

# Critical Risks Facing the Healthcare Industry

Diane Doherty and Renee Carino

CHUBB®

Medical Risk

As part of a comprehensive risk management strategy, healthcare organizations should work with insurers that have proven expertise in working with the healthcare sector and that understand the unique challenges facing the industry.

Hospitals and healthcare organizations face enormous challenges on a daily basis as they seek to provide quality care to patients. Over the last few years, the healthcare industry has come under pressure to respond to new regulatory requirements under the Affordable Care Act. While those demands continue, new challenges are emerging that have the potential to disrupt facility operations and put employee and patient safety at risk.

From pandemics to violence in hospitals, alarm fatigue to healthcare-acquired infections and contamination from pollutants, healthcare organizations will be put to the test in the coming months and years. Failure to adequately address these issues could not only put patient and employee safety at risk, it also could lead to heightened liabilities, an increase in workers' compensation claims, fines and penalties and damage to an organization's reputation.

To minimize their exposures, hospitals should have a comprehensive risk management program that addresses each of these issues. Hospital risk management teams should be familiar with these challenges and should be empowered to take action to mitigate the risks. Because of the potential adverse consequences, risk management teams should report directly to the top leadership, including the chief executive as well as the hospital board.

As part of a comprehensive risk management strategy, healthcare organizations should work with insurers that have proven expertise in working with the healthcare sector and that understand the unique challenges facing the industry. While hospitals are under constant pressure to do more with less, those that have the foresight to prepare for these emerging risks can reduce the chances of debilitating losses while

strengthening their ability to deliver quality patient care.

### **1. Preparedness for Pandemics**

---

Growing concern about Ebola in the United States has forced healthcare facilities to review their current practices and consider the impact that a potential nationwide pandemic would have on their organizations and the communities they serve.

The ability to deliver care with minimum disruption and safeguard the health of workers and patients will depend on planning and preparation measures that facilities undertake today. Organizations should consider a number of critical steps as they prepare for the possibility of a potential pandemic, whether as a result of Ebola or any other infectious disease.

### **Top Critical Issues Facing Hospital Leadership:**

---

1. Preparedness for Pandemics
2. Violent Incidents in Hospitals
3. Healthcare Reform/  
Physician Integration
4. Disruptive Staff Behavior
5. Telemedicine
6. Cyber Risk
7. Environmental Pollutants
8. Emergency Preparedness
9. Alarm Fatigue
10. Obesity Epidemic
11. Healthcare-Associated Infections

### **A Pandemic Action Committee**

Healthcare facilities should form a pandemic action committee to help identify, respond to and recover from a broad range of potential business and clinical interruptions. The committee should include representation from: senior administration, risk management,

the emergency department, occupational health, human resources, nursing administration, medical staff, hospital disaster services, infection control, engineering and institutional safety, and laboratory and therapeutic services. The committee should designate a response coordinator who is well versed in federal, state and local government planning for pandemic conditions as well as being knowledgeable of private sector efforts.

### **Education and Training**

A healthcare organization's infection control practitioner should provide mandatory in-service training for all shifts to review measures for the prevention and control of a virus. Suggested topics include: selection and proper use (including proper removal and disposal of) of personal protective equipment, hand hygiene, cleaning and disinfection of environmental surfaces, handling of laboratory specimens, safe work practices, and post-mortem care.

### **Triage and Containment**

One measure proven to have a temporizing effect on pandemic transmission is to quarantine patients to a single treatment area or unit or floor. Facilities should establish a separate entry and waiting room for patients with suspicious symptoms and erect a temporary structure near the emergency department to treat infectious patients, and reserve the emergency department for regular patients. They should screen all patients according to a standardized protocol for the presence of Ebola associated symptoms or of the particular disease and should move suspected emergency department patients from triage into isolation units until diagnostic tests are negative for the applicable virus. All infected patients should be admitted to a floor that is designated for the inpatient care of those who are afflicted with the virus. Organizational policy also



should prohibit staff members who work in close contact with quarantined patients from rotating to other units until the local health department has determined the outbreak is under control. Remember to include contracted agency workers, housekeeping, volunteers and administrative staff in any policy statement that restricts work assignment.

Electronic and other documentation formats utilized during the triage process must allow for shared access across established nursing and physician workflow processes. Critical data, including a history of travel to affected regions and/or prior contact with infected persons must be prominently noted in the patient care record when members of the treatment team access the electronic or paper record.

A multitude of other issues should be addressed as well. These include: disease surveillance, facility access and security, hospital communication, vaccine and antiviral use, occupational health policies, surge capacity planning, supply chain and resources, waste management and mortuary needs.

## **2. Violent Incidents in Hospitals**

---

Hospitals may be places of healing, but they also have become the scene of an increasing number of violent incidents. Such incidents not only put patients at risk but also medical professionals, who are often the targets of attacks, harassment, intimidation and other disruptive behavior.

The incidence rate for violence and other injuries in the healthcare and social assistance sector in 2012 was over three times greater than the rate for all private industries.<sup>1</sup> The Joint Commission, meanwhile, reports increasing rates of assault, rape and homicide in healthcare facilities.<sup>2</sup> Perpetrators can include patients, family members, visitors and vendors as well as current and former healthcare employees.

The costs to hospitals and healthcare organizations can include increases in malpractice litigation and workers' compensation claims, federal and state fines, damage to the organization's reputation, as well as difficulties with staff retention, morale and absenteeism.

As part of a comprehensive risk management strategy, healthcare organizations should work with insurers that have proven expertise in working with the healthcare sector and that understand the unique challenges facing the industry.

To address the problem, hospitals and healthcare organizations should:

- Enact a zero-tolerance policy. The policy should state that no form of violence – physical, verbal or psychological – will be tolerated, and that all offenders will be subject to disciplinary action, including termination. The policy should be communicated to management, employees, volunteers, contracted workers and patients.
- Conduct an assessment of risk factors. Assess current practices and attitudes toward workplace violence and develop a violence prevention program. Healthcare organizations may wish to consult with their insurer for guidance.
- Educate and train all personnel. Institute policies and procedures on how to spot danger, how to defuse conflict and how to respond to violent incidents, and personal safety training.

### **3. Healthcare Reform/ Physician Integration**

---

As hospitals move ahead with the implementation of the Affordable Care Act, they have been hiring physicians at a rapid rate; but the integration of doctors and their practices opens hospitals up to increased liability risk.

The changes in the employment relationship between hospitals and physician practices have been dramatic. In 2014, about 64 percent of newly hired physicians were employed by hospitals, up from just 11 percent in 2004.<sup>3</sup> Fewer than one percent were going into solo practice in 2014, down from 20 percent in 2004. These changes are expected to continue.

While hospitals pursue the strategy of hiring more physicians, they should be mindful of the impact on their

own liability risk. As the employer, for instance, hospitals could be held vicariously liable for their physicians' negligent acts or omissions.

In spite of this risk, the hospital risk management team has often been left out of contract talks with doctors and physician practices, resulting in employment arrangements that may be less than ideal from a risk management perspective.

Before reaching any agreements, hospitals should consult with their risk management team and include the team in the development of contracts with doctors and their practices. Hospitals should rely on the risk management team to help integrate the physicians and their practices into the hospital's system, including its reporting of incidents and managing risks. Hospitals also should consider using a self-assessment tool to determine whether a physician's office policies and practices may fall short of the organization's standards.

### **4. Disruptive Staff Behavior**

---

Disruptive behavior by physicians and medical staff is a serious problem that can lead to medical mistakes and put patient safety at risk by promoting an environment of hostility and distrust. If left unaddressed, disruptive behavior can create significant liabilities for healthcare organizations.

Behavior such as verbal outbursts, bullying, condescending language and refusal to answer questions also comes with other risks. Individuals with a history of disruptive behavior pose the highest litigation risk for hospitals. This also contributes to poor teamwork, low staff morale, poor patient satisfaction; impedes operational efficiency and

## Hospitals should rely on the risk management team to help integrate the physicians and their practices into the hospital's system, including its reporting of incidents and managing risks.

causes difficulties with staff recruiting and retention.<sup>4</sup>

In 2009, the Joint Commission began requiring hospitals to establish formal codes of conduct as well as processes for managing disruptive and inappropriate behavior by medical staff<sup>5</sup>; however the existence of a written policy can only go so far. Healthcare organizations need to develop an effective intervention process to address each complaint and make appropriate recommendations. A formal conflict management committee that reports directly to the governing board should be established and charged with the development of policies and procedures as well as the education and training of medical and clinical staff. The committee should be accountable for responding to reports of disruptive behavior, investigating incidents and overseeing the negotiation process to the point of resolution.

Confronting the problem of disruptive behavior ahead of time will help administrators, physicians and nurses to recognize and respond to incidents before they become a liability.

### **5. Telemedicine**

---

Advances in technology, the current physician shortage and the dramatic increase in the number of patients seeking care under the Affordable Care Act have led a growing number of healthcare facilities to expand their use of telemedicine to deliver services to patients in hospitals as well as in remote locations. Over half of all U.S. hospitals now use some form of telemedicine to treat patients.<sup>6</sup>

Healthcare professionals are using technology such as interactive video and

email to communicate with patients and they are gathering information remotely through the transmission of diagnostic images and test results. Many of today's monitoring devices also allow doctors to remotely collect information about patients who are in the intensive care unit or at home.

While this can provide patients with better access to healthcare and offer physicians more detailed information in less time than ever, healthcare professionals should keep in mind the risks.

Telemedicine could result in allegations of negligence if healthcare providers do not have the proper training, experience and credentials. Currently, there is no federal standard of clinical guidelines for telemedicine. The practice is regulated by varying state laws, and Centers for Medicare and Medicaid Services (CMS) guidelines. Hospitals and physicians may find it difficult to manage telemedicine risks because there is often a lack of clarity about legal, licensing and regulatory requirements, as well as which jurisdictions take precedence. Strategies to mitigate telemedicine risks include:

- The credentialing and privileging process at the facility should be evaluated to ensure CMS guidelines are met.
- Medical staff bylaws, rules and regulations should reflect the full integration of CMS telemedicine standards with other lines of clinical practice in the organization. Any state specific licensure requirements should be incorporated.
- Written agreements, service contracts and risk-transfer plans should be carefully reviewed by the board of directors to minimize potential lapses in the standard of care as well as disputes with telemedical partners.

- Physicians should be educated about essential informed consent elements and audit documentation for inclusion of telemedicine consent in the patient record. Explanations should include how the technology is used and any limitations.
- The credentialing committee should have the authority to grant membership to telemedical providers.
- A new medical staff membership category should be created for telemedicine practitioners and should adhere to the American Medical Association's model bylaw language.
- A board-approved list of authorized telemedical procedures and services should be established.
- Compliance with all aspects of the CMS Final Rule regarding credentialing of telemedicine practitioners should be documented. Insist on mutual hold harmless and indemnification clauses in all business contracts between telemedicine partners.

## 6. Cyber Risk

---

As the healthcare industry adopts electronic healthcare records and increasingly relies on technology, hospitals face new challenges and evolving regulations in their efforts to protect patient information and minimize their exposure to cyber risk. In its Fourth Annual Benchmark Study on Patient Privacy & Data Security, the Ponemon Institute said that while the total number of data breaches declined slightly over previous years, almost every healthcare organization represented in the research experienced a data breach.<sup>7</sup> In addition, security experts have been cautioning that cyber criminals are increasingly targeting the U.S. healthcare industry as medical information contained in healthcare records is extremely valuable

and worth 10 times more than credit card information on the black market.<sup>8</sup>

Data breaches cost healthcare organizations millions of dollars every year, with the average cost for organizations represented in the Ponemon study estimated at \$2 million over a two-year period. The potential cost to the healthcare industry could be as much as \$5.6 billion annually based on the experience of the healthcare organizations in the study.<sup>9</sup>

The healthcare system's move to electronic healthcare records has created new exposures as records are now more easily accessed by consultants, vendors and other third parties for efficient operation. Additionally, healthcare organizations face exposure to cyber risks that could have significant impacts on their operations, including shutting down critical, health-related systems.

Data breaches and network disruptions can jeopardize an organization's financial stability, security, and reputation. Standard general liability policies often do not adequately cover perils associated with cyber and technology related exposures. Cyber liability insurance can address coverage gaps and the underwriting process increases awareness of exposures while also enabling companies to transfer risks associated with cyber, such as patient notification, crisis management, and forensic analysis expenses as well as certain regulatory fines, indemnity payments, legal costs in addition to business interruption exposures associated with the technology supply chain. Healthcare organizations should look to their insurance carrier for solutions to help manage and mitigate these types of risks.

## 7. Environmental Pollutants

---

Rapid advances in medical technology, combined with industry consolidation driven by economic and regulatory challenges, are leading many healthcare organizations to build new facilities or expand and remodel existing ones. Construction and maintenance work, however, may lead to a wide variety of environmental exposures involving indoor air quality, water systems and other areas. These risks are of particular concern when projects take place in a facility that is still in use. Fugitive dust, fumes and mold spores spread by construction work can cause life-threatening reactions for patients with weakened immune systems. Renovation and expansion projects may spread mold, bacteria or viruses through heating, cooling, ventilation and water systems. The risks also include exposures that arise from the transportation and disposal of construction materials and debris off site.

Besides the potential for bodily injury among patients and staff, major considerations include the potentially significant remediation costs should a pollution problem occur and the possibility that all or part of a facility may have to be shut down during environmental remediation.

Reputational damage should not be overlooked. Pollution problems at a healthcare facility may attract negative news coverage. In that case, the facility may want to work with public relations experts to help limit the potential damage to their reputations.

To address these risks, healthcare organizations should make sure that building projects are conducted by qualified contractors in an environmentally sound manner that mitigates the potential exposures.



Given a healthcare organization's obligation to protect patient health, governing boards should remain abreast of applicable environmental laws regarding infection control measures and standards of care as established by professional entities that govern construction. Boards should recognize that many pollution and environmental exposures are specifically excluded from general liability policies.

Environmental insurance policies especially designed for the healthcare industry provide coverage against a broad range of pollution exposures, while reducing potential coverage gaps found in general liability policies. The coverage should include the costs of remediation as well as business interruption.

## 8. Emergency Preparedness

---

Disasters can strike anywhere at any time. In just the last few years, events such as the Boston Marathon bombing, the explosion at a fertilizer plant in West Texas and the Asiana Airlines crash in San Francisco have resulted in mass casualties, forcing hospitals and healthcare workers to deliver care to

badly wounded patients under crisis conditions.

While events such as these come as a shock to local communities, they happen frequently enough to underscore the urgent need for additional emergency preparedness planning for all hospitals. Mass casualty incidents happen, not only in large cities like Boston and San Francisco where emergency planning may be routine, but in smaller communities as well.

Hospitals should be prepared to provide emergency medical care to the victims who may have injuries more commonly seen on a battlefield and who may overwhelm the capacity of a local emergency department. In many cases, the injuries can strain the capabilities of the medical staff. In the case of the Asiana plane crash, for instance, many of the victims were children, who required specialized care, which presented additional challenges to an already overwhelmed medical staff.

In addition to being prepared to provide medical care, healthcare organizations should also be ready for the other pressures they may face in

Environmental insurance policies especially designed for the healthcare industry provide coverage against a broad range of pollution exposures, while reducing potential coverage gaps found in general liability policies. The coverage should include the costs of remediation as well as business interruption.

a mass casualty situation. The media, government organizations and family members will all require attention at a time when the healthcare organization's leadership will already be under pressure.

The healthcare organization itself may be directly impacted as well. Superstorm Sandy, for instance, caused flooding and power outages in certain states, forcing some healthcare organizations to rely on backup generators and consider questions such as whether to evacuate patients. Leadership and communication are critically important in ensuring that a healthcare organization is prepared to deliver care to victims, while, to the extent possible, protecting staff and patients from being exposed to any further risk.

Organizations should designate an incident response team to take charge in any disaster. It is vitally important that healthcare organizations review and update their emergency disaster plans on an ongoing basis. Without proper planning, the organization may be unable to provide care as it should, while simultaneously dealing with the media, family members and disaster management organizations. The disaster management plan should be fully integrated with those of other organizations and agencies at the local, state, regional and national levels.

Communication becomes critical during a disaster, and staff should be designated to provide accurate information to employees, patients and their families, and to work with local, state and federal agencies. Employee training is an important component of emergency preparation. Hospitals should implement and practice drills of different disaster scenarios across all shifts.

Emergency preparedness planning has become a necessity in today's world and no hospital should consider itself immune to the threat of a mass casualty incident or a catastrophe that could disrupt operations.

## 9. Alarm Fatigue

---

Hospital nurses hear them constantly – the beeps and chirps of alarms on medical devices, such as ventilators, cardiac monitors and pulse oximetry devices. While alarms are designed to draw attention to a potential problem, they can easily be tuned out by overwhelmed medical professionals, who may then fail to respond as they should.

Alarm fatigue is a growing problem for hospitals and the consequences can be fatal. The Joint Commission's Sentinel Event database includes reports of 98 alarm-related events between January 2009 and June 2012. Of the 98 events, 80 resulted in death, 13 in permanent loss of function and five in unexpected additional care or extended stay.<sup>10</sup> Alarm fatigue was rated a top concern by 19 out of every 20 hospitals in the United States, according to a national survey presented at the annual meeting of the Society for Technology in Anesthesia in 2014.<sup>11</sup>

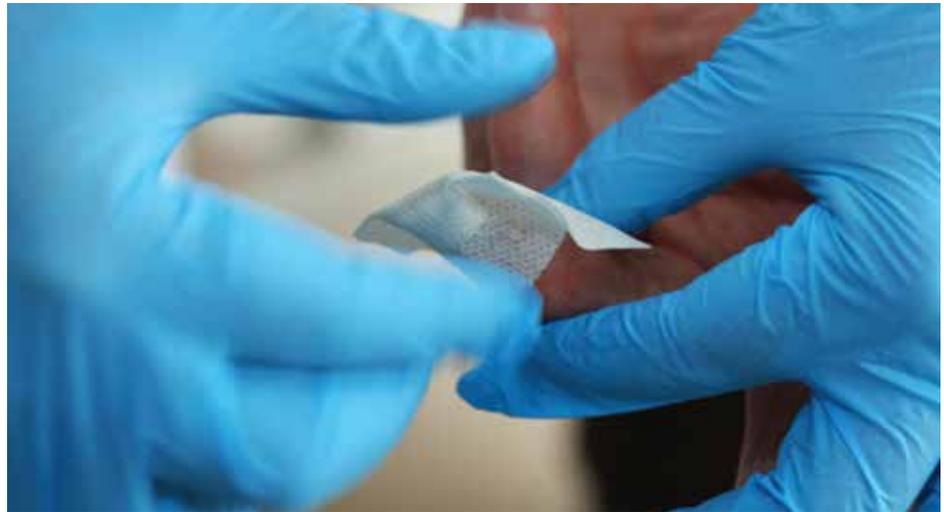
Alarm hazards were also at the top of the ECRI Institute's Top 10 List of Technology Hazards in 2014.<sup>12</sup> In recognition of the problem, the Joint Commission made alarm system safety a National Patient Safety Goal in 2014, requiring hospitals to improve their systems. To reduce the risk of patient harm from alarm fatigue, The Joint Commission, along with the Association for the Advancement of Medical Instrumentation and the ECRI Institute offer the following recommendations:<sup>13</sup>

- Ensure that there is a process for safe alarm management and response in high-risk areas.
- Prepare an inventory of alarm-equipped medical devices used in high-risk areas and for high-risk clinical condition, and identify the default alarm settings and the limits appropriate for each care area.
- Establish guidelines for alarm settings; including identification of situations when alarm signals are not clinically necessary.
- Establish guidelines for tailoring alarm settings and limits for individual patients. The guidelines should address situations when limits can be modified to minimize alarm signals. Check and maintain alarm-equipped devices to provide for accurate and appropriate alarm settings, proper operation and detectability.

## 10. Obesity Epidemic

Obesity is one of the country's most serious health problems. Adults with a body mass index (BMI) of 30 or higher are considered obese and in the United States, more than one-third of adults, and about 1 in 5 children, are considered obese.<sup>14</sup> With the increase in obesity in the overall population, there has been a noticeable increase in the number of bariatric admissions to healthcare facilities and ambulatory care facilities as well. This trend presents a challenge to healthcare organizations and providers striving to deliver dignified care that is effective and safe both for the patient and the providers.

Obese patients often require specific attention, and healthcare professionals should be sure that they have the appropriate equipment to accommodate this high-risk population. To provide for the safety and dignity of obese patients,



hospitals should investigate specialized exam tables, wheelchairs, toilets, blood pressure cuffs, hospital gowns and scales. A lack of appropriate equipment or failure to treat obese patients with respect and dignity could lead to liability claims.

The safety of medical professionals working with obese patients is another concern. Lifting, handling and transferring obese patients has always been a challenge for healthcare professionals and healthcare professionals may be injured when trying to care for or move an obese patient, leading to workers compensation claims, lost time claims, increased staff turnover and new employee training costs. Hospital staff, meanwhile, may require enhanced training or additional assistance in order to prevent injuring themselves and to ensure appropriate care, transport and patient satisfaction. Today's healthcare leaders should recognize the challenges of caring for obese patients, and develop policies to address the issue. They also should ensure that they have appropriate equipment to meet the needs of these patients, and should educate staff so as to promote patient and staff safety.

The American Society for Healthcare Risk Management recommends healthcare organizations:<sup>15</sup>

- Establish a multidisciplinary committee responsible for analyzing and responding to obese-related care issues.
- Ensure that patient care is preceded by a frank discussion of all known and possible complications associated with obesity and is documented in the patient's medical record.
- Assess facility layout and design accommodations for patients who are obese.
- Assess staff training and education in areas such as patient handling and transport, special care needs and staff sensitivity.
- Evaluate supplies including: beds; exam tables; wheel chairs; gowns; blankets; ID bracelets; blood pressure cuffs; compression stockings; needles and catheters; chairs in waiting rooms; patient lifts; bariatric commodes; scales; stretchers; and tracheal tubes.
- Adopt a zero-tolerance policy toward discriminatory attitudes and behaviors that are directed at obese patients and which specify disciplinary measures for non-compliance.

## **11. Healthcare-Associated Infections**

---

Healthcare-acquired infections (HAIs) cost the U.S. healthcare system billions of dollars each year and lead to the loss of tens of thousands of lives.<sup>16</sup> At any given time, about 1 in 25 hospital patients has at least one such infection, according to the Centers for Disease Control and Prevention. These infections can have severe consequences for patients. In 2011, there were an estimated 722,000 HAIs in U.S. acute care hospitals, and about 75,000 hospital patients with HAIs died during their hospitalizations.<sup>17</sup>

Healthcare-acquired infections also come with a financial price, costing \$9.8 billion a year, according to research published in 2013 in *JAMA Internal Medicine*.<sup>18</sup> The U.S. Department of Health and Human Services, which has made the reduction of these infections one of its top priorities, has put the added financial burden due to HAIs at \$28 billion to \$33 billion a year.<sup>19</sup>

Reducing the risk of HAIs is one of The Joint Commission's National Patient Safety Goals and the goal specifically requires adherence to hand hygiene practices and considers death or serious disability due to an HAI to be a sentinel event.<sup>20</sup>

Hospitals now face reductions in reimbursements associated with such infections. Since 2008, hospitals have not been reimbursed by Medicare and Medicaid for the cost of care associated with certain HAIs.<sup>21</sup> In addition, Medicare has been docking hospitals since 2012 for excess readmissions.<sup>22</sup> While readmissions can take place for a number of reasons, healthcare-acquired infections are a frequent cause. In October 2014, the third year of the Hospital Readmissions Reductions Program, Medicare increased the maximum penalty for hospitals and expanded the number of conditions the

government evaluates.<sup>23</sup> Hospitals can lose as much as three percent of their Medicare payments under the program.<sup>24, 25</sup>

In 2013, nearly 18 percent of Medicare patients who had been hospitalized were readmitted within a month for additional treatment. While that is lower than in past years, roughly 2 million patients return a year, costing Medicare \$26 billion. Officials estimate that \$17 billion of that comes from potentially avoidable readmissions.<sup>26</sup>

Healthcare organizations should ensure all sanitation systems are up to date and operational and that staff know how to properly use the systems to keep patients safe.

They also should continue to remind staff and visitors about basic infection control techniques. Medical personnel should take extra care to wash their hands with antiseptic soap and water before treating patients. A new study shows only 13 percent of emergency medical providers reported cleaning their hands before patient contact.<sup>27</sup> Simple steps such as installing alcohol-based hand sanitizers also can help to reduce infection rates.

### **A Comprehensive Risk Management Program**

---

As hospitals and healthcare organizations adapt to the changing regulatory, technological and demographic trends, these critical issues will demand attention in the coming months and years. Some of these issues may already be making headlines in some communities, but sooner or later they will affect nearly all hospitals, from busy big city institutions to those in small towns.

Hospitals and healthcare organizations should begin to take action now by making sure they are familiar with each of these issues and that they have a comprehensive risk management program in place to address them. Hospital risk management teams should report directly to the chief executives and hospital boards and should have the authority to take action to manage the hospital's risks and develop solutions.

As part of this effort, hospitals should work with an insurer that understands the risks facing the healthcare sector and that can offer solutions to help mitigate those risks. In addition to loss control, insurance is a critical element in any risk management program. Hospitals and healthcare organizations should have comprehensive coverage including property and general liability, environmental and cyber coverages. When selecting an insurer, hospitals should consider the breadth of the carrier's underwriting experience, years of experience, product offerings and dedication to the healthcare sector.

The healthcare industry is changing rapidly, and hospitals are coming under intense pressure to meet existing and emerging challenges and still provide quality care. With a comprehensive risk management strategy and appropriate insurance coverages, healthcare organizations can better fulfill their primary mission and deliver the best care to their patients.

With a comprehensive risk management strategy and appropriate insurance coverages, healthcare organizations can better fulfill their primary mission and deliver the best care to their patients.

#### About the Authors:

---

**Diane Doherty, M.S., CPHRM** is Vice President, USA operations at Chubb Medical Risk based in New York City. Ms. Doherty is responsible for providing a broad range of risk consulting services to clients that are designed and customized to help meet the evolving healthcare industry challenges and proactively address unique risk management needs. Ms. Doherty has more than 25 years of healthcare risk management experience. Her areas of specialization include clinical risk management, hospital administration, quality management, patient safety, claims management, and patient relations. Ms. Doherty is an active member of ASHRM and several regional ASHRM chapters, including GHSHRM, SCAHRM, GASHRM, and CASHRM. She received and maintains her CPHRM designation since December 2001.

**Renee Carino** is Vice President and Chief Underwriting Officer of Chubb's Medical Risk division. Based in New York, Ms. Carino is responsible for overseeing Chubb Medical Risk's underwriting operations including the development of Medical Risk and Life Sciences products and underwriting strategy and training. Ms. Carino has over 16 years of insurance industry experience including 10 years in healthcare professional liability insurance. Her diverse insurance background includes roles in claims, legal and underwriting. She has been with Chubb for over 12 years.

#### Endnotes:

---

1. "Nonfatal Occupational Injuries and Illnesses Requiring Days Away from Work, 2012," Bureau of Labor Statistics, U.S. Department of Labor, Nov. 26, 2013. See: <http://www.bls.gov/news.release/pdf/osh2.pdf>
2. "Preventing Violence in the Health Care Setting," The Joint Commission, June 3, 2010. See: [http://www.jointcommission.org/assets/1/18/SEA\\_45.PDF](http://www.jointcommission.org/assets/1/18/SEA_45.PDF)
3. "Merritt Hawkins 2014 Review of Physician and Advanced Practitioner Recruiting Incentives," Merritt Hawkins, June 30, 2014. See: [http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Surveys/2014\\_Merritt\\_Hawkins\\_Physician\\_Recruiting\\_Report\\_Infographic.pdf](http://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Surveys/2014_Merritt_Hawkins_Physician_Recruiting_Report_Infographic.pdf)
4. "Revisiting Disruptive and Inappropriate Behavior: Five Years after Standards Introduced," JC Physician Blog, Oct. 2, 2013. See: [http://www.jointcommission.org/jc\\_physician\\_blog/revisiting\\_disruptive\\_and\\_inappropriate\\_behavior/](http://www.jointcommission.org/jc_physician_blog/revisiting_disruptive_and_inappropriate_behavior/)
5. "Behaviors that undermine a culture of safety," The Joint Commission, July 9, 2008. See: [http://www.jointcommission.org/assets/1/18/SEA\\_40.PDF](http://www.jointcommission.org/assets/1/18/SEA_40.PDF)
6. "Telemedicine Frequently Asked Questions," American Telemedicine Association. See: <http://www.americantelemed.org/about-telemedicine/faqs#.U8Rb117Xn8t>
7. "Fourth Annual Benchmark Study on Patient Privacy & Data Security," Ponemon Institute, March 2014.
8. "Your Medical Record is Worth More to Hackers than Your Credit Card," Reuters, Sept. 24, 2014. See: <http://www.reuters.com/article/2014/09/24/us-cybersecurity-hospitals-idUSKCN0HJ21I20140924>
9. "Fourth Annual Benchmark Study."
10. "Medical Device Alarm Safety in Hospitals," The Joint Commission Sentinel Event Alert, The Joint Commission, April 8, 2013. See: [http://www.jointcommission.org/assets/1/18/SEA\\_50\\_alarms\\_4\\_5\\_13\\_FINAL1.PDF](http://www.jointcommission.org/assets/1/18/SEA_50_alarms_4_5_13_FINAL1.PDF)
11. "Alarm fatigue' a top-of-mind concern for U.S. hospitals, finds national survey presented at Society for Technology in Anesthesia Annual Meeting," The Physician-Patient Alliance for Health & Safety, Jan. 22, 2014. See: <http://www.prnewswire.com/news-releases/alarm-fatigue-a-top-of-mind-concern-for-us-hospitals-findsnational-survey-presented-at-society-for-technology-in-anesthesia-annual-meeting-241468331.html>

## Endnotes: (continued)

---

12. "ECRI Institute Releases Top 10 Health Technology Hazards Report for 2014," ECRI Institute, Nov. 4, 2013. See: <http://www.prnewswire.com/news-releases/ecri-institute-releases-top-10-health-technology-hazardsreport-for-2014-230500731.html>
13. "Medical Device Alarm Safety in Hospitals," The Joint Commission Sentinel Event Alert.
14. "Adult Obesity Facts," Centers for Disease Control and Prevention. See: <http://www.cdc.gov/obesity/data/adult.html>
15. "ASHRM Webinar: Patient Safety and the Obesity Epidemic. How to Tackle the Risks of an Expanded Patient Population," American Society for Healthcare Risk Management, March 13, 2014.
16. "Health Care-Associated Infections (HAIs)," Office of Disease Prevention and Health Promotion. See: [http://www.health.gov/hai/prevent\\_hai.asp#hai](http://www.health.gov/hai/prevent_hai.asp#hai)
17. "Healthcare-Associated Infections (HAIs)," Office of Disease Control and Prevention. See: <http://www.cdc.gov/HAI/surveillance/index.html>
18. "Hospital-Acquired Infections Rack up \$9.8B a Year," FierceHealthcare, Sept. 3, 2013. See: <http://www.fiercehealthcare.com/story/hospital-acquired-infections-rack-98b-each-year/2013-09-03> See also: <http://archinte.jamanetwork.com/article.aspx?articleid=1733452>
19. "AHRQ's Efforts to Prevent and Reduce Health Care-Associated Infections," Agency for Healthcare Research and Quality. See: <http://www.ahrq.gov/research/findings/factsheets/errors-safety/haiflyer/index.html>
20. "Health Care-Associated Infections," Agency for Healthcare Research and Quality. See: <http://psnet.ahrq.gov/primer.aspx?primerID=7>
21. Ibid.
22. "Hospital Readmissions Reduction Program," medicare.gov. See: <http://www.medicare.gov/hospitalcompare/readmission-reduction-program.html?AspxAutoDetectCookieSupport=1>
23. "A Guide to Medicare's Readmissions Penalties and Data," Kaiser Health News, Oct. 2, 2014. See: [http://www.kaiserhealthnews.org/Stories/2014/October/02/A-Guide-To-Medicare-Readmissions-Penalties-And-Data.aspx?utm\\_source=khn&utm\\_medium=internal&utm\\_campaign=related-content](http://www.kaiserhealthnews.org/Stories/2014/October/02/A-Guide-To-Medicare-Readmissions-Penalties-And-Data.aspx?utm_source=khn&utm_medium=internal&utm_campaign=related-content)
24. Ibid.
25. "Medicare Fines 2,610 Hospitals in the Third Round of Readmission Penalties," Kaiser Health News, Oct. 2, 2014. See: [http://www.kaiserhealthnews.org/Stories/2014/October/02/Medicare-readmissions-penalties-2015.aspx?utm\\_source=khn&utm\\_medium=internal&utm\\_campaign=viewed](http://www.kaiserhealthnews.org/Stories/2014/October/02/Medicare-readmissions-penalties-2015.aspx?utm_source=khn&utm_medium=internal&utm_campaign=viewed)
26. Ibid.
27. "Hand-washing rates low among emergency medical personnel, study finds," CBS News, Nov. 13, 2013. See: <http://www.cbsnews.com/news/hand-washing-rates-low-among-emergency-medical-personnel/>



## Contact Us

---

Chubb  
436 Walnut Street  
Philadelphia, PA 19106  
O +215.640.1000  
www.chubb.com

Diane Doherty  
*Senior Vice President*  
Chubb Healthcare  
O +212.703.7120  
E diane.doherty@chubb.com

Renee Carino  
*Senior Vice President,  
Chief Underwriting Officer*  
Chubb Healthcare  
O +212.827.3823  
E renee.carino@chubb.com

## Chubb. Insured.<sup>SM</sup>

Chubb Group is one of the world's largest multiline property and casualty insurers. With operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients. Chubb Limited, the parent company of Chubb Group, is listed on the New York Stock Exchange (NYSE: Chubb) and is a component of the S&P 500 index. Additional information can be found at [www.chubbgroup.com](http://www.chubbgroup.com).

The opinions and the positions expressed in this paper are the author's own and not necessarily those of any Chubb company. Insurance is provided by Chubb American Insurance Company, Philadelphia, PA, or, in some jurisdictions, other insurance companies in Chubb Group. This publication is for educational purposes only. The suggestions and information are not intended to be professional or legal advice. The advice of a competent attorney or other professional should be sought prior to applying this information to a particular set of facts.

Copyright © 2018, Chubb Group. All rights reserved.