

Critical Issues Facing the Healthcare Industry

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Top Critical Issues

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Over the years, Chubb has addressed critical issues in the healthcare industry from a risk management perspective in order to help executive leaders and risk managers control potential liability exposures through effective administrative and procedural processes. In keeping with tradition, this publication examines a number of trending issues, ranging from infection control, pandemic readiness and a surge in virtual care to the troubling upticks in provider burnout, sexual abuse and violence that are plaguing healthcare settings.

Each of these critical issues presents an array of risk exposures, which have been compounded by the recent pandemic in terms of their severity and frequency threat. Within the following discussion of individual issues, guidance is imparted on clinical, operational and strategic measures in an effort to encourage organizations to undertake a proactive evaluation and systematic approach to the day's most pressing issues.

Pandemic Readiness

Healthcare risk managers across the nation are focused on retooling enterprise risk management (ERM) programs to ensure a more agile response in times of crisis. Traditionally, ERM programs contemplate anticipated risks, such as those created by natural and man-made disasters. However, the recent pandemic has signaled an urgent need to re-examine organizational readiness to address a broader range of risks, including not only perils to patient and public health but also IT security threats, supply chain emergencies and climate change adversities.

Based upon the valuable lessons learned during the pandemic, the following priority steps can help ensure that organizations are capable of swiftly responding to local, national or global events:

Align business continuity planning with ERM

Business continuity planning encompasses far more than backing up data and reviewing fiscal resources. It includes a range of activities that require the full resources of an enterprise to fully address the exposure to the operation. For this reason, business interruption-related risks are well suited to an ERM application. By approaching continuity planning from an enterprise-wide view, organizations reduce uncertainty in these critical areas:

- **Staff contracting** – Allowing for sufficient numbers of service providers during the height of a crisis.
- **Daily census gathering** – Ensuring patient numbers are documented using alternative manual methods.
- **Supply resourcing** – Anticipating shortages of key medicines, equipment and services.
- **Generator readiness** – Securing reliable sources of electricity in the event of a prolonged power outage.
- **Heavy equipment availability** – Meeting the demand for boilers, heaters and compressors in make-shift or “surge capacity” spaces.
- **Information systems integrity** – Avoiding potential disruption in access to clinical and business data.

Draft a strategic plan for supply chain emergencies. Access to critical medication, vaccinations, medical equipment and other life-sustaining items is less predictable in times of crisis. Organizations can mitigate problems posed by poor distribution networks, inadequate inventory and limited storage capacity by taking these strategic initiatives:

- **Convene a risk team** to evaluate supply chain readiness, focusing on high-usage supplies, names of alternative sources, ordering time requirements and patterns of late or incorrect deliveries.
- **Appoint an executive level professional to oversee supply chain management** and work closely with the risk team to recommend enterprise-wide improvements.
- **Report all supply chain related deficiencies to executive leadership** and through organizational quality improvement channels.
- **Draft a crisis management plan** that includes measures to secure multiple supply sources, identify inventory capacity needs and respond to delays in the receipt and distribution of supplies.

Step up corporate compliance efforts

The pandemic shed light on the need for a robust compliance program as healthcare organizations faced volumes of new and updated public health, regulatory and reimbursement mandates. In order to ensure that auditors’ demands are satisfied and exposure to both criminal and civil penalties minimized, organizations will need to fortify their compliance efforts in these notable ways:

- **Digitalize compliance management activities** in order to afford instant access to an inventory of compliance mandates as well as an archive of policy and procedure revisions and updates.
- **Disseminate compliance directives to staff and key stakeholders** utilizing online training forums, hotlines, messaging systems and roundtable discussions.
- **Audit compliance activities** through annual assessments of risk-prone areas, including medical record documentation and coding, whistleblower complaints, claim payment and denial procedures, among others.

Draft a strategic plan for supply chain emergencies. Access to critical medication, vaccinations, medical equipment and other life-sustaining items is less predictable in times of crisis.

Rethink facility use for surge situations

The recent pandemic experience was a lesson in reconfiguring existing healthcare buildings and clinical spaces to accommodate the demand for surge capacity. Architectural changes and conversions were required to facilitate the separation of infected and non-infected patients, as well as safeguard the flow of staff, equipment and supplies. Healthcare organizations are encouraged to assess the flexibility of existing spaces in anticipation of critical needs.

Realistic solutions start with a comprehensive review of building plans and regulations in an effort to identify structures that can flex for future multi-purpose use. In some cases, adequate preparation may require renovations to create a more modular infrastructure that is easily adapted or relocated during times of crisis. For additional reading on this subject, see [“Hospitals After COVID-19: How Do We Design For an Uncertain Future?”](#) from WSP.com, October 6, 2020.

Universal biosafety practices should be firmly rooted in clinical settings, including hand hygiene, use of personal protective equipment, respiratory etiquette, proper disposal of medical waste and safe injection practices.

Infection Control

Even before the historic COVID-19 pandemic placed an intense spotlight on infection control (IC) practices in hospitals and healthcare organizations, national and federal agencies focused on increasing accountability and transparency regarding infection rates in those settings. The Centers for Medicare and Medicaid Services (CMS) created the [Hospital Compare](#) website to publicly report the infection rates of hospitals. In addition, the Centers for Disease Control and Prevention (CDC) established the [National Healthcare Safety Network](#) for the purpose of identifying healthcare-associated infections (HAIs), reporting their rates and tracking infections over time.

Despite increased awareness and improvements made to organizational policy in recent years, HAIs remain a persistent threat and are a continued source of reduced reimbursement rates for institutions. As the pandemic wanes, healthcare organizations should perform a thorough review of their IC programs to gauge whether preventive measures comply with the latest mandates and to ensure that recent revisions will continue to curb infection transmission, particularly with respect to the following HAIs:

- Catheter-associated urinary tract infections
- Central line-associated bloodstream infections
- *Clostridium difficile* infections
- *Methicillin-resistant Staphylococcus aureus* (MRSA) infections
- Ventilator-associated pneumonia

A comprehensive program review should include an assessment of these fundamental elements at a minimum:

Universal precautions

Universal biosafety practices should be firmly rooted in clinical settings, including hand hygiene, use of personal protective equipment, respiratory etiquette, proper disposal of medical waste and safe injection practices. As revisions are made to organizational policy, communicate changes to staff members through intermittent training sessions. Document the dates of those sessions, names of program attendees and testing results, if applicable.

Antibiotic stewardship

A variety of antibiotic stewardship standards have been issued at the national level in response to the upward trend of “superbug” infections and antibiotic resistance. In particular, the CDC’s Core Elements of Antibiotic Stewardship recommend that healthcare organizations adopt an antibiotic stewardship program. The CDC outlines key principles to improve antibiotic use that are based upon these core elements:

- **Leadership commitment** to human, financial and information technology resources.
- **Accountability** at the medical staff and pharmacy levels for program management and outcomes.
- **Pharmacy expertise**, as reflected in the appointment of a pharmacist to co-lead the stewardship program.
- **Action** in the form of pre-authorization requirements for antibiotic usage, audit activities and clinical feedback.
- **Tracking** of antibiotic prescribing activities, the impact of interventions and clinical outcomes.
- **Reporting** on antibiotic use, patterns of resistance and other quality indicators to prescribers, pharmacists, nurses and hospital leadership.
- **Education** of prescribers, pharmacists and nurses regarding the importance of optimal prescribing, adverse reactions to antibiotics and the occurrence of antibiotic resistance.

To learn more about the features of an antibiotic stewardship program, visit the [CDC website](#).

Antibiotic therapy protocol

Industry experts recommend the following additional measures be addressed in policy and procedure in order to ensure appropriate antibiotic therapy:

- Antibiotic selection criteria for common infectious conditions.
- Standing physician order sets for antibiotic therapy.
- Review of antibiotic effectiveness within 48 to 72 hours after initiation.
- Outcome monitoring for adverse reactions and the occurrence of antibiotic resistance.
- Annual peer review of antibiotic usage.

Environmental hygiene

Hand washing protocols, the use of PPE, isolation requirements and environmental hygiene formed the backbone of healthcare IC practices during the pandemic. Going forward, hospitals must ensure continued compliance with routine cleaning and

disinfecting procedures, as delineated in the CDC's [Guidelines for Environmental Infection Control in Health-Care Facilities](#) and the [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#).

Healthcare organizations are required to complete terminal cleaning in patient rooms and treatment areas where patients with an active communicable disease are treated. Attention should be placed on cleaning of hard surfaces, soft and porous surfaces and laundry items with approved cleaning substances, including the use of diluted household bleach solutions, alcohol solutions and [EPA-registered disinfectants](#).

As always, scrupulous documentation of environmental hygiene practices can help to mitigate potential liability in the event of claims alleging viral or bacterial transmission.

Needle and injection safety

As COVID-19 vaccination efforts increase nationwide, healthcare organizations and providers face heightened exposures from unsafe injection practices. The following safeguards should be incorporated into written policies, staff orientation and educational activities:

- Utilize single-use needles and syringes, and adhere to [aseptic injection technique](#).
- Adhere to “sharps” precautions per the [OSHA Blood-borne Pathogen Standard](#) and the [Needlestick Safety & Prevention Act](#).
- Store and use multi-dose vials according to manufacturer recommendations in order to reduce the risk of contamination.
- Dispose of syringes and sharps through appropriately designated waste management systems.



Telemedicine

Given the pandemic's restrictions on in-person clinical encounters, telemedicine and the practice of telehealth (i.e., remote patient monitoring and interaction) played a central role in ensuring the continuity of care. In response to the increased demand for virtual care, federal and national agencies loosened restrictions regarding patient access to these services. Most notably, the [Coronavirus Aid, Relief, and Economic Security Act \(CARES Act\)](#) authorized remote services to patients regardless of their location or underlying condition. In addition, [CMS simplified reimbursement policies](#) in an effort to promote services across state lines and outside of the customary rural areas.

It behooves healthcare organizations to monitor the status of these and other virtual care-related directives, as it is yet unknown whether regulatory easing will continue post-pandemic. In particular, organizations should remain cognizant of the following areas of change and their implications for liability:

Provider credentialing

A diverse group of healthcare providers are now engaged in the delivery of telemedical/telehealth services, including physicians, nurse practitioners, physician assistants, psychologists, social workers and therapists. Healthcare organizations can minimize the risk of unsafe delegation by drafting a provider-specific scope of practice that aligns with state-prescribed treatment parameters and authorized procedures.

Provider licensure

Prior to the pandemic, physicians and providers who practice telemedicine were required to be licensed in the state where the patient is located. The crisis spurred many states to lift their restrictions in order to facilitate boarder access to virtual care. CMS also temporarily waived in-state licensing requirements for Medicare and Medicaid patients who receive telemedicine and telehealth services.

Risk managers and medical staff administrators must closely monitor the current status of licensing requirements in their respective state when authorizing providers to legally practice virtual care. A good source for licensure standards and policy statements is the [Federation of State Medical Boards](#). In addition, a growing number of states participate in [interstate licensure compacts](#), which have allowed providers to acquire an out-of-state license from participating states.

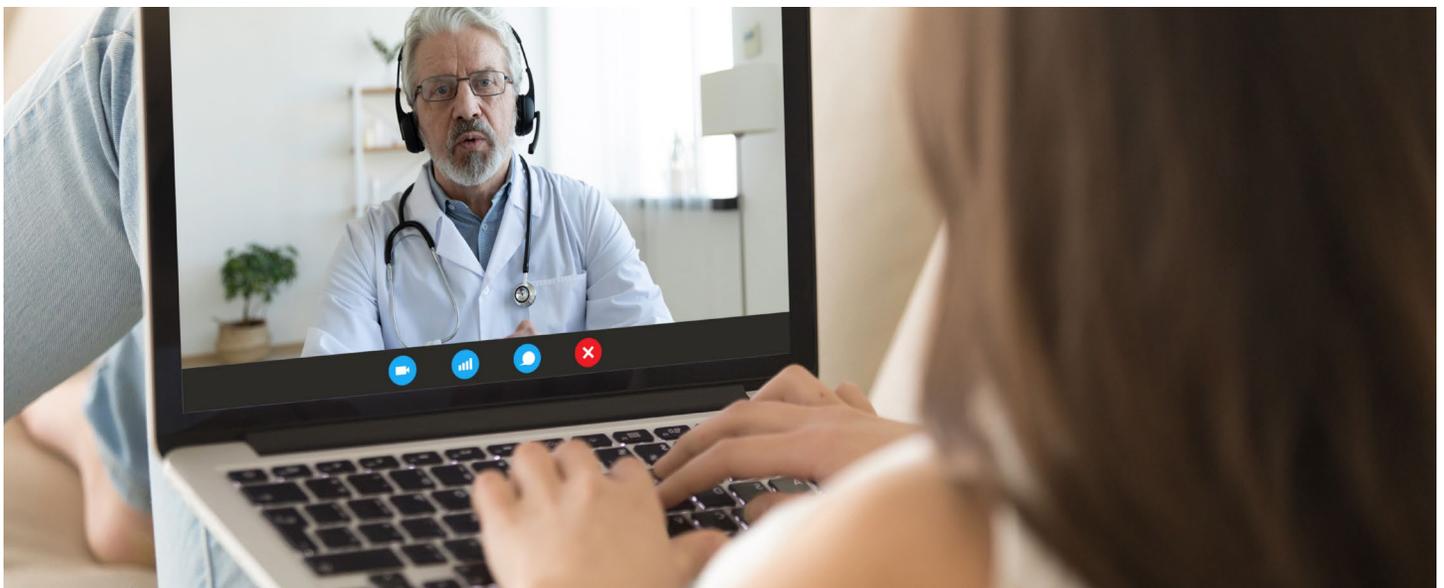
Recordkeeping

Scrupulous attention to documentation is essential to defending a claim of negligent care. Documentation standards for telemedical and telehealth services are the same as in-person care. In addition to noting clinical documentation – i.e., patient assessment, consultation and treatment – the medical record should reflect the patient's consent, the provider who is delivering the service, the location of the patient and the provider and the names and roles of other professionals involved in the virtual event.

Video conferencing exposures

During the height of the pandemic, the federal government authorized the use of Zoom, Skype and other video applications to facilitate patient care encounters. While these platforms were not designed for use in healthcare settings, the government signaled a willingness to waive HIPAA privacy violations against providers who use them in good faith.

In order to protect against potential security and privacy risks during video conferencing, hospitals and healthcare organizations should ensure basic privacy protections, such as end-to-end data encryption during transmission and password protected access to applications. Additional safeguards include encrypted chat features, passcodes for digital waiting rooms, screen sharing restrictions and privacy and mute features.



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Clinical Burnout

The pandemic compounded what was already a growing epidemic of clinical burnout among healthcare providers. Ranging from stress and exhaustion to diminished worth and indifference towards patients, the symptoms of clinical burnout impact nearly every type of caregiver, including physicians, nurses, advanced practice providers, therapists and social workers.

According to the National Taskforce for Humanity in Healthcare, clinical burnout among physicians alone may cost healthcare systems [\\$17 billion per year](#). The staggering costs of absenteeism, staff turnover and related medical errors warrant a comprehensive and objective examination of the phenomenon by healthcare leadership. The following recommendations help ensure organizations are thoroughly evaluating provider burnout and its consequences:

Identify the root causes of burnout

Most healthcare professionals encounter some degree of stress in the course of their practice. While stress factors may vary by provider type depending on the nature of clinical work, the following root causes of burnout are generally considered universal:

- Work overload
- Loss of control over practice
- Lack of appreciation
- Substandard compensation and benefits
- A non-trusting work environment
- Clashing values in a cost-driven environment

Acknowledge the link between digital overload and burnout

Inefficient IT interfaces, computer entry demands and a cacophony of clinical alarms from digital devices rob providers of precious time with patients. To combat digital overload, ensure providers are adequately trained on IT systems and

have immediate access to support staff regarding technical glitches stemming from the use of medical devices, diagnostic software, communication platforms and electronic health records.

Regularly screen providers for burnout

Annual screening for clinical burnout can help identify at-risk providers. A number of standardized tools are suitable for healthcare settings, including the [Maslach Burnout Inventory](#) and [Nurse Well-Being Index](#). These tools, among others, help detect common signs and symptoms of burnout, such as:

- Emotional exhaustion
- Sadness and malaise
- Chronic health problems
- Decreased attention span and frequent errors
- Communication breakdowns

Implement team-based care

Improved patient outcomes and provider well-being have been linked to team-based care. Through shared goals, mutual trust, effective communication and feedback, a team-based care model enhances clinical efficiency and helps improve provider engagement. To learn more about the benefits of healthcare teams, see Mayo, A. T. and Woolley, A. W. "[Teamwork in Health Care: Maximizing Collective Intelligence via Inclusive Collaboration and Open Communication](#)."

Capture wellness data

Wellness data – including absenteeism rates, overtime hours, staffing assignments and provider satisfaction levels – provide valuable insights into the frequency and severity of clinical burnout. Data reports, compiled by a dedicated wellness committee, also can complement quality improvement activities by facilitating action plans to reduce burnout that are targeted to provider type and clinical specialty, among other characteristics of burnout.





Sexual Abuse Prevention

Sexual abuse by healthcare providers against patients is a credible threat to organizations, as they may be civilly and criminally liable for the hiring, supervision and retention of perpetrators. Consider the following [recent media accounts](#) involving sexual abuse of patients:

- A former Pennsylvania pediatrician was sentenced to 79 years in prison for sexually assaulting 31 children, many of whom were patients.
- An emergency department doctor in New York was sentenced to two years in prison after pleading guilty to assaulting four female patients.
- A California-based gynecologist was charged with 29 felonies related to the sexual abuse of 16 patients in a health clinic setting.

While most hospitals address sexual abuse within the context of a larger violence prevention program, the healthcare industry is trending toward the adoption of a separate policy that specifically targets the prevention of sexual assault and misconduct. By committing to a targeted protocol, organizations prioritize safety and signal to patients that incidents will be reported, investigated and responded to in a prompt, transparent and confidential manner.

The following strategies address key components of a sexual abuse prevention policy:

Define sexual abuse and misconduct

All caregivers must be trained to recognize acts of sexual abuse and misconduct. These may include sexual assault and battery, rape, oral copulation and sexual penetration, among other acts. Training sessions should include real-life examples of sexual abuse in the clinical setting so that caregivers and providers can recognize early warning signs of abuse.

Conduct background screens on all hires

Checking references and conducting criminal and sex-offender background checks can help organizations ensure that providers and caregivers are qualified to care for patients in vulnerable circumstances. A background check should be conducted in all states where an applicant has lived or worked and scrupulously documented in the personnel file.

Identify types of sensitive care

Clinical care that requires the handling and/or exposing of a patient's genitalia, rectum or breasts requires the utmost attention to professional standards. The following clinical tasks, among others, are generally considered sensitive in nature

and should be outlined in written policy, along with provider expectations:

- Treatment involving the genitalia, rectum or breasts.
- Administering medications or inserting medical devices in the genitalia or rectum.
- Cleansing of intimate body parts.
- Examinations that require a full disrobing by the patient.

Adopt a medical chaperone policy

Medical chaperones can help diminish unwanted exposure to sexual abuse and misconduct claims during sensitive care encounters. The American Medical Association recommends that chaperones be clinically trained professionals, such as medical assistants, physician assistants, nurses and therapists. Patient consent to the presence of a chaperone should be documented in the medical record along with the rationale for the encounter.

Dedicate a reporting channel for instances of abuse

Ensure that all patients and healthcare workers know how to report and file incidents of sexual abuse and misconduct. A thorough and accurate accounting of events via a confidential medium helps organizations comply with time frames for investigating incidents and reporting findings to protective service organizations, law enforcement agencies, state licensing boards and professional liability insurers.

Safeguard the care environment

Visitors and other third parties to a healthcare setting are a potential source for abusive acts to patients. They should therefore register at dedicated points of entrance and document the reason for their visit. In addition, simple security measures can help mitigate abuse and misconduct, including well-lit spaces, locked outer doors at designated times, 24-hour hospital campus surveillance and the liberal use of panic buttons and alarms in patient care areas.

Violence in Healthcare

Workplace violence has long topped the list of critical issues in healthcare. For over two decades, the Occupational Safety and Health Administration (OSHA) has trended incidents of workplace violence, finding their occurrence is [four times more common in healthcare](#) than in private industry. Today, most hospitals and healthcare organizations have implemented a violence prevention program (VPP) in varying degrees. However, voluntary safety improvements are just one step towards mitigating the adverse exposures associated with physical and verbal abuse. Industry experts are signaling that more initiatives need to be taken in order to hold executive leaders and administrators accountable for acts of violence in their healthcare settings.

In particular, the [Workplace Violence Prevention for Health Care and Social Service Workers Act](#) was introduced in Congress in 2018, essentially requiring healthcare and social service industries to develop and implement a comprehensive workplace VPP. Pursuant to the Act, organizations may incur fines for failing to report violent incidents involving patients, staff and visitors to OSHA.

More recently, healthcare CEOs from across the nation formed a coalition to examine standards of safety and trust for healthcare professionals. The coalition aims to ensure that organizations have the systems, tools, technologies and resources they require to ensure healthcare workers remain safe. In addition to physical safeguarding, the alliance expands the definition of safety in its [Declaration of Principles](#) to include psychological and emotional safety. The declaration also promotes health justice by advocating for equity-focused policies and practices that advance diversity, inclusion and belonging.

With a renewed national focus on improving efforts to reduce workplace violence, healthcare organizations of all types are encouraged to revisit the OSHA [Guidelines for Preventing Workplace Violence for Healthcare and Social Service Workers](#) and track their progress toward reducing work-related assaults.

According to the guidelines, an effective VPP must focus on processes and procedures to identify, report and resolve violent and confrontational situations. The VPP should expressly state a zero-tolerance policy toward violence in any form, including verbal harassment and intimidation.

These additional guidelines help ensure organizations have an effective strategy that combines workplace policies with physical and administrative security measures:

Define violence

Most working definitions of workplace violence include physical, verbal and psychological acts, as well as sexual abuse, which can encompass both physical and care-related offenses.

Identify danger signs of patient aggression

Staff members should be trained to recognize signs of violent outbursts and confrontations in patients and other staff members, including but not limited to unmotivated cursing, paranoid thoughts, speaking loudly and restless and nervous movements.

Conduct background checks on staff

A pre-employment screening to verify references and check for criminal convictions and sexual offenses helps to reduce exposure to staff-related violence and abuse.

Train staff on de-escalation procedures

The ability to safely diffuse a potentially explosive situation can be the difference between a controlled confrontation and harmful event. De-escalation techniques include establishing a rapport with the perpetrator by talking in a calm and respectful fashion, being firm and direct in manner and acknowledging feelings of helplessness, among other interventions.

Implement security practices

Common security measures include locked or guarded entrances, video surveillance, visitation logs and well-lit spaces, among other procedural and physical controls. The presence of security personnel can be an effective deterrent to violence, but individuals should be selected based upon their professional training and experience.

Draft a reliable reporting protocol

Violent and abusive acts must be promptly reported and thoroughly investigated. Written procedures and methods for reporting events should be addressed in staff educational programs and reflect staff-friendly measures. Ensure that all incidents are reported to the appropriate agency according to state law.

In these unprecedented times, Chubb Insurance is ready to assist healthcare organizations in meeting the exposures addressed above, as well as other pressing challenges.



About the Author

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