Effective Health Care Risk Management Programs:

Components for Success

CHUBB

It's Chubb. Or it's Chance.

Health care "old timers" remember that the first real focus on risk management occurred in the late 1970s and early 1980s when hospitals were faced with a malpractice crisis. The price of insurance in the commercial market became so high that many larger institutions established their own captive insurance or trust arrangements for self-insurance. This was the beginning of formal "incident reporting" and the addition of in-house risk managers to analyze trends and suggest interventions to prevent or mitigate claims. The ensuing "soft insurance market" (i.e., low commercial insurance prices) of 1985 to 2000 allowed health care providers to almost entirely transfer their malpractice risk through insurance, and therefore many providers moved away from tight internal risk management controls. In fact, with the current budgetary constraints in health care, many institutions have eliminated the risk manager position or have overloaded this function by adding new responsibilities, such as oversight of quality assurance initiatives, compliance activities, and privacy officer functions.

However, times have changed and providers are facing new challenges. A general increase in claim frequency and severity have resulted in:

- A renewed awareness and concern about patient safety and medical errors.
- Decreased insurance availability (i.e., fewer carriers are offering coverage and most carriers are only offering lower limits of coverage).
- Increased financial risk that must be assumed by the insured through higher retentions or deductibles.
- Higher premiums.
- Minimal, if any, coverage enhancements, and often coverage exclusions (such as exclusions for sexual misconduct or abuse claims).
- More selectivity by carriers (i.e., they limit whom they do business with and prefer organizations with effective quality assurance or risk management operations).

These converging factors have created a heightened need for effective risk management, not only for hospitals and acute care settings, but also for long-term care, home health, and physician practices. Although each of these patient-care settings has unique risk management needs, they have much in

common. The purpose of this brochure is to underscore the importance of an effective risk management program and to outline the components integral to ensuring success.

So, What Is Risk Management?

The American Society of Healthcare Risk Management (ASHRM, which is affiliated with the American Hospital Association) defines risk management as:

> The identification, analysis, and evaluation of risk and the selection of the most advantageous method of treating it. This process involves a four-step general model:
>
> 1. Risk identification.
> 2. Risk analysis.
> 3. Risk treatment:
>   - Risk control.
>   - Risk financing.
> 4. Evaluation of risk treatment strategies.

Practically speaking, risk management can be defined as identifying, addressing, preventing, and monitoring situations that could result in:

- Injury or liability,
- Financial loss, or
- Regulatory noncompliance.

Risk management should be a common thread throughout the entire organization. Each employee and volunteer should be charged with risk management, and someone must be responsible for integrating all components of the program. In hospitals, this is typically the risk manager; in other inpatient settings, it may be the quality manager; in outpatient settings, it is often the head nurse or office manager.

Risk Management Program Elements

Depending on the setting, a comprehensive and effective risk management program should include the following elements:

- ☐ Safety/security programs.
- ☐ Occupational Safety and Health Administration (OSHA) requirements/employee health program.
- ☐ Clinical Laboratory Improvement Act (CLIA) requirements.
- ☐ Infection control.
- ☐ Medicare/Medicaid patient rights requirements.
- ☐ Informed consent procedures.
- ☐ Clinical standard of care/negligence.
- ☐ Property damage and property accessibility.
- ☐ Medical waste and needle disposal.
- ☐ Medical record documentation.
- ☐ Confidentiality policy and standards for release of medical information.
- ☐ Mandatory reporting requirements.
- ☐ Licensure requirements.
- ☐ Accreditation standards.
- ☐ Credentialing/privileging guidelines.
- ☐ Contract management.
- ☐ Monitoring of marketing/public relations/external representations.
- ☐ Complaint/grievance management.
- ☐ Claim investigation and management.
- ☐ Employment practices guidelines.

- Construction/physical plant requirements, permits, etc.
- Regulatory compliance activities.
- Risk transfer and financing management.
- Retention of insurance policies.
- Insurance broker relations management.

Risk Management Processes

Consistent and thorough processes are the hallmark of a successful risk management program. In addition, they should be reviewed and updated on a regular basis. Risk managers should look to available resources such as the organization's insurer for updates and standards to use as a foundation for process development and revision. A risk management program should include:

1. Policies and procedures, specifically developed for the risk management function, that:
    - Describe the risk manager position and to whom it reports (i.e., the board of directors, legal department, CEO, etc.)
    - Outline incident reporting requirements.
    - Delineate claims handling and reporting requirements.
2. A process to review all the organization's policies and procedures in order to:
    - Ensure that they are consistent with the standard of care delivered in the facility or practice (to avoid having them used as evidence of negligence or deviation from the standard of care).
    - Delete/repeal unused or incorrect policies or procedures.
    - Make sure policies and procedures reflect actual operations or practices.
    - Ensure consistency between departments, to the fullest extent possible.

- □ Maintain historical archives of policies and procedures.
- □ Schedule reviews/revisions/updates, as necessary.
- □ Confirm appropriate signatures with effective dates and revision dates.

3. Exposure identification mechanisms, such as:
   - □ Formal reports (i.e., incident, accident, occurrence, etc.).
   - □ Formal review of:
     - ◦ Prior claims.
     - ◦ Patient complaints.
     - ◦ Employee complaints.
     - ◦ Standardized surveys/questionnaires.
     - ◦ Inspections/surveys/audits/consultants or expert reviews.
     - ◦ Quality assurance reports.
     - ◦ An environment in which everyone has a responsibility to identify risk exposures.
4. A formal and standardized incident reporting process that:
   - □ Defines:
     - ◦ What "incidents" must be reported.[1]
     - ◦ What form to use.
     - ◦ When a report needs to be completed.
     - ◦ Who completes the report.
     - ◦ What needs to be reported (reportable events) and to whom.
     - ◦ Who does the follow-up investigation.
   - □ Solicits just facts, not opinions.

- ☐ Utilizes any available legal protections for confidentiality and disclosure, to the fullest extent possible, including:
  - ◦ Quality assurance privilege.
  - ◦ "Medical or peer review committee" privilege.
  - ◦ Attorney-client privilege (generally not available in most states for routine incident reports).[2]
  - ◦ Attorney work product (anticipation of litigation)—generally protects mental impressions, conclusions or opinions, but not facts.[3]
- ☐ Is part of quality assurance program or peer review process to enhance nondisclosure.
- ☐ Is nonpunitive.
- ☐ Identifies when an attorney needs to be involved.
- ☐ Prohibits copying of reports or putting reports in patient records.

5. An incident follow-up process that addressees:
   - ☐ Who does the investigation?
   - ☐ What was the outcome?
   - ☐ What needs to be done to avoid the problem in the future?
   - ☐ Documentation.
6. A tracking/trending process for:
   - ☐ Incidents.
   - ☐ Claims and lawsuits.
   - ☐ Specified indicators (may be quality assurance indicators—e.g., medical errors, reports of lab results, follow-up on canceled appointments, lost records, falls, patient complaints).

7. Staff training/education that:

   - Is incident-specific.
   - Involves new-employee orientation, as well as periodic training.
   - Uses both internal and external training.
   - Documents all training.

Finally, a risk management program should also be fully integrated within the organization. Elements should include a new-employee orientation (for all employees, not just clinicians), periodic inservices, and full interaction with the following groups:

- Quality Assurance Committee.
- Safety Committee.
- Clinical Committee.
- Administrative Committee.
- Corporate Compliance.
- Board of Directors.

Although initially this may seem overwhelming, it can be accomplished with organizational commitment and one or two senior-level professionals.

Risk Management and JCAHO

Risk management is inherent in almost all Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards. However, one specific standard addresses risk management—Standard Performance Improvement (PI) 3.9—which requires that:

> *The organization collects data about risk management activities, and risk management is integrated with quality control activities. There should be full cooperation and exchange of information among those responsible for risk management, patient care, and safety activities.*

Although PI 3.9 is the only specific standard addressing risk management, two other significant areas within the JCAHO standards clearly involve traditional risk management: the Sentinel Events Policy and the new incorporated standards on "Patient Safety and Medical/Health Error Reduction" that went into effect July 1, 2001.

Conclusion

Due to deteriorating malpractice litigation trends, the medical malpractice insurance crisis, and heightened expectations about patient safety, all health care providers must focus on enhancing the effectiveness of their risk management programs. Those who fail to do so will find themselves exposed to greater risk for failing to implement appropriate patient safety protections and will definitely have difficulty securing adequate professional liability coverage.

1 This can be as broad as any happening that is not consistent with routine patient care or operation of the organization, or as narrow as a medical error resulting in patient injury.

2 *See* Nebraska ex rel. *AMISUB, Inc. v. Buckley*, No. S-99-1058 (Neb. 2000) (Peer review privilege does not protect hospital incident report or list of patient falls from discovery in a patient malpractice suit).

3 *See Binkowski v. Danbury Hospital*, No. CV 960055127S (CT. 1997). (Hospital incident report not privileged under either state peer review statute or attorney-client privilege).

CHUBB HEALTH CARE

Chubb Group of Insurance Companies

82 Hopmeadow Street
Post Office Box 2002
Simsbury, CT 06070-7683

Phone: 800.432.8168 • Fax: 860.408.2002
Web site: http://csi.chubb.com
Email: csi-info@chubb.com

Form 14-01-0579 (Rev. 9/04)