse exposure. I expect to submit this to the Journal as soon as possible.

Nomination Questionnaire

Name:	**Victor R. Klein, M.D.**
Date:	**April 23, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

As a physician, I will continue to add clinical risk management insight to the BOD.
I also am very active nationally and promote AHRMNY to other chapters.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

Education is my favorite- I have been able to bring several speakers to our conferences

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

I am interested in clinical risk management. Promoting areas of Patient safety and quality are an integral part of our organization

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I try to attend all meetings and all conferences-I probably have missed 1-2 /year . I have attended all educational programs unless I was out of town.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

I have written over 75 publications, including several for ASHRM- OB tool kit, Patient safety tool kit, multiple ASHRM pearls as well as being past editor of the J Healthcare Risk Management.

Nomination Questionnaire

Name:	**Robin Maley**
Date:	**4/22/18**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

I have been involved on the Board for many years and therefore, can add historical perspective. I would like to actively participate, more so than I have in recent years. I am especially interested in supporting and activating a mentorship program as we recently discussed at our committee meeting. I have taught risk management at graduate programs, workshops and one on one and very much enjoy transferring knowledge and helping those new to the field become a success.
I would also be happy to facilitate workshops and educational programs, as needed, and share risk management information I have picked up through my exposure country-wide and internationally.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

I would like to be on the Education Committee and/or the Publications Committee. I have had the honor of meeting and working with many risk management experts and know them well enough to ask for their participation in our programs as speakers or as contributors to our publication. I also am happy to be a presenter and write articles. I am also happy to be on another committee that may be less desirable for others or in need of staff. In that case, I am still happy to make recommendations to the Education and Publication committees. Wherever the greatest need is, I am happy to help out. I have served on the Education Committee several times over the years as well as on the Nominating, Fundraising and Public Relations committee.

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

I think the organization has done well advancing its strategies and needs to continue to move forward. As the landscape of healthcare delivery is changing rapidly, I think it is important that we keep our pulse on the strategic initiatives of health care providers and institutions to assure that our educational programs and outreach activities are aligned. In concert with the goals outlined within the Strategic Map, I believe we need to reach out to physician groups, allied health professionals and industry thought leaders and "outsiders" introducing innovations within the health care industry. We need to do this to assure that our risk management approaches are modern, meaningful and targeted so that we can really make a difference and add value.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I am able to attend all meetings unless I have an unanticipated travel commitment.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

Yes, please find these attached.

Challenging Times: Transitioning from Volume- based to Value-based Rewards

Providers today are being required to enter a value-based world. This means they must work on cross-disciplinary teams, often as leaders, to implement measures designed to continually improve upon the value, cost and quality of patient care. For many providers, this transition from volume-based care, where financial rewards were reaped based upon the number of services provided, often regardless of necessity or outcome, is challenging. Now, rewards are based upon positive patient outcomes and pleased consumers. Value-based reimbursement for services provided has been gradual until now but is forging ahead full steam. The Medicare Access and CHIP Reauthorization Act of 2015, "MACRA" has forged the way for value-based payments, laying out specific payment plans for health care providers. Plans emphasize clearly that cost control and quality care are necessary in order for payments to be approved.

New Attitudes and New Models of Care

As a result of the sea change focused on value vs. volume, providers are being asked not only to change their methods of practicing but, most importantly, to to adopt a new mind set. They must actively partner with health care institutions to establish, promote and practice within a culture of safety. These transformations in business models and ways of thinking require new skills and education. Many providers, anxious to understand the complexities of the new health care environment are going back to school, both literally and figuratively.

Accountability for patients' total experience is being vigorously enforced and has risen to the forefront of providers' responsibilities. Models of health care are changing to focus more on the health and well-being of populations, rather than on the "break-fix" model or treating individuals primarily when they experience acute episodes of illness. It is being emphasized that patients' clinical, financial and emotional status, as well as their expectations, must be assessed on an ongoing basis. Careful consideration of the needs of specific populations and cultures is being stressed. The health care organization/provider relationship has changed. Institutions, once focused on pleasing providers as a strategy for maintaining and growing market share have shifted gears and have become patient-centered.

New Roles, New Job Skills, New Insights

The role of "physician executive" is fast becoming one of the most important roles in the health care paradigm. Innovative educational programs are preparing physician leaders and other providers to focus upon the importance of quality vs. quantity, patient safety and process improvement. These programs are often designed to take the provider out of his/her comfort zone by exposing them to the experiences of other industries, such as manufacturing, engineering, finance and even the airline industry. A very strong focus has been placed on the impact of systems vs. individual actions. There has been recognition that patient harm and poor outcomes can be improved when process improvements are identified and acted upon swiftly vs. blaming an individual. This is not news to risk management, quality and patient safety professionals. However, concepts that promote the reduction of patient harm are not necessarily well-known to others practicing within the health care profession. Many clinicians

may have seen risk management, patient safety and process improvement as administrative functions secondary to their provision of clinical treatments.

The role of risk managers, patient safety and quality professionals has changed, too, with the increased emphasis on demonstration of value and quality. A major responsibility for these professionals is to teach all levels of health care workers how to implement safe, standardized and evidence-based processes that enable health interventions to reach those who need them on a timely basis. Pro-active, innovative means to accomplish safety goals is imperative. Data collection is important, but is the actions taken following the observance of trends and/or system breakdowns that make the difference in ultimate outcomes. Herein are the greatest challenges. Actions risk management, safety and quality professionals must take to assist others to embrace value include the following:

- Educate
    - Share knowledge regarding the science of patient safety, the principles of risk management and methods of process improvement. Multidisciplinary forums, such as at root cause analyses presents an ideal stage to share knowledge and problem solve as a team.

- Engage
    - Let team players know "what's in it for them". Value-added services are designed to eliminate waste and streamline activities. A more efficient workplace equate to happier employees, better communications and better patient outcomes.
- Strategize
    - Help members of health care teams and departments set goals and objectives through the establishment of benchmarks that support positive patient outcomes. For example, decreased infection rates.
- Promote
    - Secure leadership support and make it well known that providing value to patients is part of the mission and vision of the organization. Use social media, newsletters, broadcast emails, job fairs, posters and other means to keep the focus on providing value to patients
- Evaluate
    - Implement success monitors that are realistic and use technology to ease the workload, as possible. Modify measures as changes occur so they remain meaningful and applicable to patient care and workflow.
- Innovate
    - Look to other industries and support new ideas to improve patient care. It is a new frontier in health care. New challenges create new risks and opportunities and demand new approaches.
- Celebrate
    - Create reward systems to recognize staff and departments that are promoting value and achieving positive outcomes.

- Sustain
    - Build in systems that check for “slippage” in improvements.

The Bonus

Risk management, patient safety and performance improvement efforts have been bolstered by the new mandates to demonstrate value. Goals are now better aligned and with the dedicated efforts of health care staff working in teams, the patient experience will be ultimately improved and outcomes improved.

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Concurrent and overlapping surgery: Addressing the risks

By Kathleen Shostek, RN, ARM, FASHRM, CPHRM, CPPS
Vice President, Healthcare Risk Management

Concurrent and overlapping surgery has been described as when a surgeon begins a second operation, leaving the rest of the first procedure to another surgeon or practitioner to complete.[1] Long a common practice in teaching hospitals, concurrent and overlapping surgery has been thought of as an acceptable way to optimize surgeons' skills, reduce delays, and allow surgeons in training or assistants to complete routine procedures. However, the practice came under scrutiny when Boston Globe reporters published an investigative report on the topic, spurring state and federal investigations. The report detailed patient-related events and subsequent complaints and lawsuits, and described concerns that had been raised by surgeons to hospital administration about the practice.[2] Professional and public outcries prompted the American College of Surgeons (ACS) to address concurrent and overlapping surgery by revising its Statements on Principles to address the practice.[3] With patient safety as a primary consideration, and the desire to avoid claims and lawsuits, hospitals where concurrent or overlapping surgery is performed are reexamining their surgical policies and practices.

Definitions: What's the difference?

In its Statements on Principles, ACS makes an important distinction between **concurrent** surgery and **overlapping** surgery by ascribing the term "simultaneous" to concurrent surgery. The ACS statement notes that when the critical or key components of the procedures for which the primary attending surgeon is responsible are occurring all or in part at the same time, it is considered simultaneous. ACS goes on to state that the primary attending surgeon's involvement in concurrent or simultaneous surgeries on two different patients in two different rooms is inappropriate.

Continued on page 2

The term overlapping surgery is used by ACS to describe surgeries performed by the primary attending surgeon in two situations. One situation is when the critical elements of the first operation have been completed by the primary attending surgeon, who then starts a second operation in another operating room. In this circumstance, a qualified practitioner completes the noncritical components of the first operation, such as wound closure. The second situation is when the key or critical elements of the first operation have been completed and the primary attending surgeon is performing key or critical portions of a second operation in another room. ACS notes that, when this occurs, the primary attending surgeon must also assign immediate availability in the first operating room (OR) to another attending surgeon.

In both situations, the critical or key components of an operation are to be determined by the primary attending surgeon. An approach by one hospital to define critical components, described in the Senate Finance Committee White Paper, *Concurrent and Overlapping Surgery*,[4] uses Current Procedural Terminology (CPT®) codes for hip procedures; the critical portions identified include finalizing bone cuts or bone preparation, implant trialing, and final placement of implants.

Considerations for risk management

There are a number of ethical, risk management and patient safety issues surrounding concurrent and overlapping surgery. Sedgwick healthcare risk management consultants have encountered several of these issues and concerns while performing surgical risk assessments and making observations in the OR. We have also received calls from our clients asking for information, resources and advice on the topic. Some of these issues and concerns have included the following:

- Longer anesthesia time for patients waiting for the attending surgeon, when delayed in the first procedure
- Lack of patient awareness (consent) regarding what portions of the surgery are being performed by which surgeons or practitioners involved in the procedure
- Inadequate supervision of surgical residents and surgical assistants, and scope of practice creep when the primary surgeon leaves the OR for a second procedure
- OR nurses reporting fears of "patient abandonment"
- Inadequate pre-procedure briefings and the absence of surgical debriefs

In general, ethics and informed consent, regulatory compliance, professional practice guidance, and surgical department policies are all areas that deserve special risk management attention when considering your own organization's concurrent and overlapping surgeries.

Informed consent requirements and compliance

It is common in academic and teaching facilities for patients to give general consent during their admission to have students and residents participate in their care. More specific consent forms, obtained later, often contain language permitting the attending surgeon and his or her assistants or delegates to carry out procedures related to the planned surgery. However, there is often inconsistency regarding the amount and type of information provided to patients regarding the involvement of those other than the attending surgeon. One study reported that, while patients preferred having detailed information about resident participation in their procedures, consent rates declined significantly when such information was provided.[5]

When addressing informed consent, the ACS Statements on Principles guide the surgeon to include, "a discussion of the different types of qualified medical providers who will participate in their operation and their respective roles." The Centers for Medicare & Medicaid Services (CMS) does not specifically address informed consent for concurrent or overlapping surgery. However, CMS' interpretive guidelines include a statement about the elements of a well-designed informed consent process that includes, "whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, ... and, in the case of residents, based on their skill set and under the supervision of the responsible practitioner." CMS also includes recommended patient discussion items for surgeries in which residents will perform important parts of the surgery.[6] In addition, various statutory requirements for informed consent apply.

Examples of statements in surgical policies that address disclosure include:

- "If the surgeon will not be present for any portion of the surgical procedure, the patient must be informed"
- "Overlapping surgery should be disclosed to the patient during the informed consent process"

In December 2016, a U.S. Senate Finance Committee published its report on concurrent and overlapping surgeries, calling for additional measures and oversight of the practice.[4] The report noted that just half of the hospital policies reviewed by the committee included a requirement to inform patients that their procedure would be scheduled as an overlapping one. Also, experience with medical malpractice claims shows that, in cases involving residents or surgical assistants, the plaintiffs have often claimed they were unaware of the roles and responsibilities of providers involved in their procedures. It was only during discovery and record review that they became aware of who performed what part of the surgery.

More on regulations and compliance

CMS permits providers to bill the Medicare program for up to two simultaneous or overlapping surgeries, but the regulations note that the surgeon must be available for "critical" portions of both operations. CMS does not define what is meant by critical.[7] The Medicare rules include requirements for another surgeon to be immediately available when the attending surgeon leaves to begin a second procedure and note that the attending surgeon must document his or her presence for the surgery.

At the state level, the Massachusetts Board of Registration in Medicine recently approved a rule to regulate the practice of concurrent surgery that mirrors CMS' rules.

According to a 2015 Boston Globe report, a Wisconsin medical school paid $840,000 to settle a lawsuit alleging that neurosurgeons illegally billed Medicare for simultaneous spine surgeries largely done by unsupervised medical residents. Similar settlements have been made by other facilities and providers.[8]

ACS guidelines

The ACS principles note that when the primary attending surgeon is not present, nor immediately available, another attending surgeon should be assigned as being immediately available. This is in keeping with the Medicare requirements that the surgeon be available for critical portions of both operations, which cannot occur simultaneously.

In the case of operations where several surgical specialists are involved, each may only be present for the component of the operation for which he or she is responsible. The ACS principles state that, in these operations, an attending surgeon must still be immediately available for the entire operation.

Within the ACS principles, "critical or key" portions of an operation are defined as "segments when essential technical expertise and surgical judgment are required, as determined by the attending surgeon"; "physically present" means that the attending must be in the same room as the patient; and "immediately available" means he/she must be reachable and able to return to the OR immediately.

The U.S. Senate Finance Committee report on concurrent and overlapping surgeries noted above compares the guidance provided by CMS and ACS. The report can be found here: http://www.finance.senate.gov/imo/media/doc/Concurrent%20Surgeries%20Report%20Final.pdf.

Surgical department policy considerations

It is important to consider a number of things when developing policies or reviewing existing policies on concurrent or overlapping surgery, including the applicable regulations and professional practice guidelines discussed above. Also, it is key to review available studies on the safety and efficacy of the practice as support for your own decisions. For example, a recent study published by the Mayo Clinic on over 10,000 overlapping surgeries revealed no difference in the rates of postoperative complications or deaths within a month after surgery.[9] One earlier study involving 3,000 simultaneous cardiothoracic surgeries at the University of Virginia found no negative impact on surgical complications, length of hospital stay, or operative mortality.[10]

As there has been a general dearth of information in the literature on concurrent surgery and its effect on patients and outcomes, surgical departments must define practices and policies with patient care and safety at the forefront.

Once developed, it is essential to communicate policies to the surgical, teaching, scheduling and nursing staff. Implement a process to review surgeon compliance and provide feedback to physicians and department chairpersons. Establish a clear means of communication and chain of command for OR nurses and surgical support staff to ask questions and voice concerns.

Recommendations for addressing concurrent surgery risks include:

- Have the surgical executive committee define concurrent or overlapping surgery, identify what surgeries are acceptable for concurrent or overlapping performance, and specify the "critical parts" of the operation.
- Implement a comprehensive informed consent process – the process should include a discussion about which surgeons and other surgical practitioners will perform what parts of the operation; consent practices and forms should be reviewed with medical staff and legal counsel.
- Establish a process to ensure that a surgeon is immediately available to return to the OR as necessary.
- Ensure all surgeons' entry and exit times from the OR are documented, noting the portions of the procedure when the surgeon was present and the extent of their involvement.
- Address application of standard safety procedures such as the universal protocol for prevention of wrong patient, procedure or site surgeries, and responsibility for conducting pre-procedure briefs and post-procedure debriefs.
- Review any unexpected outcomes in cases involving concurrent performance or overlaps, as well as any extended anesthesia times while awaiting a surgeon's arrival.

Healthcare risk managers can work with surgeons and clinical staff, legal counsel and administrators to proactively address the patient safety, clinical and regulatory issues that currently surround the practice of concurrent or overlapping surgery. Bringing the topic to an appropriate decision-making body or committee, with related guidelines and regulations for review and recommendations for action, can foster the development of policies that aim to protect patient safety, set guidance for providers, and mitigate risks for the organization.

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Robin Maley joins Sedgwick

Sedgwick is pleased to welcome Robin A. Maley, RN, MPH, MS, CPHRM, CPHQ, who has joined our professional liability and healthcare risk management team as SVP, Healthcare Risk Management and Patient Safety. Robin is an industry-recognized expert in risk management and patient safety with 30 years of experience. Prior to joining Sedgwick, she gained experience as a hands-on clinician and held executive leadership positions within the healthcare divisions of leading medical malpractice insurance companies and a highly regarded insurance broker. Robin also led risk management, patient safety, insurance and regulatory affairs at major academic medical centers. Additionally, she managed her own successful risk management consulting firm for many years.

At Sedgwick, Robin is responsible for overseeing and providing innovative consultative services to improve patient safety and risk management programs at healthcare organizations and among healthcare practitioners. Sedgwick's expertise in education, tool development and project management supplements a vast array of consultative services offered to acute care, long-term care and specialty-specific healthcare organizations, as well as clinical provider groups.

Robin received her Bachelor of Science degree in nursing from Skidmore College, Saratoga Springs, NY, a Master of Public Health degree from Columbia University, New York, NY and a Master of Science degree in healthcare delivery leadership from the Mount Sinai School of Medicine, New York, NY. She also attended the Columbia University Graduate School of Nursing, majoring in adult psychiatry. She holds both the CPHRM and CPHQ professional designations. Robin is on the Board of the American Society of Healthcare Risk Management, New York Chapter and served on numerous ASHRM committees. She also served on the Board of the Columbia University School of Public Health and was a faculty member there teaching risk management, quality and healthcare finance for several years. Robin has been a frequent speaker at national forums on risk management and patient safety issues and authored several award-winning articles on these topics.

Reducing risks in magnetic resonance imaging

By Robin Maley, RN, MPH, MS, CPHRM, CPHQ, SVP, Healthcare Risk Management and Patient Safety

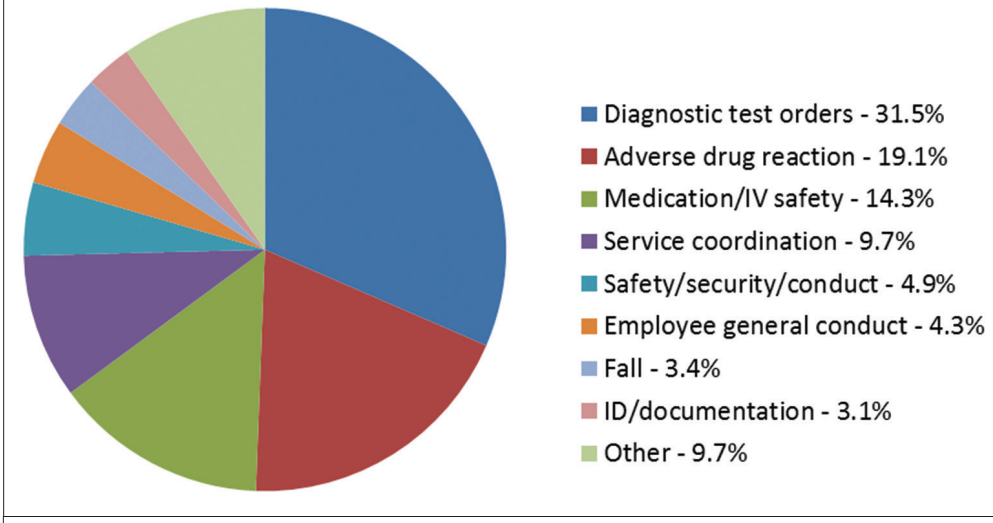
Magnetic resonance imaging (MRI) was introduced in 1977 as a groundbreaking technology that uses electromagnetic waves to differentiate healthy tissue from diseased tissue in three-dimensional images. MRI results have created numerous opportunities for healthcare practitioners to monitor, prevent, control, and cure a broad range of healthcare conditions and improve both the quality and length of life. Over 35 million MRI scans are performed per year in the United States and this number is increasing.[1]

MRI-related risks

The MRI magnet weighs 10 tons and has a magnetic force 30,000 times as powerful as the earth's magnetic field. As a result, there is great risk for harm related to the MRI magnet's ability to cause ferromagnetic objects to be projected toward it, possibly striking and killing persons in their path. An example occurred in 2001, when an oxygen tank was introduced into the MRI scan area at a New York hospital. The tank was propelled toward the magnet

and struck the skull of a six-year-old boy, killing him. This case was settled for $2.9 million in 2010. Additional fines were levied against the hospital for safety violations.[2]

These powerful magnets also have the ability to displace metal objects implanted within the body, such as pacemakers and aneurysm clips, potentially causing severe or fatal injuries. Other well-documented MRI-related risks include errors in diagnostic test orders, adverse drug reactions, thermal burning, contrast agent reactions, medication/IV safety issues, and complications from poor or interrupted clinical monitoring. Percentages of incidents by risk description may vary by organization. Collecting and analyzing incident data increases awareness of trends, helps to pinpoint corrective actions to be taken, and allows for both internal and external benchmarking. This pie chart shows distribution in percentages of incidents collected during a study conducted over a six-year period.



Percentage of incident reporting categories (Mansouri Study, April 2006-2012)

Frequency and severity of MRI-related events

Overall, MRI-related incidents are infrequent in comparison to the number of images taken and often don't result in patient harm. Upward of 7,000 events and near misses involving MRI are reported per year, with report frequency increasing over recent years.[3] One study reported a 500% increase in MRI-related events since 2000, while MRI use increased 112% during the same time period.[4] The Food and Drug Administration (FDA), a recipient of MRI event data, suspects that events are underreported.[5]

MRI safety was cast into the limelight, and a Sentinel Event Alert released by the Joint Commission in 2008, following five reports of MRI-related deaths. One event was caused by a projectile, three cases related to cardiac events and one event was due to a misread MRI that resulted in delayed treatment.[6] Of note, there have been no sentinel events reported to the Joint Commission since the release of this report.[7] Data contained within other databases indicated a need for a focus on MRI safety. For example, an analysis of the FDA's Manufacturer and User Facility Device Experience (MAUDE) database revealed 389 reports of MRI-related events over a 10-year period, including nine deaths. Three of the deaths were related to pacemaker failure, two to insulin pump failure and the others were due to implant dislodgement, a projectile and asphyxiation from a cryogenic mishap during installation of the MRI imaging system. Statistical analyses revealed that more than 79% of the 389 reports were related to burns and 10% were projectile-related.[8]

Most reported errors have led to less serious consequences than death or permanent injury. Nonetheless, events such as burns from thermal heating, dislodged implanted devices, or allergic reactions to contrast can have serious consequences. Both serious and less serious events have led to claims of medical malpractice and negligence against providers, staff and institutions.

MRI scans have been in increasingly high demand by consumers and clinicians and, in order to meet demands and maximize workflow, screening has sometimes been rushed or incomplete. Contributing to the risk has been the improper use of MRIs due to patient demand, referring physicians' lack of knowledge of the proper medical imaging modality for the patient's condition, and/or lack of standardized guidelines for MRI diagnostic use. Efforts to enhance the patient experience, at the forefront of most healthcare organizations' goals, have sometimes been prioritized over adherence to best practices, compromising standards in favor of maintaining patients' perception of quality care. For example, some facilities have encouraged patients to wear sportswear for examinations to decrease changing time and increase comfort. However, there are metallic particles in some clothing that can cause burns. Use of facility-issued garments is now a recommended best practice.

Low tolerance for error

Most MRI-related events are preventable. Liability and negligence claims related to MRI-related adverse events are extremely hard to defend. Further, claimants are not reticent to sue radiologists and other radiology department staff, as they generally have not developed a personal relationship with them.

Best practices

The American College of Radiology (ACR) was the first

organization to take a hard look at developing MR safety best practices when they developed and issued the Guidance Document on MR Safety Practices in 2002,[9] followed by the Joint Commission's 2008 Sentinel Event Alert.[10] The two documents, considered the premier guidance documents for best MR safety practices, were initially confusing as to which guidelines should take precedence. Thus, they were subsequently cross-referenced for ease of use and compliance. The latest ACR guidelines, issued in 2013, are compatible with the Joint Commission's recommendations and Environment of Care standards.[11] These resources are invaluable and should be well-known to all involved with MRI.

Key risk management and patient safety considerations

There are many actions that can be taken to eliminate or significantly reduce the likelihood of adverse events related to MRI. Several of these are outlined under the topics that follow. These key considerations, summarized largely from published guidance documents, are not all-inclusive. ACR, Joint Commission and other guidelines by experts should be consulted (see resources).

» ***Plan MRI sites with experts***

For MR installation, consider access, patient flow, security, cryogen and vent locations, and proximity to other locations. Those involved in planning must be experienced in MR facility design. Further direction can be found within Appendix 3 of The ACR Guidance Document on MR Safe Practices: "MR Facility Safety Design Guidelines."[12]

» ***Limit and restrict access to MRI areas***

Zone 1:	Freely accessible to the general public
Zone 2:	Location where patients are greeted and screened; people are not free to roam in this area and must be supervised by MR personnel
Zone 3:	Strictly supervised and controlled by MR personnel under the authority of a physician, with no exceptions; parents, guardians and support staff, such as anesthesiologists who have been appropriately screened and determined to be free of ferromagnetic items, may be allowed to enter, but must be supervised closely by MR personnel.
Zone 4:	Where the MRI magnet is located and "live;" signs identifying the area must be prominent and illuminated at all times, supported by backup power.

The various zones must be clearly demarcated. Remember that magnetic fields may reach to areas such as rooftops and storage areas and warnings must extend to those areas. Ferromagnetic detectors should be used to supplement other screening processes.[13]

» ***Know where MRI is being performed and identify persons at risk***

MRI safety guidelines must apply to not only diagnostic settings, but also research, interventional, intraoperative and ambulatory settings where MRI may be performed. MRI, CT and PET scans done during ambulatory visits continue to increase (see chart, opposite page).[14]

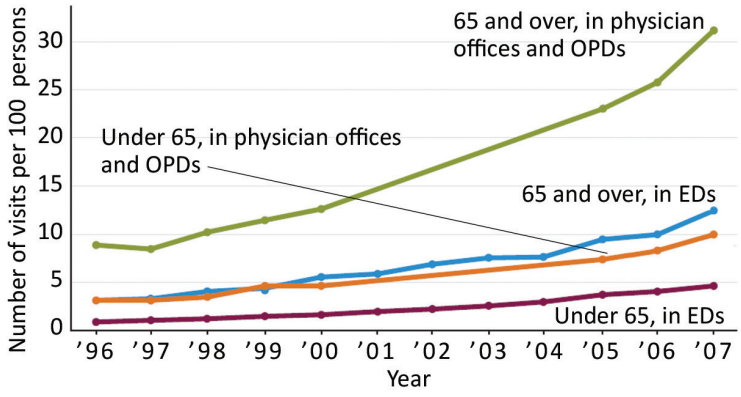
Populations requiring special attention

- High-risk patients, including those:
  - Coming from non-intensive care units with comorbidities and vital sign alterations prior to arrival
  - Requiring respiratory support
  - Receiving sedatives around the time of medical imaging

  Patient distress encountered is most often cardiac (41%), respiratory (29%) or neurological (25%).[15] Suggestions for preparedness include:
  - Utilize standardized handoff protocols.
  - Perform vigilant vital sign monitoring.
  - Establish sound policies and procedures describing actions to be taken when patients arrive in MRI, during the MRI and in the event of an emergency and/or transfer to an alternate location.
  - Require emergency response drills several times per year within all MRI locations.
  - Review the availability and location of MRI-compatible equipment in the event of an emergency.
  - If EKG leads are present, all must be MRI-conditional leads and removed and repositioned as possible throughout the procedure to avoid heat buildup (consider the use of pulse oximetry with an MRI-compatible device for patients with poor oxygenation).
- Other special populations
  - Pregnancy-related
    - › Pregnant employees can help position patients. They should not remain in the MR scanner bore or Zone 4 during scanning.
    - › Pregnant patients should be screened and consideration given to whether the MRI is medically necessary during the pregnancy or could wait until after pregnancy. All risks and benefits should be explained and documented if imaging proceeds. Contrast should not be used.
  - Pediatrics
    - › Provide special attention to temperature monitoring, especially for neonates and small children.
    - › Adhere to standards of care established by the American Academy of Pediatrics, American Society of Anesthesiologists, the Joint Commission and individual

state laws and institutional policies and procedures.

- Persons with tattoos
  - 1/5 of all Americans have at least one tattoo. The ink used to create tattoos may contain iron oxide or other substances that may react to the MRI and cause burns.[16] Tattoos may also distort images.
  - Determine the location, size and age of all tattoos – large tattoos and older tattoos are more likely to lead to untoward reactions. Tattoos in sensitive areas such as the face, including permanent makeup, will react faster and more severely.
  - During MRI, watch for swelling and irritation around the tattooed area. To decrease risks of adverse events, cold compresses may be applied pre-scan.



Ambulatory care visits with MRI/CT/PET scans ordered or provided within the visit, by age and location of care: United States, 1996-2007. OPD = hospital outpatient department, ED = emergency department.

» ***Establish, implement, and maintain policies and procedures***

- Maintain a current MR safety policy and procedure manual that pertains to all MR clinical and research sites.
- Review policies and procedures concurrently whenever there are any changes to the MR environment.
- Be familiar with and comply with all applicable national standards, state laws, professional guidelines, accreditation and institutional requirements.

» ***Assign accountability for the oversight of MRI operations***

- For each site where MRI is performed, name a medical director responsible for assuring MR safe practices guidelines.
- Establish written guidelines describing the roles and responsibilities of the MR medical director, safety officer, physicist, managers and all MR staff.

» ***Assure that staffing of MRI areas is optimal***

- Level 1 MR personnel must have at least minimal safety education to work in Zones 1-3.
- Level 2 MR personnel must be provided with more extensive education involving recognition and treatment of thermal injury and neuromuscular excretion from rapidly changing gradient. No level 2 personnel may assign responsibility to supervise non-MR personnel still in Zone 3 or Zone 4 until they formally sign off to another Level 2 MR person.

Those who have not been trained within the past 12 months are considered non-MR personnel, regardless of their professional designation.

Except in emergencies, there must be a minimum of two MR techs or one MR tech and one other person with the designation of MR personnel within the Zone 2 to 4 environments. In an emergency, an MR tech can scan a patient without another individual in Zone 2 to 4 environments, but there must be a radiology attending or house staff member in-house and available to respond in the event of an emergency.

» ***Conduct thorough screening of patients and MR personnel***

- Persons undergoing non-emergent MRI must be screened by a minimum of two people. One of the screening processes must be verbal and interactive and performed by Level 2 MR personnel.
- Emergent patients may undergo only one screening but it must be performed by Level 2 personnel.
- In preparation for MRI:
  - Advise patients to remove all metallic personal belongings. Note: some cosmetics include metal and, thus, makeup should also be removed. Clothing can contain some metallic substances. Facility-issued garments are recommended.
- Patients with a history of ferromagnetic foreign objects must undergo further investigation:
  - Take detailed patient history regarding the object(s).
  - Obtain plain films of area(s) in question.
  - Acquire prior CT or MRI films of the area in question.
  - Obtain written documentation of type, model and maker of implant.
  - Check product labeling.

Note: Above also applies to anyone with a history of orbit trauma by a potential ferromagnetic object.

- Non-emergent patients must complete screening before entry to Zone 3.
- If the patient is unconscious or unreliable, a family member or guardian must complete the screening on their behalf. Check patients for scars that indicate a possible implant and perform a plain x-ray prior to MRI. If no prior films are available, a plain skull and orbit x-ray should also be done to exclude a metallic foreign body.

- The person completing the screening as well as the MR staff member must sign the form, which then becomes part of the medical record. Leave no blank spaces on the form.
- The final determination to scan a patient with an implant should be made by a Level 2 designated attending radiologist.
- Occasionally an object is found that was not identified during screening. This may be detected upon review of the images taken. In these cases, the medical director should be notified immediately and determine next actions.
- Prisoners or parolees with RF bracelets should have the restraining devices removed by the authorities.
- In the event of a fire, firefighters should be met by MR personnel and only MR-compatible equipment should be used. If the fire is in Zone 4, quenching the MRI should be seriously considered. All non-MRI people must be excluded from the area until it has been determined that the static field is no longer detectable.

» ***Use only MRI-approved equipment***

- NEVER assume that equipment is MRI-compatible unless it is specifically noted to be so.
- Equipment should be audited on a routine basis to assure that it is MRI-safe and that staff is aware of its location and safe use.

» ***Track and review adverse occurrences***

Learning from adverse events and near misses is important so that improvements can be made and future adverse events eliminated and minimized.

- Hold debriefs immediately following any adverse event or near miss to determine the surrounding facts, and decide whether a root cause analysis is indicated. Also establish whether the event needs to be reported to any outside authorities.
- Examine the processes that led to the event to determine whether protocols were followed and, if so, what gaps in the process need to be addressed.
- In the event that a root cause analysis is required or desired, assure that all parties with expertise to add to the analysis of the event are invited to attend. This may include radiologists, nurses, technicians, administrators, pharmacists, MR staff and ancillary staff. Those directly involved should not attend to eliminate potential bias.
- Keep a log of MRI-related events for internal trending to explore and address common contributing factors, and to make improvements.
- Share information obtained with key staff so they are better prepared to address MRI-related issues in the future.

Conclusion

MRI has become a widely used technology in the U.S. and its use is expected to grow. While adverse events and near misses are not frequent, increasing reports of both have been made in recent years. Information from such reports provides all involved in MRI with opportunities to make improvements that will enhance patient safety and allow patients to reap the benefits of improved and precise diagnoses.

Resources

- ACR Guidance Document on MRI Safety Practices 2013: http://onlinelibrary.wiley.com/doi/10.1002/jmri.24011/pdf
- ACR MR Safety Website: http://acr.org/Quality-Safety/Radiology-Safety/MR-Safety
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10 STRATEGIES FOR SUCCESSFULLY RESOLVING A MEDICAL MALPRACTICE CLAIM

By Jayme T. Vaccaro, J.D., Vice President, Specialty Claims Operations

From never being afraid to try a case, any case, to knowing what ultimately motivates the plaintiffs, thinking outside the box and utilizing creativity can be a mantra for successfully resolving medical malpractice claims. In a series of ten articles, Jayme T. Vaccaro shares time-tested strategies for resolving a medical malpractice claim.

Ten strategies:

1. **Never be afraid to try a case – any case**
2. **Always be aware of the plaintiff's attorney vulnerabilities – leverage**
3. **Always know where your codefendants lie and wait – friend or foe**
4. **Use your tools – from high/lows to bifurcation**
5. **The courtroom is sometimes not the place – alternative forums**
6. **Know when to hold – and know when to fold**
7. **Know what the plaintiff wants out of the case – the sweet spot, and it may not be money**
8. **Back to basics – know your case inside and out, legal, medical and the like**
9. **Anyone can help you mediate – from the judge to the structured settlement representative**
10. **Understand risk appetites – client/insured/defendant**

Read strategies 1 and 2 in our recent *Risk Resource* newsletters, archived at: http://www.sedgwick.com/news/Pages/newsletters.aspx. In this issue, we will explore Strategy 3.

Strategy 3: Always know where your codefendants lie and wait – friend or foe

In malpractice actions, the codefendants attempt to avoid pointing fingers at one another to maintain a unified defense. The theory is once you start attacking your codefendant you make the case for the plaintiff. This can result in letting the plaintiff's attorney sit back and have the jury sort out the exposure between the codefendants. Even better, robust finger-pointing can lead to a jury finding all defendants liable.

Knowing the strengths and weaknesses of your codefendant(s) can facilitate a more favorable resolution. While understanding how to effectively deal with the plaintiff's attorney is important, working with a codefendant can be just as challenging and, if done successfully, render more acceptable outcomes. A major factor with a codefendant is allocation and apportionment. If codefendants disagree on how much each party contributes to the eventual settlement, it can tear them apart. This friction can also increase the value of the settlement for the plaintiff as he observes the discord.

Take the codefendant with a large policy limit vs. the codefendant with lower limits. Even if the lower limit defendant has the lion's share of the exposure, many times the plaintiff's attorney will take their limit and pursue the remaining codefendant with the larger limits. Why? It's much easier to go after the larger limits than go into the personal assets of the other codefendant. Also, most plaintiff's attorneys don't want a reputation of bankrupting physicians or medical groups. Taking the easier target streamlines the process and ruffles fewer feathers – unless you are the codefendant with large limits.

In addition to policy limit tensions, consider the other types of business relationships that may exist between the individual physicians, their groups and the hospital where the incident took place. For example:

- A codefendant in contract renewal with their codefendant hospital
- A codefendant that is a general partnership and, due to how it is legally formed, all partners are individually exposed in the event of a mega verdict
- A codefendant medical group that is incorporated, where the physicians are shareholder employees and the entity is exposed through labor code for excess losses
- A codefendant that has experienced an adverse verdict and is apprehensive about trials
- A codefendant hospital system that is experiencing negative publicity or is risk adverse and wants the case to just go away

Knowing more than the facts of the case can help you navigate the business and political agendas of the codefendants to your advantage.

EXAMPLE A

A physician and his group are named in a case involving the failure to diagnose a spinal abscess. There are three other codefendant physicians and their groups named. Throughout the litigation, one attorney represented the co-defendants. At the end, just prior to the first settlement conference, separate counsel is assigned to the five codefendants – three physicians and two groups.

If you are the claims person for our physician and his group, how do you play your hand with your codefendants?

Conflict often arises when codefendants suddenly get separate counsel. Strategize accordingly; the pressure this may create for the conflicted codefendant(s) could reduce your share. Many of us have had the opposite result and were left the last man standing, only to pay more at settlement.

In our example, the conflicted codefendants paid three times more than the non-conflicted codefendant. The reason being a good temperature was taken on their "panic" as well as effective dealing with the plaintiff's attorney. The non-conflicted codefendant achieved the best outcome.

EXAMPLE B

The case involves a catastrophic injury with high medical and loss of earning damages. Your codefendant is a physician and his group. The group is an "asset-rich, intentionally underinsured mega entity." It also happens to be a general partnership. The codefendant physician is refusing to consent, thereby putting great pressure on you, a large self-insured program, to settle the case.

How can you put pressure as a codefendant in such a scenario? Is the entity concerned, given they are exposed with their low limits, assets and legal makeup? Under a general partnership, the partnership is exposed, as well as all individual partners. Is the one physician keeping his partnership hostage exercising the right to control the consent over the settlement decision?

Physicians and groups continue to maintain lower limits not withstanding their assets or legal makeup. Plaintiff's attorneys may not go after a physician or group's assets, especially if there is an easier dip into a codefendant's larger policy limits. The plaintiff may opt to go after the defendant's hospital or healthcare system. As the codefendant with more to lose (if you are the hospital or even a doctor with significantly higher limits), getting your codefendants in agreement to contribute their fair share is crucial.

Large systems/programs continue to have larger limits. Adjusting their deep-pocket outcomes is increasingly important to stay financially healthy. This is especially true when facing a strategically underinsured, legally vulnerable codefendant. There is a belief among physicians and defense attorneys that you do not want to stand out among codefendants with higher policy limits. Hospitals and health systems have high limits to protect their assets and their employees and stakeholders. As a result, entities need to strategically consider their alternatives. Use of indemnity agreements, bylaws of hospitals that increase minimum limits and other pre-litigation measures also may assist in having your codefendant contribute their fair share. Medical groups can consider having partners waive their right to consent through their partnership agreement.

Step up your strategy as you attempt a more acceptable apportionment among your codefendants. This would include putting safeguards in place prior to litigation, but once in litigation, using all the tools in your toolbox and considering the intangibles.

Word to the wise: if a business relationship is valued, negative interactions during a claim need not develop and threaten the relationship. Building collaborative relationships with your potential codefendants well in advance of an incident should be an objective. After all, in the end it will come down to people sitting across the table from one another. In the heat of negotiations, professionalism and respect are critical. For example, if you and your codefendants disagree on apportionment, but you do agree the case should be settled and for how much, then settle the case. Take your differences on apportionment to a separate arbitrator or mediator. Let someone else be the bad guy.

Before closing, consider this checklist:

- ✓ Know your codefendants' legal structure
- ✓ Learn about your codefendants' insurance coverage
- ✓ Think through the economic and political implications for everyone involved
- ✓ Learn about your codefendants' settlement philosophy
- ✓ Above all, remain professional and respectful – long-term relationships matter

In the end, while a case may not go as planned, you can work to raise awareness of the need to redefine the allocation/apportionment found in a claim. Many would say tensions are best dealt with not in the heat of a medical malpractice claim, but in the boardroom, long before and certainly after the claim is resolved. Doing your homework with insight and perception, while being mindful of the short-term and long-term implications to business relationships, is the best approach to working with codefendants.

Next time, strategy 4: Use your tools – from high/lows to bifurcation.

Originally published in The SCAHRM Source, February 2015 – vol. 7.

Unit-based champions promote risk management culture

Pamela E. Freiling, RN, BSN, LNC, Professional Liability Sr. Nurse Consultant

Today, leading-edge organizations systematically share internal control knowledge across their organization, departments and functions to promote best practices and to minimize loss. Healthcare organizations, especially larger systems with multiple hospitals, clinics, freestanding outpatient surgery centers and urgent care units, are leading the way with this new approach using risk champions. "Risk Champions" help to create and maintain a system-wide risk management culture in all of their activities and departments using an embedded risk management framework to promote decisions that align with their overall risk tolerance strategy. Institutions such as the University of California and New York University have implemented such a program under their enterprise risk management programs and published their successes.[1,2]

The goal for creating such a system-wide risk-aware culture from a multidisciplinary staff is to identify, assess, and control risk, and then review the controls in place. The objectives are also to prevent and reduce loss, improve quality of care, maximize patient safety, reduce liability, and highlight risk management strategies.

Formation of a risk champion steering committee, consisting of loss control/risk managers, is critical to a risk awareness culture. The steering committee encourages risk management strategies to be shared throughout their healthcare system with the participation of facility-based risk managers and facility-based risk champions – the existing personnel/staff of each department. Embedded unit risk champions become the "boots on the ground" as well as the "eyes and ears" for the facility risk manager and the steering committee. A risk-aware culture can also help nurture a pool of potential future risk managers from existing facility staff.

Program creation process

The process of creating such an awareness culture initially should come from leaders at the highest level who incorporate the program into clearly defined annual goals. The risk champion steering committee should define the charter for the risk champion program. The charter should include the mission of the program, as well as the roles of the steering committee, facility-based risk managers and unit-based risk champion staff.

The steering committee oversees the strategy, tactics and logistics of creating and maintaining a risk management culture, proposes risk initiatives to implement, and monitors a metric tool for program assessment. Additionally, the steering committee creates a common language for managing loss and reducing risk.

Once the charter and general strategy of the implementation phase is well-defined, the steering committee members communicate this information to the respective facility risk managers. By doing so, the culture of system-wide risk awareness and management is communicated from the top down.

The goal for risk managers of each facility within a large healthcare system is to create a network of risk champions from the existing staff in every unit/department, including the emergency department, operating room, medical and surgical units, pharmacy, respiratory, etc. Risk managers would advocate for risk initiatives, communicate and educate champions, and encourage risk issues to be communicated from the specific units/departments.

Risk champion staff members can be volunteers or nominees within each unit/department who are interested in taking on the role of a risk management/loss control advocate. They are not experts in the field of risk management, but should be influential and respected staff members within the departments they represent. They should possess teamwork skills, effective communication skills, be allotted time to devote to the function and the ability to take actions to implement solutions. A good champion is a communication channel between the department staff, the facility risk manager and the steering committee.

Risk champions in action

One large healthcare system embraced the risk champion program by defining and ratifying their charter. Once strategy and logistics were defined in concept, the program was implemented in a pilot study with identified risk managers who, in turn, created a network of risk champions. The risk managers met with the group of champions for initial training, and maintained the program to create a system-wide culture of risk awareness. For this healthcare system, that meant the unit/department risk champions recognized unsafe or risky practices and took steps with the facility risk manager to reduce the risk/potential loss.

An example of risk awareness in the new program involved the dispensing of medications via the Pyxis system. A risk champion observed that two similar medication bottles were stored in sections right next to each other by brand names, potentially leading to a mix-up and medication error. The risk champion worked with pharmacy staff to rearrange bottles by their generic names. Thus, the similar looking bottles were no longer kept next to each other, reducing the possibility of medication errors.

Other areas of potential risk and loss, as defined by the Centers for Medicare & Medicaid Services, sparked initiatives for this healthcare system. Some of these included prevention of pressure ulcers, nosocomial infections, medication errors and falls.

The success for the program was assessed using a survey tool, the number of event reports generated monthly, and a decrease in the number of complaints or claims generated monthly. A pre- and post-risk champion initiative questionnaire measured the change in the general staff's awareness of risk and how they could be a part of minimizing loss. By proactively addressing risk issues and taking loss prevention measures before an event occurred, the facility hoped to increase quality of care through the participation of engaged risk champions.

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Upcoming events

Connect with Sedgwick's professional liability and healthcare risk management team at these upcoming conferences:

- **Crittenden Medical Insurance Conference**
  April 2-4 | Miami, FL
- **Becker's Hospital Review 8th Annual Meeting**
  April 17-20 | Chicago, IL
  – *visit the Sedgwick booth*
- **Risk & Insurance Management Society (RIMS)**
  April 23-26 | Philadelphia, PA
  – *visit Sedgwick at booth #2127*
- **Northern New England Society for Healthcare Risk Management (NNESHRM) Regional Healthcare Conference**
  April 30 - May 3 | Mystic, CT
  – *visit the Sedgwick booth*
- **Southern California Association for Healthcare Risk Management (SCAHRM) Annual Educational Conference**
  May 3-5 | Rancho Mirage, CA
  – *visit the Sedgwick booth*
- **Society for Health Care Risk Management of NJ (SHCRM-NJ) Annual Spring Meeting**
  May 5 | Princeton, NJ
  – *visit the Sedgwick booth*
- **National Patient Safety Foundation (NPSF) Annual Patient Safety Congress**
  May 17-19 | Orlando, FL
  – *visit the Sedgwick booth*
- **Association for Healthcare Risk Management of New York (AHRMNY) Annual Meeting**
  June 9 | New York, NY

About Sedgwick

Sedgwick is a leading global provider of technology-enabled risk and benefit solutions. Our healthcare risk management consultants bring years of risk management and patient safety experience to help clients identify risk and patient safety strategies for success. Our team of national experts addresses both traditional and emerging risks affecting healthcare organizations.

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Nomination Questionnaire

Name:	**Rob Marshall**
Date:	**4/17/2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?
I will act as the treasurer.
2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.
I can assist in Publications and Fundraising committees.
3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.
I can act as the treasurer and participate in either the publications and fundraising committees.
4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.
I attempt to attend conferences and telephone conferences when available. I do travel for business so sometimes I am unable to attend or make calls/conferences due to work conflicts
5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee
I had written insurance marketplace updates but haven't done so in quite a few years. Work and home life has been challenging.

Nomination Questionnaire

Name:	**Robert Martin**
Date:	**4/23/18**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

It is my intention to continue my regular participation in board meetings and events, as well as volunteer to assist in operating the desk at events in the stead of Kisha after she moves to Texas. I wish to continue my role with public relations. I also intend to fulfill the directions of the map as best I can and assist the president and president elect towards those ends in ways she/he finds helpful

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

I am interested in continuing as public relations co-chair. It is an important committee that is undersubscribed. The goal is to use primarily social media and inter group outreach to grow awareness of the organization as well as grace langan's Crain's outreach to grow awareness of our programs. I utilized opportunity to organize panel discussion before Nysba to both obtain cosponsorship at no fee and bring in Jon on what will be a live and webcast event to expand ahrmny exposure

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

It is my intention to continue through board presence to continue efforts to support development by promoting educational programs and coordination with neighboring organizations such as nj as well as other organizations such as Nysba

It is my intention to continue to work to amplify the voice of ahrmny through use of social media, outreach to organizations with membership interested in issues dealt with at our events, parallel ashrm organizations in the region and organizations such as NYSBA

I view information and Awareness are essentially as other sides of the same walnut as voice

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I intend to continue my record of participation as well as to assist in covering front desk after Kisha moves to Texas

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

I last wrote in 2011 for RMQ on electronic discovery and malpractice. I will be giving a NYSBA CLE lecture on nursing home care with Jon Rubin and Mario Giannettino and will be happy to share slides for my presentation.

Nomination Questionnaire

Name:	**Michael Milchan**
Date:	**4/20/18**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?
Having been a medical malpractice defense attorney for 22 years, I am well versed in issues surrounding the management of risk and patient safety in the healthcare industry. My focus will be on preventing and/or minimizing the type of care patterns which typically lead to malpractice actions. Furthermore, my years of service in the Israeli Army have taught me valuable lessons in discipline, organization and functioning under pressure which I will incorporate into any role I am given on the board.
2)Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.
I am interested in being involved in the Education Committee as I am looking to become more involved in lecturing and publishing on legal issues challenging the industry.
3)As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.
While all aspects of the STRATEGIC MAP vision are of great importance for this organization, I believe my skills would best fit the Development and Voice aspects of the mission. I firmly believe I would be an asset in developing and promulgating and promoting policies and procedures designed to advance patient outcome, safety and care. I am highly interested in sharing my vast legal experience in the healthcare industry by way of publications, lectures and participation in events.
4)AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.
Barring unusual circumstances, I will be available to attend and actively participate in all meeting and conferences.
5)Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee
No

Nomination Questionnaire

Name:	**Pamela Monastero**
Date:	**April 17, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?
I have proudly served on the AHRMNY Board of Directors for several years and actively participate in Board meetings and Committee work, namely the Publications Committee. I solicit authors for contributions to the Quarterly Newsletter and author the featured column *Risky Business*.
2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.
I currently serve on the AHRMNY Publications Committee and offer to assist with other workgroups as needed.
3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.
My interest in continuing to serve on the ARHMNY Board emanates from my passion for patient safety and the desire to continue to contribute to shaping the education and development of the risk management community in New York State. This is done via AHRMNY's lecture series, Newsletter and the continued identification, and promotion, of best practices to our members. AHRMNY works closely with ASHRM leadership to align our goals with the parent organization and continues to advocate for measures that improve patient outcomes.
4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.
I make every effort to attend Board meetings and Committee meetings and participate actively in the majority of these. I participate in the annual education fully day conference and, based on scheduling, attend the additional educational programs that we sponsor.
5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee.
Yes, I author the *Risky Business* column quarterly and attached are some recent articles.

"When common sense is uncommon"
by: Pamela Monastero, MBA

ROOT CAUSE ANALYSES – A to Z

A History Lesson:
This quarter's column is devoted to reviewing the efficacy of the root cause analysis (RCA) tool and its contributions to improving patient safety, quality of care and reduction of risk exposures. Prior to delving into a review of RCAs, a brief history of quality improvement initiatives in healthcare is in order. Before the term 'patient safety' became an official part of our vocabulary, the function of patient safety was performed, in part, by quality and risk management professionals. In illustration, quality improvement initiatives can be traced back as early as the 19th century, with the introduction of hand hygiene. More formal focus on quality in healthcare likely began in the mid-20th century. In fact, the Joint Commission on Accreditation of Hospitals (JCAH, now known as The Joint Commission or TJC) was established back in 1951 as a non-profit organization to provide voluntary accreditation to hospitals based on a rubric of defined minimum quality standards. Therefore, while the concept of improving outcomes and quality is not necessarily new, its evolution through the mid-20th to early 21st centuries is compelling.

Since the 20th century, population health issues such as poverty and poor living conditions are identified as contributory factors in high death rates. In the 1960's, the U.S. government responded, in part, vis-a-vis the introduction of the Medicare and Medicaid programs, originally entitled "Health Insurance for the Aged and Disabled" and, in the 1970's, utilization review (UR) was born in an effort to identify whether hospitals and medical personnel were providing appropriate clinical services that met 'conditions of participation.' Ultimately, the government recognized that the UR committees were ineffective and, thus, Professional Standards Review Organizations (PSROs) came into being. PSROs were a federally funded network of nonprofit physician-run organizations that were tasked with assessing the necessity, applicability and quality of healthcare services rendered. In the 1980's the PSROs were deemed unsuccessful and Peer Review Organizations (PROs) were introduced in 1983. PROs introduced the concept of diagnostic-related groups (DRGs) e.g. prospective cost-per-case to assist in reducing unnecessary admissions and readmissions and to lower complications and mortality rates. What differentiated PSOs from prior models is that the PSOs were tasked with going beyond identifying problems and were given the authority to implement solutions, e.g. continued medical education requirements, disciplinary action, loss of Medicare billing privileges, etc.[1] In 1989, the Agency for Health Care Policy and Research (now known as Agency for Healthcare Research and Quality or AHRQ) was founded.

At this point, it would be remiss not to mention that our own American Society for Healthcare Risk Management (ASHRM, originally entitled American Society for Hospital Risk Management) was established in 1980, mostly in response to the medical malpractice insurance crisis. ASHRM has always been historically focused on patient safety and improving the quality of care; this is illustrated in a statement by the second president of ASHRM (W. Ernest McCollum) in 1981 when he said "*Our challenge as hospital risk managers is to provide a safe and secure environment for patients, employees and visitors. Our job is to manage risk and assure quality despite the problems and increasing controls that we encounter. In the risk management profession, problems are opportunities, and all of our efforts are needed more than ever to formulate solutions. … As risk managers, we must keep in mind that our ultimate product is a safe environment in which the best possible patient care can be rendered at a reasonable cost.*" [2]

<u>The 1990's—learning our "ABCs"—the introduction of the RCA tool in healthcare:</u>
In the 1990's, the healthcare industry began to focus in earnest on improving the quality of healthcare in the US. In 1990, the National Committee for Quality Assurance (NCQA) was created. As the quality movement progressed, there was a focus on data driven quality initiatives, and introduction of additional programs and projects such as the 1994 National Surgery Quality Improvement Project (NSQIP) developed within the Veteran's Administration network and, from 1995 to 2000, introduction of the sentinel event policy by TJC, the founding of the Leapfrog group and, of course, the publishing of the iconic "*To Err is Human: Building a Safer Health System*" by the Institute of Medicine (IOM) which really brought patient safety to the forefront of the healthcare psyche.[3]

With the advent of the sentinel event policy by TJC, the concept of using RCAs (to identify 'root causes' of events and implement strategies to avoid recurrences of such events) was introduced to healthcare. As is the case with other tools used in healthcare, the RCA was adopted from the engineering sector, specifically from Toyota, whose founder, Sakichi Toyoda, is first credited with using the RCA tool—to ask the '5 Whys' to get to the 'root cause.'[4] Shortly after the introduction of the RCA methodology by TJC in the mid-1990's, the New York State Department of Health (NYSDOH NYPORTS—NY Patient Occurrence and Tracking System) required performance of RCAs by hospitals. Facilities in NYS utilize the NYSDOH RCA form, which is somewhat similar to the RCA format used by TJC. Other tools and methodologies to improve safety were also borrowed from industry, e.g. fishbone diagrams (to identify cause and effect), Failure Mode and Effect Analysis (to demonstrate workflow), Pareto charts (to perform data analysis) and, my favorite, James Reason's Swiss Cheese Models.[5]

<u>*To Err is Human* is published, the patient safety movement is born and the RCA methodology reigns:</u>
Following the publishing of *To Err is Human,* the patient safety movement began in full swing. Hallmarks include the establishment of the National Patient Safety Foundation

(NPSF) in 1997, publishing of *Crossing the Quality Chasm: A New Health System for the 21st Century*[6] in 2001, creation of the John M. Eisenberg patient Safety and Quality Awards in 2002, launch of HospitalCompare.HHS.gov (to provide a public report of hospital outcome measures) in 2004 and TJC's issuance in 2004 of the first patient safety goals. In 2005, the *100,000 Lives Campaign* was introduced by the Institute for Healthcare Improvement (IHI) to promote patient safety/evidence-based medicine, and the World Health Organization (WHO) launched "Nine Patient Safety Solutions" and the Safe Surgery Checklist in 2007 and 2008, respectively. During this time, the use of RCAs proliferated as the standard tool to review adverse events to identify the '5 Whys' and to develop and implement risk reduction strategies and monitors to measure the success of those strategies.

The second decade of patient safety:

As we move through the second decade of the patient safety movement, more attention is focused on the prevention of adverse events vis-à-vis identification of close calls or near misses. Attention is being given to concepts of human factors engineering and recognition of the value of systems redesign vs. blaming individuals, as well as evolving into high reliability organizations (HROs) that are '*constantly preoccupied with the possibility of failure.*[7] In response to this focus on prevention, human factors engineering, systems based issues and becoming HROs, we have seen challenges to the traditional RCA methodology. In 2015, the IHI and NPSF introduced the concept of RCA^2, acknowledging that the "use of traditional RCAs has met with inconsistent success." [8] The methodology of the RCA^2 is to focus attention on preventing future harm and that prevention requires actions to be taken, with the result that "identification and implementation of sustainable systems-based improvements will make patient care safer in settings across the continuum of care. The approach is two-pronged: (1) to identify methodologies and techniques that will lead to more effective and efficient RCA^2; and (2) to provide tools to evaluate individual RCA^2 reviews so that significant flaws can be identified and remediated to achieve the ultimate objective of improving patient safety. The purpose of an RCA^2 review is to identify system vulnerabilities so that they can be eliminated or mitigated; the review is not to be used to focus on or address individual performance, since individual performance is a symptom of larger systems-based issues."[8]

The RCA^2 approach integrates human factors engineering (a subject profiled in this *Risky Business* column frequently over the past few years) to help ascertain the true "why" of an adverse event or close call. Effective RCAs focus on systems, not individuals, and veer away from the blame game. RCA^2 focuses on using an "explicit risk-based prioritization system to credibly and efficiently determine which hazards should be addressed first."[8] The major difference between this approach and traditional RCAs is the focus on learning and taking preventive actions vs. reactively responding after patient harm has been experienced or after a problem has been identified. Criticism of the traditional RCA approach is that that it is "not standardized or well defined and can result in the identification of corrective actions that are not

effective—as demonstrated by the documented recurrence of the same or similar events in the same facility/organization after completion of an RCA." The RCA^2 methodology maintains that the underlying causes for this lack of effectiveness includes "lack of standardized and explicit processes and techniques to identify hazards and vulnerabilities and prioritize these, identify systems-based corrective actions, ensure timely execution of an RCA and formulation of effective sustainable improvements and corrective actions, ensure follow-through to implement recommendations, measure whether corrective actions were successfully and to ensure that leadership at all levels participate in the process."[8] Again, the traditional RCA tool tends to be linear in nature and the supposition that there is only one real root cause in and of itself is problematic, given the complex nature of health care delivery, the variables and moving parts. The RCA^{2}methodology also explores reporting and timely feedback to the reporter and the associated vulnerabilities that reporters believe their concerns are not being addressed. This column is not an exhaustive review of the RCA^2 methodology but is intended to provide an overview and highlights with insights from personal experience as a hospital-based risk manager for over three decades. RCA^2 methodology reviews: (a) the identification and classification of events (blameworthy events, risk-based prioritization of events, hazards and system vulnerabilities, close calls); (b) timing of review, interviews and team members; and (c) event review process—analysis and tools, actions, measuring action implementation and effectiveness, feedback, leadership/Board spot, measuring effectiveness and sustainability of the RCA^2 process. The most important step in the RCA^2 process is the identification of actions to eliminate control system hazards or vulnerabilities as identified in the causal statements. Of course, leadership involvement and support is also essential to the success of any program.[8]

Of particular interest, the publication outlines the warning signs of an <u>ineffective</u> RCA^2 and these are:

1. There are no contributing factors identified, or the contributing factors lack supporting data or information.
2. One or more individuals are identified as causing the event; causal factors point to human error or blame.
3. No stronger or intermediate strength actions are identified.
4. Causal statements do not comply with the Five Rules of Causation.
5. No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
6. Action follow-up is assigned to a group or committee and not to an individual.
7. Actions do not have completion dates or meaningful process and outcome measures.
8. The event review took longer than 45 days to complete.
9. There is little confidence that implementing and sustaining corrective action will significantly reduce the risk of future occurrences of similar events.

The publications concludes with the following recommendations: (a) importance of leadership's active involvement and support in the process with a minimal annual look-back for effectiveness; (b) delineation of blameworthy events that should potentially be excluded from the RCA[2] review process; (c) utilization of a transparent, formal, explicit risk-based prioritization system to identify adverse events/close calls/system vulnerabilities; (d) timeliness of review (to commence within 72 hours of recognition of a review-worthy event); (e) RCA[2] team to consist of 4-6 people, with process and subject matter experts from all levels of the organization and a patient representative; the team should exclude individuals who were involved in the event but they should be interviewed for information; (f) working in time into staff scheduling to allow participation in the RCA[2] process; (g) utilize interviewing techniques and tools (e.g. flow diagrams, cause and effect diagrams, five rules of causation, etc.) as defined in the publication); and (h) provision of feedback to involved staff, patients and their families regarding findings.[8]

In summation, we have been grappling with optimization of the RCA process for at least two decades now. We have consulted literature-based sources for best practices, have worked towards perfecting interview and investigation techniques, embraced analytic tools and have considered the integration of human factors engineering aspects into patient safety review processes. We have evolved towards systems redesign from blaming individuals, including the introduction of the concepts of Just Culture[9], Zero Tolerance[10]. We have focused on improving collaboration and communication by integrating TeamSTEPPS[11] training and Crew Resource Management[12].

Looking forward:
More than likely, we can predict that the healthcare industry will continue to look towards aviation, manufacturing, transportation and other industries for tried-and-true tools in continuance of the quest for patient safety. One thing is certain--there is no magic bullet and the most integral component of patient safety lies in unequivocal and unwavering support from senior leadership who are *"constantly preoccupied with the possibility of failure."*[7] Focusing on organizational culture by addressing and eliminating significant, and sometimes intangible, barriers to patient safety—e.g. arrogance, ego, silos and "institutional ethnocentricity" can yield exponential returns and bolster the efficacy of patient safety methodology, tools and concepts.

Please look for the companion piece to this column in the next edition of the *Risky Business* column.

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RISKY BUSINESS
"When common sense is uncommon"
by: Pamela Monastero, MBA

What motivates us to be better?

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

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

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

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

Core Processes of Care

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

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

1. Extrinsic factors, such as monetary rewards or penalties based on performance, are used as incentives (or sometimes as disincentives) to try to achieve differences in performance. The article looks at publicly reported performance data vs. pay-for-performance data. The author's state that publicly reported performance data is more effective in motivating clinicians to improve their own performance. In illustration, they cite several clinical collaboratives, one of which compares New York State's publicly reported performance on percutaneous coronary intervention outcomes with the same collaborative study in Michigan. In the Michigan collaborative, the

performance data was not publicly reported. Findings indicate improved performance at a greater speed in the New York collaborative. In contrast, the author's point out that pay-for-performance data generated conflicting results, citing both U.S. and international studies, suggesting that the mixed success is multifactorial.

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

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

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

The authors list supportive literature which describes the impact of publicly reported performance data and pay-for-performance on quality improvement, as well as collaborative learning and strategies to improve provider engagement in practice improvement, all of which are structured to motivate providers to improve the quality of care. As we consider motivational theory below, parallel conclusions can be drawn to the key findings in the Austin and Pronovost piece, that is: (a) intrinsic motivators are much more powerful than extrinsic motivators; (b) it is imperative to have clearly defined and clearly communicated goals; and (c) the overall importance of operating within a supportive system structure.

Overview of Popular Motivational Theories

1. Herzberg[2]'s Two Factor Theory (motivator, hygiene): as previously mentioned, this is a two-dimensional paradigm of factors affecting people's attitudes about work. Herzberg describes factors such as organizational policy, supervision, interpersonal relations, working conditions and salary as hygiene factors, not motivational factors. The absence of hygiene factors can create job dissatisfaction but their presence does not motivate or create satisfaction. He cites five factors that are strong determiners of job satisfaction: achievement, recognition, the work itself, responsibility and advancement. Herzberg maintains that hygiene factors (dissatisfiers) produce only short-term changes in job attitudes and performance and that motivators (satisfiers) were associated with long-term positive effects on job performance. Because this theory was developed based on industrial settings, there has been criticism of its validity outside of the industrial sector.
2. Maslow's[3] Hierarchy of Needs: (self-actualization, esteem, belonging, security, physiological): this theory puts forth that there is a general pattern of needs recognition and satisfaction that people follow in generally the same sequence and that an individual cannot recognize or pursue the next higher need in the hierarchy until his/her currently recognized need is substantially or completely satisfied. Needs are usually depicted as a pyramid with the survival need at the broad based bottom and self-actualization at the narrow top. From bottom to top, the needs are: physiological (thirst, sex, hunger), safety (security, stability, protection), love and belongingness (avoidance of loneliness, to love/be loved, sense of belonging), esteem (self-respect, respected by others) and self-actualization (fulfill one's potentialities).
3. McClelland[4]'s Acquired Needs Theory (power, achievement, affiliation): an individual's specific needs are acquired over time and are shaped by one's life experiences. Most of these needs can be classified as achievement, power or affiliation. The need for achievement underlies Maslow's self-actualization and also has similarities to Herzberg in maintaining that high achievers are interested in Herzberg's motivators and low achievers are interested in Herzberg's hygiene factors. In terms of motivation: (a) for those who have the need for power (these individuals exhibit behaviors conducive to organizing, motivating and leading others); (b) for those who need a sense of achievement (these individuals are results oriented, like to reach a goal and be recognized for it, and like reasonable challenges); and (c) for those who have the need for affiliation (these individuals seek acceptance and belonging and like being part of a team).
4. McGregor[5]'s X Y Theories: is also rooted in Maslow's self-actualization level of motivation and is based on the assumption that self-direction, self-control and maturity control motivation. Reward systems must correspond to intrinsic factors if staff is to be motivated. The theory explores management of two different types of workers: Theory X states that management believes that workers will do as little as possible to get by and thus require a great deal of

direction. Theory Y maintains that management believes that workers are interested in doing their best and, given the freedom, will perform well.

Overview of Cognitive Theories

1. Expectancy Theory[6] (V. Vroom): the intensity of work effort depends upon the perception that an individual's effort will result in a desired outcome. Individuals are motivated when they believe that putting in more effort will yield better job performance, better job performance will lead to organizational rewards (e.g. salary increase, promotion, etc.) and that predicted organizational rewards are valued by the employee. This is a theory that proposes that people are motivated by their conscious expectations of what will happen if they do certain things, and are more productive when they believe their expectations will be realized.
2. Equity Theory[7](J.S. Adams): a concept that people derive job satisfaction and motivation by comparing their efforts (inputs) and income (outputs) with those of others in the same or other firms. In other words, fairness and equity are key components of a motivated individual and that when an individual identifies inequities (whether in inputs or outputs), they will seek to adjust their input to reach their perceived equity or, conversely, become de-motivated. A simple example is staff doing the same work for different pay.
3. Goal Setting Theory[8](E. Locke): a technique based on the concept that the practice of setting specific goals enhances performance and that setting difficult goals results in higher performance than setting easier goals. Simply stated, goals indicate and give direction to staff about what needs to be done and how much effort is required and that a main source of motivation is the attainment of a challenging goal. The technique calls for clear, unambiguous and measurable goals with deadlines. Goals should be challenging and realistic with relevant rewards, including appropriate feedback.

Organizational Behavior

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

Human Factors Engineering

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

1. *Usability testing*--the testing of new systems and equipment in real-world conditions to help identify potential problems and unintended consequences, e.g. implementation of new technology and the avoidance of staff workarounds which can arise from flawed or poorly designed systems;
2. *Forcing functions*—these prevent unintended or undesirable actions from being performed or permits performance only after another action is first taken, e.g. removal of concentrated potassium from nursing units;
3. *Standardization*—standardizing equipment and processes wherever possible to increase reliability, information flow and minimize staff cross-training, e.g. use of one defibrillator across the organization, implementation of checklists, etc.; and
4. *Resiliency efforts*—acceptance that unexpected events will occur and focus on detection and mitigation before events escalate. *Resiliency efforts* focus on the anticipation of events and adapting to change to recover from system anomalies.

According to Agency for Healthcare Research and Quality (AHRQ), "human factors principles are underutilized in the examination of safety problems and in designing potential solutions. An example cited by AHRQ of a failure to consider human factors principles is the implementation of computerized provider order entry (CPOE) where *usability testing* was not considered in

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

Conclusion

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

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[6]Expectancy Theory. https://www.businessdictionary.com. Retrieved Aug 14, 2016.
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[10]https://www.boundless.com/management/textbooks. Retrieved Sep 3, 2016.
[11]Schiff GD, Amato MG. *Computerised physician order entry-related medication errors: analysis of reported errors and vulnerability testing of current systems*. BMJ Qual Saf., 2015 Apr;24(4):264-71. doi: 10.1136/bmjqs-2014-003555. Epub 2015 Jan 16.
[12]https://www.AHRQ.gov. Retrieved Sep 3, 2016.

Nomination Questionnaire

Name:	**Ruth Nayko, RN, MBA, CPHRM, CPPS, CPHQ, FASHRM**
Date:	**April 23, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

If nominated for the position of Secretary, I am able to support and facilitate communication between the various Committee Chairs and Board. I am able to continue facilitating the Publications Committee and would like to participate on the Education Committee.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

If nominated as Secretary, I am able to continue my involvement with the Publications Committee and would like to join the Education Committee. As a member of the ASHRM New Member Committee, I have the opportunity to engage members from different parts of the country in publication opportunities for AHRMNY.
As a prior member of the ASHRM Education Task Force as well as being a Lifetime Member of NPSF, I have the network and the ability to work to recruit engaging speakers for AHRMNY.

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

I would like to continue to promote sound risk management and patient safety through the AHRMNY journal. Additionally, I would like to further support AHRMNY's and ASHRM's promotion of the use of Enterprise Risk Management (ERM) in the healthcare industry as there is still a long way to go with this. I have recently recruited an article on ERM for the AHRMNY Journal from one of the educators at ASHRM Academy. I will be speaking at ASHRM in 2018 with a co-presenter on breaking down silos between Finance and Risk Management/Patient Safety and will be happy to share with AHRMNY in an article for the AHRMNY journal, webinar or education program.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

During my 2014-2018 Board Member Terms, I have participated in most Board Meetings. I attended most education conferences with the exception of a conference during a required medical leave in 2017. I am able to continue to participate in Board Meetings and Education Conferences.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

ASHRM Physician Office Risk Management Playbook, Published 2016
Co-author of Chapter 1 and Chapter 2:

- Chapter 1 Clinical Care, "Universal Protocol", pages 57-61. [content code = 1, 4]
- Chapter 2 Human Capital, "Workplace Violence", pages 67-70. [content code = 1, 4]

(I can loan a copy of this ASHRM Playbook to the Nominating Committee upon request).

AHRMNY, *The Risk Management Quarterly*, "The Impact of the New York State Office of the Medicaid Inspector General on Long Term Care", Summer 2009.

AHRMNY, *The Risk Management Quarterly,* "The Mental Health Parity And Addiction Equity Act of 2008 Final Rule Highlights", Spring 2014.

Nomination Questionnaire

Name:	**Linda A. Rowett**
Date:	**April 23, 2018**

SECTION I - Please answer the following five (5) questions

1) What professional contribution will you make to the AHRMNY Board of Directors?

Having served on the AHRMNY Board of Directors in the past, I will participate in meetings and decision-making related to Board activities and governance and contribute my risk management experience and knowledge to discussions and committee activities.

2) Which AHRMNY Committee(s) are you interested in being involved with and why? The current committees are: Membership, Finance, Publications, Education, Public Relations, Fundraising and Bylaws.

I currently serve on the Public Relations Committee and have served on the Publications Committee in the past. When my schedule and time become more predictable, I may consider volunteering to join another committee if reelected to the Board.

3) As the AHRMNY Board continues to move forward with our STRATEGIC MAP please explain your interest in being involved with the AHRMNY Board to fulfill our goals.

As a /contributor to the original AHRMNY Strategic Map and a supporter of AHRMNY since 2006, I would continue to support the organization through participation in meetings and events and would continue to encourage other colleagues to join and/or attend events. In the past I have offered suggestions on ways to innovate or open activities to a broader audience and would continue to use creative and forward thinking to enhance AHRMNY's presence in the risk management and healthcare community.

4) AHRMNY Board meets monthly from September through May via teleconference with the exception of once a quarter when an in person meeting is scheduled. Meetings are usually held on the first Wednesday of the month, between 4-5 PM for about one (1) hour. Additionally, there are approximately 3-5 AHRMNY educational programs annually in, which Board Members are expected to attend. Please comment on your availability to attend the required monthly meetings / conference commitments.

I have participated in the majority of meetings and events as time permits. There have been occasions when my professional demands have created conflicts; however, for the most part I have made my participation in AHRMNY events a priority and have carved out time in my schedule to attend meetings and educational programs as well as volunteer time to participate in committee meetings and assignments.

5) Have you written any articles or professional publications? If so, please submit a copy to the Nominating Committee

Risk for HIV and Other Bloodborne Pathogen Exposure in Emergency Workers and First Responders. *The Risk Management Quarterly (AHRMNY),* Winter 2010, 3-6.

New York State Legislative Requirements for Office-based Surgery. *AHRMNY News (AHRMNY)*, Winter 2008, 2-5.

The Changing Code of Ethics: Ethical Issues Are Shaping the Role of the Physician in Health Care Today. *InFocus* (FOJP), Volume 4, September 2007, 2-3.

Never Events May Never Pay. *InFocus* (FOJP), Volume 4, September 2007, 8-9.

Choosing the Right Look-Alike/Sound-Alike Drug: JCAHO Expands List of Dangerous Medication Interchanges. *InFocus* (FOJP), Volume 3, April 2007, 9-10.

Expensive Complications: How Leadership-Supported Multidisciplinary Prevention Strategies Reduce the Cost of Pressure Ulcers. *InFocus* (FOJP), Volume 3, April 2007, 13-15

RISKY BUSINESS
"When Common Sense is Uncommon"

By: Pamela Monastero, MBA, CASHRM
Linda Rowett, RN, BSN, Risk Management Consultant

Dear Risk Manager:

This column, which will appear regularly in the AHRMNY Newsletter, is designed to assist both the novice and seasoned risk manager by presenting brief *pearls of wisdom* based on the experiences of our colleagues. The column is anonymous and we encourage our members to submit their experiences which may be e-mailed to Pamela.monastero@nychhc.org or mailed to AHRMNY, P.O. Box on the RISKY BUSINESS form which can be found on our website at AHRMNY.org. The form permits confidentiality.

This edition of our column is devoted to violence in the workplace, particularly in hospitals and other healthcare settings. Television shows frequently depict violence in healthcare settings—especially in hospital emergency rooms. The perpetrators can include visitors, staff or even other patients. Such events are highly unpredictable. Ensuring a safe environment in the healthcare setting is complicated, given the need to maintain an open/public environment while protecting a vulnerable patient population and ensuring that barriers to entry for those seeking healthcare remain low. Policies and security tactics vary from facility to facility and from region to region. Some healthcare entities may have strict policies, including the use of metal detectors, wands and bag checks, fingerprinting, biomedical recognition (e.g. optical imaging), etc. Yet others may view such methods as barriers to entry for the underprivileged (e.g. undocumented immigrants) who seek care at their facilities. When addressing violence prevention in the workplace, there is no clear "one size fits all" solution.

Currently, Federal regulations do not exist mandating the use of metal detectors/wands/bag checks or other methods (such as those used for airport security) to aid in preventing persons from entering a healthcare facility with guns, knives, box cutters and other dangerous weapons (e.g. explosives). Such a mandate would no doubt be expensive for already financially-strapped facilities to comply with; however, in terms of patient safety and risk avoidance, this would be a proactive step towards protecting a vulnerable patient population, as well as other innocent visitors and staff.

The United States Department of Labor's Occupational Safety & Health Administration (OSHA) website (http://osha.gov/SLTC/workplaceviolence/index.html) is a useful resource for workplace violence and offers sample policies and tools for healthcare (and other) entities. The OSHA website is rich in statistics on workplace violence and offers countless links on *Hazard Awareness, Federal Register* (links to legal references), *Guidelines for Preventing Workplace Violence for Health Care & Social Service Workers* and a *Hospital e-tool* (e.g. for Emergency Departments as well as other areas of hospitals). The OSHA "Survey of Occupational Injuries and Illnesses" (2000) indicates that health care and social service workers face an increased risk of work-related assaults stemming from several factors. These include:

- The prevalence of handguns and other weapons among patients, their families or friends;
- The increasing use of hospitals by police and the criminal justice system for criminal holds and the care of acutely disturbed, violent individuals;
- The increasing number of acute and chronic mentally ill patients being released from hospitals without follow-up care (these patients have the right to refuse medicine and can no longer be hospitalized involuntarily unless they pose an immediate threat to themselves or others);
- The availability of drugs or money at hospitals, clinics and pharmacies, making them likely robbery targets;
- Factors such as the unrestricted movement of the public in clinics and hospitals and long waits in emergency or clinic areas that lead to client frustration over an inability to obtain needed services promptly;
- The increasing presence of gang members, drug or alcohol abusers, trauma patients or distraught family members;
- Low staffing levels during times of increased activity such as mealtimes, visiting times and when staff are transporting patients;
- Isolated work with clients during examinations or treatment;

- Solo work, often in remote locations with no backup or way to get assistance, such as communication devices or alarm systems (this is particularly true in high-crime settings);
- Lack of staff training in recognizing and managing escalating hostile and assaultive behavior; and poorly lit parking areas

What is workplace violence?

Violent acts (including physical assaults and threats of assault) directed at persons at work or on duty."
[National Institute for Occupational Safety and Health (NIOSH)]

- Any form of violence in the workplace, including:
  - verbal assault
  - threat of assault or intent to harm
  - physical assault
  - use of weaponry including firearms, sharp objects, chemical weapons
  - terrorism

Recognizing violence

- Uncontrolled behavior
- Threat of harm
- Actual harm caused by physical force
- Irrational reaction to stress, frustration, jealousy, worry
- Use of weaponry to overpower or create an outcome related to false empowerment

Contributing factors

- Anger, frustration, disappointment
- Stress, worry, loss
- Inability to cope
- Inability to respond to a change or stressor
- Insecurity/feeling powerless
- Mental illness or sudden change in mental status
- Insanity
- Threat of or actual physical force

Situations leading to agitation and potential for violence

- Arguments/differing opinions leading to verbal threat or physical force
  - Patients
  - Employees
  - Family members
  - Visitors
- Impaired mental status/disorientation
  - Dementia, Alzheimer's Disease, mental illness
  - Anesthesia, medications, illicit drugs, alcohol, metabolic disorders
- Poor coping and communication skills
  - Difficulty communicating in a productive manner
  - Unable to express needs or feelings
  - Insecurity and feelings of inferiority
  - "Loose cannon"

Physical warning signs

- Facial expression
  - Grimacing
  - Furrowed brow
  - Clenched jaw
- Speech
  - Angry tone
  - Loud voice
  - Rapid or forceful
  - Profanity

- Body language
  - Agitation
  - Pointing fingers
  - Lunging or leaning forward
  - Shifting stance
  - Quick, sudden movements
  - Crossed arms
  - Raised arms
  - Clenched fists

Preventive Measures

- Use metal detectors to screen all persons who enter a facility
- Use surveillance cameras or post security staff where needed
- Institute practices such as sign-in sheets for all visitors including name, destination and reason for visit
- Enforce visiting hours
- Wear & inspect employee identification badges
- Use buddy systems to travel to isolated areas or call for Security escort
- Screen patients and flag charts for history of aggressive or combative behavior
- Create and use "safe rooms" when tension escalates
- Avoid openly carrying sharp objects that can easily be grabbed and used as weapons– scissors, keys, pens
- Remove objects from environment that could be used as weapons (heavy or sharp objects, glass, etc.)
- Keep entryways, hallways and parking lots brightly lit
- Lock all unused doors /windows to prevent unauthorized access to the premises
- Restrict or closely monitor visitors who are known to be disruptive
- Any suspicious individuals or activities should be reported to Security immediately
- For difficulty de-escalating a hostile situation, seek help immediately

Safety Strategies

- Recognize the potential for violence
  - Be aware at all times
  - observe surroundings and activities/interactions
  - Pay attention to heated interactions or angry behavior
  - Notify appropriate department heads and supervisors

- Be proactive – report unsafe conditions
  - unsecured entry points (open doors, open/broken windows)
  - poorly lit areas (hallways, parking lot, restrooms, etc.)
  - suspicious visitors
  - unusual behavior
  - potential hiding places

- Immediately replace/repair broken locks, burnt-out light bulbs and broken windows
- For any violent situation already underway, leave area and summon help immediately
- Require staff to privately and discreetly report personal orders of protection or any threats of violence to supervisor and Security Department
- Discourage and prevent personal/family disputes on hospital premises through policy
- Use self-defense in the event of hostile interaction involving verbal or physical threat of harm
  - avoid physical contact of any kind
  - maintain safe distance
  - back away while staying focused on aggressor
  - get to a place where assistance is available, if possible
  - call for help

- Plan in advance when patients/employees/visitors are known to be disruptive
  - Be prepared to handle conflict if and when it arises
  - Avoid becoming trapped – position self near door and have someone else present to seek help if necessary
  - Develop and use safety codes to alert other staff
  - Ask Security to escort disruptive visitors off the premises
  - Make supervisor and Human Resources aware of disruptive employees

- Assign staff to:
  - Secure patient care units, treatment areas and doors to patient rooms
  - Prevent entry by outsiders
  - Direct individuals to safety

- Post phone numbers for Security Department, Crisis Intervention Team and local law enforcement on all units and in all departments that are clearly visible and near all telephones
- Document hostile or violent behavior on incident reports for improvement purposes
  - Use experiences to establish and improve prevention strategies

- Conduct drills, simulate events, role play, etc.
- Share ideas for improving safety with leadership – encourage input from all

COMMON SENSE TIPS FOR STAFF:

Tip: Review the Occupational Safety & Health Administration (OSHA) website for tips on:

- elements of a violence prevention program
- management commitment and employee involvement
- worksite analysis including:
  - screening surveys
  - conducting a workplace security analysis
- hazard prevention and controls including:
  - workplace adaptations to minimize risk
  - administrative and work practice controls to minimize risk, employer responses to incidents of violence
  - safety and health training
  - record keeping and elements of program evaluation
  - sources for assistance
  - supportive references.

Be certain to review the Appendix A Workplace Violence Program Checklists and Appendix B Violence Incident Report Forms on the OSHA website.

Reason: Healthcare settings are public places and are unpredictable and vulnerable environments. These environments are filled with emotion, tragedy and sometimes with dysfunction and chaos. Pre-planning for violence and the implementation of proactive measures, such as violence prevention policies and procedures and improving security at entryways by thoroughly screening visitors and employees, serve to minimize the risks and consequences of violence.

Tools & Resources:

www.OSHA.gov

http://www.crisisprevention.com/program/nci.html

RISK FOR HIV AND OTHER BLOOD-BORN PATHOGEN EXPOSURE IN EMERGENCY WORKERS AND FIRST REPONDERS

By: Linda A. Rowett, BSN, RN

A Day in the Life of Emergency Workers

"911, what is your emergency?" These words are uttered multiple times a day every day whenever a call is placed for emergency assistance. This initial event then sets off a series of actions starting with the dispatch of an emergency vehicle. Specialized personnel trained to respond to emergency calls are contacted and engage in the operation and management of ambulance services for every call received. Emergency medical technicians and assistants, by virtue of what they do on a regular basis, come in contact with numerous risks each day starting with the high-speed journey to the place of the emergency. Once on site, emergenc workers enter into a variety of settings including private residences, apartment complexes or accident and crime scenes to provide emergency services. Each encounter starts with an initial assessment to evaluate a chief complaint and/or the disposition of the caller or victim along with the need for on-site emergency care or transport to an appropriate medical center.

In the face of duty, all emergency personnel are constantly exposed to risks for infectious disease or blood-borne pathogens. Unless emergency callers or victims are conscious and honest, reliable historians, emergency workers may be challenged with obtaining accurate and thorough information on a patient's past medical history. In particular, the presence of infectious disease and communicable diseases transmitted via blood and other body fluids may remain a secret if the emergency victim is unable to speak or their consciousness has been altered, which is often the case in many emergencies. If knowledgeable family or friends are present, they may be able to shed light on pre-existing conditions or health-related information regarding the events leading up to the emergent condition and any other relevant details such trauma, exposures or medications that may have contributed to the condition or that might potentially complicate treatment for the patient. All of these details are essential in minimizing risk to the patient and ensuring rapid and appropriate treatment and responses that promote a chance for stabilization and ultimate recovery. But what about the risks to emergency care personnel or first responders?

HIV Onset and the Advent of Universal Precautions

While sterile conditions have always been a requirement to minimize risk for patient infections in modern-day healthcare, universal precautions evolved out of the need to ensure that both patient and healthcare provider be protected from infectious disease. With the sudden prevalence of human immune-deficiency virus (HIV) infections in the early 1980's as well as the increased potential for exposure to infectious hepatitis in healthcare, the development of universal precautions was one way of responding to all patient care and emergency care situations by acting as though anyone and everyone may be potentially infected. Spurned by the introduction of the deadly HIV and AIDS virus, the wide-spread use of gloves, gowns and protective face/eye coverings was instituted to protect healthcare providers against splatter and contamination with bodily fluids and to minimize the spread of infectious disease.

Risk for exposure to blood and body fluids along with a lack of medical detail or history is common-place for emergency care workers. For this reason, compliance with universal precautions is of particular importance in emergency care settings.

Reducing Risk for Transmission

The Centers for Disease Control (CDC), National Institute for Occupational Safety and Health (NIOSH), the Occupational Safety and Health Association (OSHA) and the American Heart Association (AHA) all provide educational and training materials for healthcare workers on the proper implementation of universal precautions to protect against illnesses related to blood-borne pathogens such as HIV and hepatitis. While regular hand washing with soap and water or the use of hand sanitizers is required after every patient contact, exposure to blood and bodily fluids requires use of gloves and other personal protective equipment to reduce the chance of infected fluid from coming into contact with mucous membranes or any openings in the skin. In addition, proper handling and disposal of protective equipment and medical supplies such as needles or other sharps, intravenous catheters and oxygen tubing, masks and/or respiratory nebulizers contaminated with blood must be enforced as well. The presence of and access to red biohazard waste bags and sharps containers in the field or on an emergency vehicle is essential to ensure that any contaminated materials are contained and properly disposed. In addition, if emergency workers come into contact with blood-soaked objects at crime scenes such as sharp weapons, knives or box cutters, these objects must also be properly covered and handled to prevent exposing emergency personnel or law enforcement officers.

Because of the rapid-paced activities and actions that normally occur while providing emergency care under life-threatening conditions, it is highly recommended that emergency personnel utilize lower risk medical supplies such as safety needles and rounded bandage scissors and to have gloves, goggles, splash-proof coverings or barriers, sharps containers and red bags on hand at all times. Emergency vehicles should be routinely checked for inventory of protective equipment and supplies should be replaced quickly and on a continuous basis. While it is human nature to take short-cuts when time is limited, emergency personnel must be indoctrinated to be consistently compliant with stocking protective equipment and supplies and adherent to universal precautions for their own protection and to prevent the spread of potentially deadly infectious diseases to others. Environmental contamination of emergency vehicles requires that emergency personnel are trained in proper decontamination techniques as well. Additionally, absorbent materials used to soak up large blood spills should be available on emergency vehicles to minimize exposure to and spread of potential blood-borne contaminants and infectious disease. Disinfectants such as bleach or other agents known to kill bacterial and viral contaminants should be available and emergency personnel should be trained on the safe use and disposal of these agents and absorbents.

Simulating emergency responses in an educational setting is another way for emergency service providers and ambulance companies to ensure that their personnel are properly trained and utilize universal precautions at all times. Regular reinforcement of safety techniques helps make compliance more likely and serves to reduce risk of contamination and exposure. Regular ongoing education and observation in the field is one way to ensure that first responders and emergency personnel, both new and experienced, are utilizing proper technique and always have ample amounts of protective equipment, safety supplies, spill kits and decontaminants are readily available.

Occupational Exposure and Risk

While the most vigilant safety strategies may be employed and compliance reinforced, there is always the possibility of an emergency care worker being exposed through some freak or unanticipated occurrence such as expected movements or distraction or other sudden developments that might occur in a fast-paced and dangerous setting. Exposure would include contact by emergency personnel with a patient's blood, semen, vaginal secretions, tissue or cerebrospinal, amniotic, peritoneal, synovial, pericardial, pleural fluids. Contact would include any exposure of the emergency worker's mucous membranes, skin that is not intact or direct contact to the worker's vascular system caused by events such as needle sticks, splashes to eyes, nose or mouth or patient blood on an emergency employee's open wound. Bites from infected patients with bleeding in the mouth that cause bleeding in the emergency care worker would also be considered a potential exposure. As with any potential exposure to HIV or an infectious disease, a skin wound or skin exposure must be evaluated promptly and cleansed appropriately with mild soap and water. According to the AIDS Institute of the New York State Department of Health, the site of a wound should not be squeezed or milked as this could cause inflammation or increased chance for transmission. Exposed mucous membranes including eyes, nose and mouth should be flushed with water only.

Based on statistics from the CDC and the New York State AIDS Institute, mucous membrane exposures carry an average risk for infection of approximately 9 in 10,000 or 0.09% as opposed to needle stick exposures where the risk is 1 in 300 or 0.3%.[1,2] Risk from needle sticks may increase in cases of deep injury or when visible blood was present on a needle or instrument that caused the injury or when a needle stick is caused by a needle placed directly into a patient's vein or artery immediately before the exposure. If bodily fluids make contact with an emergency worker's intact skin or the worker has contact with a patient's body fluids not at risk of carrying infection such as tears, sweat, saliva or non-bloody stool or urine, such exposure would not be considered significant or at risk for transmission of infection. For additional details and information on exposure and risk for infection, the AIDS Institute recommends going to www.hivguidelines.org or calling New York State's 24-hour post-exposure hotline at (888) 448-4911.

Based on the Centers for Disease Control, HIV reporting to the CDC and state health departments is voluntary. It is likely that occupational HIV exposures are under-reported and the data available through the CDC is therefore limited to only those cases that have been reported.

> "Documented cases of occupationally acquired HIV/AIDS are those in which HIV seroconversion is temporally related to an exposure to an HIV-positive source and in which the exposed worker has no nonoccupational risk factors for acquisition of HIV. Possible cases of occupationally acquired HIV/AIDS are those in which a worker is found to be HIV positive, has no nonoccupational risk factors for HIV/AIDS, and has opportunities for occupational exposure to blood, body fluids, or HIV-positive laboratory material. Although seroconversion after exposure was not documented for these personnel, occupational acquisition of their infection might have been possible.
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> Of those healthcare personnel for whom case investigations were completed from 1981-2006, 57 had documented seroconversion to HIV following occupational exposures. The routes of exposure resulting in infection were: 48 percutaneous (puncture/cut injury); five, mucocutaneous (mucous membrane and/or skin); two, both percutaneous and mucocutaneous; and two were of unknown route. Forty-nine healthcare personnel were exposed to HIV-infected blood; three to concentrated virus in a laboratory; one to visibly bloody fluid; and four to an unspecified fluid. In addition, 140 possible cases of HIV infection or AIDS have occurred among healthcare personnel." [3]

Of the 57 documented cases investigated, there were no documented events involving emergency workers reported however, twelve of the 140 possible cases involved emergency medical technicians or paramedics. These numbers may signify a need to educate emergency workers on the importance of recognizing and reporting potential exposures in the field.

HIV Testing, Consent and Post-Exposure Prophylaxis

When a significant potential exposure occurs in the course of administering emergency care and services, the need for occupational post-exposure prophylaxis (oPEP) must be evaluated immediately and steps taken to determine the HIV status of the source or patient as well as the HIV status of the employee. Despite the fact that HIV status is health information protected under strict HIPAA laws, the federal government enacted a law in 1990 that created provisions for employers to determine a patient's HIV status when a potential occupational exposure occurred involving emergency first responders such as ambulance personnel, fire fighters and police. Known as the Ryan White law, this legislation stipulated that all employers were required to appoint a designated officer or "DO" to serve as a point-person who would assist in obtaining HIV information. If emergency first responders in the field had potential exposures to communicable or infectious diseases such as HIV they could report this information to the "DO." The "DO" then had the responsibility to communicate with the hospital providing care for the source patient or the patient's provider in order to determine that patient's HIV status. In 2006, this law was reauthorized and left out language on the role of the designated officer and sharing of HIV information.

In the absence of federal language outlining requirements for sharing HIV status, New York State Department of Health developed a regulation in Section 68.3(m) of Title 10 NYCRR that allows for emergency first responders to access a patient's HIV status, if known, in order to evaluate the need for post-exposure prophylaxis.[4] Emergency workers are also required to be tested when their HIV status is unknown or to confirm they were negative prior to the exposure. If the exposed worker tests positive and the source patient's HIV test results are not yet available, the source patient's HIV status will not be disclosed to the emergency care worker. If emergency personnel cannot be tested immediately following a potential significant exposure, PEP should begin and testing

should be performed at a later time during the course of prophylactic treatment. PEP should not be held up if source patient consent is pending or test results are not available. Whenever possible, a source patient's HIV status and Hepatitis B and C status should be determined and if known to be positive, it is important to determine the source patient's most recent CD4 count, viral load and prior or current use of anti-retroviral agents or resistance to those drugs. If any test results suggest drug resistance, a specialist in HIV management may be consulted for further assistance through the NYS 24-hour PEP Hotline.[5]

In instances where the source patient's HIV status is unknown, a New York State consent form (DOH-4045) allows patients to provide informed consent for testing of HIV and Hepatitis B and C in cases of occupational exposure and also permits the release of test results for post-exposure prophylaxis of the exposed employee. If a patient consents to HIV testing, an Eliza antibody test and HIV viral load test should be performed to determine whether an acute or early infection is present and the development of antibodies. Once a patient consents and HIV test results are available, the healthcare provider of the exposed emergency worker can determine whether PEP should continue or not. In cases where a source patient tests negative for both HIV antibodies and viral load, prophylaxis can be stopped for the emergency care worker. Alternately, if a worker tests positive for HIV, PEP should continue until a Western bloc can be performed since there are rare instances when false positives are reported on HIV tests. In situations where a source patient's HIV status cannot be determined due to a patient's or guardian's refusal or inability to provide consent, PEP should be continued for the emergency worker.

If an occupational exposure is significant and HIV status of the source or emergency worker has not yet been determined, immediate prophylactic treatment is indicated and a single dose of anti-retroviral medication should be administered promptly before continuing evaluation. Few consequences are associated with a single dose of anti-retroviral medication and prophylaxis is most effective when taken closest to the time of the potential HIV exposure. Research shows prophylaxis is most effective if taken within two hours of exposure. Two PEP treatment options recommended by the NYS AIDS Institute include:

1. Zidovudine 300 mg. + Lamivudine 150 mg. twice daily for persons 13 years of age and older **OR** Combivir (Zidovudine and Lamivudine combined dosing) 1 tablet twice daily + Tenofovir 300 mg. once daily.

2. Tenofovir 300 mg. daily + Emtricitabine 200 mg. daily **OR** Truvada (a co-formulated, dosed combination of Tenofovir and Emtricitabine) 1 tablet daily + Zidovudine 300 mg. twice daily.

The HIV guidelines recommend that PEP be started within the first 36 hours of a potential exposure. If exposure is reported after 36 hours of the event or if the exposed party is resistant to any of the PEP medications or is pregnant, breastfeeding, has anemia or kidney or liver disease, the NYS Hotline may be consulted for alternate prophylaxis options.[6]

Documentation of Occupational Exposure

Once occupational exposure occurs and is determined to be significant, documentation of any potential exposure to HIV in the workplace should be entered in the emergency worker's medical record to protect their rights. The information to be documented should include date and time of the potential exposure, any details about the actions being performed by the emergency worker when the exposure event occurred, information on the use of protective equipment and the type, severity and amount of fluid exposure as well as any of the details about the source patient when known to be HIV positive. These details would include CD4, viral load, past/present anti-retroviral use and history of drug resistance. Additionally, the emergency worker's record should include the names and doses of drugs used in initiating post-exposure prophylaxis.

Educational Resources

The New York State AIDS Institute provides education and training through their Center for HIV Testing, Post-Exposure Prophylaxis and Acute HIV Infection. The Center can be reached by phone at (212) 604-2980 or by email at info@ceitraining.org. There are also online resources including a PEP Widget from the NYS DOH HIV CEI (Clinical Education Initiative) that can be downloaded for direct access to video presentations on non-occupational and occupational post-exposure prophylaxis, pediatric post-exposure prophylaxis, HIV testing, acute infection and the various consent forms and guidelines for both HIV and Hepatitis screening. These training materials and resources can be used in combination with the other educational resources available from the CDC, OSHA and the AHA mentioned earlier in this article. Proactive and regular education is the best step in ensuring that emergency workers know how to protect themselves from exposure and what steps to take if a potentially significant exposure does occur. Links to national and regional educational sources of potentially helpful information follow.

- Centers for Disease Control and Prevention, Healthcare Worker Occupational Guidelines
  - http://www.cdc.gov/ncidod/dhqp/wrkr_occHealth.html

- National Institute for Occupational Safety and Health, Bloodborne Infectious Diseases (HIV/AIDS, Hepatitis B Virus, Hepatitis C Virus)
  - http://www.cdc.gov/ncidod/dhqp/wrkr_occHealth.html
  - http://www.cdc.gov/ncidod/dhqp/pdf/bbp/Exp_to_Blood.pdf

- Occupational Safety and Health Administration
  - Bloodborne Pathogens and Needlestick Prevention http://www.osha.gov/SLTC/bloodbornepathogens/index.html
  - Bloodborne Pathogens Standard (29 CFR, 1910.1030) http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051
  - Needlestick Safety and Prevention Act (November 6, 2000) http://frwebgate.access.gpo.gov/cgi-bbin/getdoc.cgi?dbname=106_cong_public_laws&docid=f:publ430.106

- American Heart Association, Heartsavers Bloodborne Pathogen Course (2009)
  - http://myportal.americanheart.org/eccportal/ecc/ecc
  - http://aha.channing-bete.com/heartsaver-courses/bloodborne-pathogens.html
  - http://www.laerdal.com/nav/36723151/AHA-ECC-Course-Materials.html
  - http://www.eworldpoint.com/products/AHA-Products/AHNI.aspx

- NYS DOH Bureau of EMS
  - (518) 402-0996 ext 2
  - http://www.nyhealth.gov/nysdoh/ems/main.htm

- NYS DOS OFPC
  - (518) 474-6746
  - http://www.dos.state.ny.us/fire/firewww.html

- NYS Division of Criminal Justice Services
  - (518) 457-2667
  - http://www.criminaljustice.state.ny.us/index.html

Global concerns and humanitarian risks for transmission

Aside from federal and state resources to educate and protect healthcare and emergency care workers in the United States, there are also international resources available that consider HIV transmission on a broader scale in the presence of widespread emergency conditions that may result from natural disasters, political conflict, war and the like. While emergency workers may be impacted in such settings, large groups of communities and societies are equally impacted and risk for transmission of communicable disease becomes a much greater concern because of the potential for a larger number of people to be impacted by such emergencies. In 1992 a resolution set forth by the United Nations General Assembly called for strengthening the coordination of humanitarian assistance in complex emergencies and natural disasters and the Inter-Agency Standing Committee (IASC) was established in 1992 to facilitate interagency decision-making for handling these complex, large-scale emergencies.

The Inter-Agency Standing Committee Task Force is comprised of representatives from international agencies including the World Health Organization, the International Red Cross and Red Crescent Societies, the United Nations and others. The group has produced a collaborative set of guidelines for HIV interventions to reduce risk of transmission when emergency conditions are pervasive. Because extensive emergency conditions require much more than the focused attention given to one patient during an ambulance call, the risks are different and harder to identify and manage at times. Emergency conditions in communities or countries generally require the attention of agencies, organizations and authorities at the local, national and international level. Following consistent international HIV guidelines in such settings allows emergency relief workers and organizations to consider and address the same risks whether great or small and approach them within the context of a population's history, the prevalence of HIV prior to the emergency, the nature of the emergency and the surrounding environmental and societal conditions.

Risks for HIV exposure in global emergencies often correspond to destruction or disintegration of systems and supports such as families, communities, healthcare facilities and social order. In 2002, 42 million people were infected and living with HIV/AIDS worldwide and often under conditions of insufficient access to healthcare and social services. "In January 2003, the IASC issued a statement in which it committed itself to "redoubling our individual and joint agency responses to promote a comprehensive, multi-faceted approach to this unprecedented crisis" as it faced the impact of HIV/AIDS on food security and human survival, as evidenced in southern Africa.[7]" Subsequently, the IASC developed the practical handbook of guidelines that could be put to immediate use for the benefit of those who most needed assistance and support during times of crisis.

> "During a crisis, the effects of poverty, powerlessness and social instability are intensified, increasing people's vulnerability to HIV/AIDS. As the emergency and the epidemic simultaneously progress, fragmentation of families and communities occurs, threatening stable relationships. The social norms regulating behavior are often weakened. In such circumstances, women and children are at increased risk of violence, and can be forced into having sex to gain access to basic needs such as food, water or even security. Displacement may bring populations, each with different HIV/ AIDS prevalence levels, into contact. This is especially true in the case of populations migrating to urban areas to escape conflict or disaster in the rural areas.
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> As a consequence, the health infrastructure may be greatly stressed; inadequate supplies may hamper HIV/AIDS prevention efforts. During the acute phase of an emergency, this absence or inadequacy of services facilitates HIV/AIDS transmission through lack of universal precautions and unavailability of condoms. In war situations, there is evidence of increased risk of transmission of HIV/AIDS through transfusion of contaminated blood.
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> The presence of military forces, peacekeepers, or other armed groups is another factor contributing to increased transmission of HIV/AIDS. These groups need to be integrated in all HIV prevention activities."[8]

Given the fact that various nations, international organizations and emergency relief resources have greater access and proximity to one another in this world of shrinking boundaries related to wars and natural disasters, it is imperative that risk on all levels be considered when evaluating HIV transmission and preventing spread. Because emergency care workers, regardless of the setting, are always at risk for exposure to HIV and other infectious diseases, effective risk management for occupational HIV prevention and rapid post-exposure prophylaxis revolves completely around pro-active education, reporting and adherence to available safety standards.

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[1] *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post-Exposure Prophlaxis,* Morbidity and Mortality Weekly Report (MMWR), Recommendations and Reports, September 30, 2005, 54 (RR09), p. 1-17, http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5409a1.htm, accessed January 9, 2010

[2] *Occupational PEP (oPEP),* New York State Department of Health, AIDS Institute, Clinical Education Initiatives (CEI) PEP Widget, accessed January 4, 2010.

[3] Surveillance of Occupationally Acquired HIV/AIDS in Healthcare Personnel, as of December 2006, *Centers for Disease Control & Prevention, http://www.cdc.gov/ncidod/dhqp/bp_hcp_w_hiv.html#2, accessed January 9, 2010.*

[4] *Title 10 NYCRR, Section 68.3(m),* April 2008.

[5,6] *Occupational PEP (oPEP),* New York State Department of Health, AIDS Institute, Clinical Education Initiatives (CEI) PEP Widget, accessed January 4, 2010.

[7] *Guidelines for HIV/AIDS Interventions in Emergency Settings,* Inter-Agency Standing Committee Task Force, November 2003, p. 4, http://www.humanitarianinfo.org/IASCWeb2/pageloader.aspx?page=content-products-products&productcatid=9, accessed December 15, 2009.

[8] *Guidelines for HIV/AIDS Interventions in Emergency Settings,* Inter-Agency Standing Committee Task Force, November 2003, p. 7, http://www.humanitarianinfo.org/IASCWeb2/pageloader.aspx?page=content-products-products&productcatid=9, accessed December 15, 2009.