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Letter from the Chair
Want to Volunteer? Start Here.

Renee G. Wenger
JD, RPLU, CPHRM

Thanks to our authors for this issue, including Kathleen Barton, Charles Conklin, Sharon Harwood and David Murray. Also, thank you to our editors for this issue, including Kimberly Hathaway, Ann Marie Swindler and Joan Westlake. And, thank you to our Board liaison – Jennifer Groszek – and our staff liaison, Mary LaRusso. It is remarkable that people carrying so much responsibility still find the time to give back to their professional community. This issue would not be possible without all their efforts.

Speaking of which, ASHRM's call for 2015 volunteers just ended but there are still ways you can participate. Have you considered volunteering with ASHRM, but have been uncertain where to pitch in? There are a number of committees, task forces and work groups available, but allow me to suggest submitting an article to the Forum Newsletter, especially if you're new to ASHRM.

The newsletter feature articles are approximately 1,200 words. Each issue typically includes at least three articles, a book or webinar review, ASHRM updates, a letter from the chair and a member profile. Forum Newsletter Task Force members also, write articles, and solicit articles from others and edit articles that have been submitted. Meetings for the Forum Newsletter, held via monthly conference calls, involve brainstorming ideas for articles, sharing names of potential authors, confirming assignments and assisting with deadlines. Oh, and getting to know each other!

ASHRM provides remarkable support to its volunteers. There is a Volunteers Meeting at the Annual Conference – usually a breakfast. The volunteers' gathering is organized and led by ASHRM Board and staff members, providing a comfortable environment in which to meet leaders of the organization. In addition, ASHRM hosts a Committee and Task Force Chair Orientation in November, which provides another excellent introduction to the leadership and structure of the organization, as well a detailed report on its strategic plan. ASHRM supports its volunteers so you are never without someone to answer questions or assist with logistics. After many years of volunteer experience, I admire the organized, thoughtful way ASHRM incorporates volunteers into its structure and makes them feel welcome and valued.

Please consider contributing to the Forum Newsletter or participating in ASHRM's many other opportunities to get involved.

Sincerely,

Renee G. Wenger JD, RPLU, CPHRM

inside

ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT
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Behavioral Health
Patient and Environmental Safety Measures In a Behavioral Health Hospital

By Kathleen Barton, RN, MS

Patient safety is a priority at all hospitals. However, there are some unique environmental and patient safety concerns and challenges in a behavioral health hospital. Reduction of risk in the environment and to patients in such a setting can be enhanced by conducting a risk assessment of every area of the hospital beginning with the lobby. The traditional or standard lobby restroom can pose a risk to some people, particularly those coming to your facility to have a behavioral health assessment and evaluation and who may use the restroom before checking in with the receptionist. If the restroom is not modified to reduce the possibility of self-harm, people may have the means to cause serious injury and may make a suicide attempt in the facility.

Begin by assessing the lobby restroom for the presence of ligature points. A ligature point is anything to which a person could tie something around and attempt suicide by strangulation or hanging. Standard faucets, fixtures and plumbing provide ligature points. By changing the faucets and fixtures, and by enclosing the plumbing, you reduce this risk.

Enhance Safety

Keep in mind that the enhanced environmental safety features which are installed at a facility do not ensure suicide prevention and should be thought of as suicide deterrence, not suicide prevention. Nothing can replace the vigilant monitoring of patients who are actively suicidal and who may require 1:1 monitoring by staff.

Moving on from the hospital lobby restroom, assess the physical environment of the cafeteria to ensure patients are safe when getting their meals as well as eating. Be mindful of the utensils you provide. This includes serving utensils at self-serve areas such as the salad bar or soup station. Most hospitals provide plastic utensils for visitors and patients, although metal serving utensils may be placed at serving stations throughout the cafeteria. If patients are not vigilantly monitored at all times while in the cafeteria, they could take the metal tongs from the salad bar or the metal soup ladle and hide it in clothing with the intent to use the item to harm themselves or even another patient or staff member back on the inpatient unit. Closely monitor patients at all times, wherever they are.

Perhaps, most importantly, you must ensure that the physical environment where patients spend most of their time is safe – that is, the inpatient unit and patient room. Standard patient room door handles or knobs provide ligature points. Installation of the type of door handle [shown in Photo No.1] on the entry door to patient rooms lessens the risk of the door handle becoming a ligature point if a patient ties clothing or linen around the door handle with the intent to self-harm. Consider the practice of keeping patient room doors open whenever patients are in their rooms so that they can be monitored visually, thereby reducing the risk of self-harm behind closed doors. Ensure that door handles to rooms remain unlocked when doors are open so that a patient cannot shut and lock the door when in the room, which could delay emergency staff intervention, if needed.

Photo No. 1

Photo No. 2

Rooms not in use – such as unoccupied patient rooms, group rooms, consult rooms, etc. – should remain locked to prevent a patient from going into a room unmonitored. The installation of a special sink faucet in patient bathrooms [Photo No. 2] is another option to enhance environmental safety.

Photo No. 3

Replace Faucets

Again, keep in mind that any modification to the environment does not ensure that patients can not harm themselves or that a suicide could not occur; it can only act as a deterrent. The same safety principle applies to replacing a standard shower faucet with a faucet as shown in Photo No. 3. Doors to patient bathrooms either can be modified as in Photo No. 4

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Photo No. 4

Photo No. 5

or replaced with a soft magnetic door, as shown in Photo No. 5. Consider your patient population when choosing whether to modify a solid door by trimming the top and bottom half of the door or by installing a soft magnetic door. Both types of doors allow staff members to visually glance above and beneath the doors during patient safety and room check, as well as to communicate with patients to ensure their safety.

Before making the commitment to modify patient room door handles, patient room doors or fixtures in patient bathrooms, pilot the product at your hospital. Ask your patients for their feedback and contact other risk managers or safety managers at behavioral health hospitals to discuss effective environmental safety features implemented at their facilities.

Linden Oaks at Edward in Naperville, Illinois, piloted and installed the safety products shown in this article. Our patients were informed of the products being installed on their unit and were asked for their opinions. Patient feedback was positive and, although they acknowledged that privacy was decreased with the altered doors, the patients understood that the new door concepts could increase their safety.

For those hospitals with outdoor space, gardens and courtyards used by patients, consider conducting a risk assessment of these areas to identify safety risks – one risk being the possibility of a patient elopement. Educate staff to check these outdoor areas for items such as plastic grocery bags that the wind may have blown into the courtyard, tree branches, sharp objects, etc. If there is a gym on-site, ensure that all equipment used by patients is in good working order and that the basketball net and volleyball net are intact, replacing the net if it is ripped.

Search for Contraband

In addition to the physical environment, contraband brought into the facility also poses a safety risk to patients, visitors and staff. At all behavioral health hospitals, the search for contraband is an ongoing process. Patients are screened for contraband when they are admitted and staff must diligently monitor patients and the environment for the presence of contraband. Tracking when contraband is found may be helpful to determine how it is getting on the unit. Finding contraband at the time of admission is not unusual, as some patients bring items with them because they do not know that it is considered contraband in a behavioral health hospital. Finding contraband within 48 hours or 27 hours post-admission should be tracked to determine how the contraband is getting onto the inpatient unit and into a patient's possession. It is important to conduct unit and patient room checks regularly, particularly after visiting hours. Some visitors knowingly bring in contraband items to the patient, such as alcohol or non-prescribed medication to patients admitted for chemical detoxification. Female patients may hide pills or other small items in individually wrapped sanitary pads. If curtains are in use at your facility, a patient may hide small items (pills or pins, for example) in the hem of the curtain. An option is to replace the window curtains in patient rooms with enclosed, tamper-proof blinds. Review and update your contraband list regularly as patients will continue to find more and more creative ways to hide it.

Linden Oaks' implementation of our Safety Ambassador program has enhanced patient and environmental safety. Our Safety Ambassadors participate in the yearly Patient Safety Week and conduct ongoing education and training for peers. Unusual Occurrences are reviewed, and Good Catches are flagged and reviewed. A staff member is selected to receive the quarterly Good Catch award; two other staff members receive an honorable mention for their Good Catch. Our staff's commitment to a culture of safety and staff recognition has increased the number of Unusual Occurrences being reported. Anecdotal information about safety concerns and Good Catches are shared with staff at the new employee orientation. Administration and staff work together to immediately respond and address safety concerns and to make necessary changes or modifications to the environment, policy, process, or procedure to eliminate the risk of harm to our patients, staff and visitors.

Informed Consent
Resident Simulation Training for Consent and Disclosure

By Amy J. Goldberg, MD and Charles B. Conklin

Imagine this, you are a first-year surgical resident at a large academic teaching hospital, you have been in the program for 35 days and your senior resident turns to you and says, "Go consent Mr. Jones for placement of a central line for the ionotrope infusion."

At Temple University Hospital, while we know that scenario is very possible, it is not a situation that any first-year resident would feel completely comfortable executing. To that end, the residency program director for General Surgery, Dr. Amy Goldberg, and the Director of Risk Management Charles Conklin have developed and implemented a simulation-based training scenario using standardized patients for Informed Consent and Disclosure.

The Society for Simulation in Healthcare defines simulation as: "Simulation is the imitation or representation of one act or system by another. Healthcare simulations can be said to have four main purposes – education, assessment, research, and health system integration in facilitating patient safety."[1]

At TUH, we believe that education and assessment are the building blocks for our simulation programs. Simulation education is a bridge between classroom learning and real-life clinical experience.[2]

The Consent and Disclosure simulation program at TUH is designed as follows.

Prerequisites
All incoming, first year-residents are required to complete two online courses about Consent and Disclosure. Following completion, the residents attend new resident orientation where they participate in a presentation on consent and the laws and regulations that govern the consent process, including the state, federal and regulatory requirements. The orientation also includes a case example involving consent.

Approximately one month later, as they continue to adjust to their new roles as first-year residents, they receive a didactic presentation regarding the purpose of consenting patients; what constitutes a sound and acceptable disclosure; the do's and don'ts of both and a discussion to help guide them through these processes during their residency.

Two to four months following these educational sessions, the residents are asked to attend their regularly scheduled Surgical Skills lab which is held in the William Maul Measey Clinical Simulation Center at Temple Medical School. In addition to consent and disclosure, the TUH Surgical Skills curriculum also includes suturing, placement of central lines, open and laparoscopic skills and other surgical techniques.

Simulation Training Sessions
We train three residents per session, one resident at a time. Each session takes approximately 45 to 60 minutes. Standardized patients are used in the simulation and observation evaluations are conducting by faculty attending physicians and risk management personnel. Evaluation forms are scored for each of the two sessions during the exercise, (consent and disclosure of complication). The evaluation forms for the consent session have 21 criteria by which the resident is evaluated, with a rating of Not Done, Partially Done or Well Done, [see Table A]. The evaluation form for the disclosure and consenting for an additional procedure have 14 criteria with the same rating scale of Not Done, Partially Done or Well Done, [see Table B].

Consent and Disclosure sessions
The resident is given a script describing a current patient situation. The script is as follows: Mr. Edward Gratham is a 55-year-old male who recently had surgery to remove kidney stones. Sepsis has developed and a central venous line (CVL) is required to administer treatment. Please obtain written informed consent for the procedure

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continued from page 4

and leave the room when you have completed this session.

The resident enters the patient's room and is evaluated from the observation booth in the simulation lab during the consent process for placement of the central line. Once the resident completes that task and exits the patient's room, the resident is given a second script describing the next scenario: *X-ray reveals Mr. Gratham has a collapsed lung following insertion of the CVL and the patient now needs a chest tube. Please disclose to the patient what has occurred and now obtain written informed consent for a chest tube insertion necessary to address the pneumothorax. You may leave the room when this has been completed.*

The resident then re-enters the patient's room and is again evaluated from the observation booth during the disclosure and the new consenting process for placement of a chest tube.

Once the residents have completed their second session with the standardized patient, the simulation part of the exercise is complete.

The next and final step in the Consent and Disclosure simulation exercise is the debriefing session.

Debriefing

The debriefing session consists of the evaluators, the resident and the standardized patient meeting in the patient's room to discuss the entirety of the process.

"The debriefing with good judgment approach is designed to increase the chances that the trainee hears and processes what the instructor is saying without being defensive or trying to guess the instructor's critical judgment."[3] This last phase of the simulation has proven to be the most rewarding for both the trainees and the instructors. The session begins with the standardized patient offering feedback to the resident regarding their comfort and understanding of the process. Then, the faculty member and the risk manager debrief using the criteria evaluation checklist. Finally, residents are given the opportunity to share with the others how the experience was for them. What was their comfort level? Was the simulation real enough for them? This debriefing session is the real teachable moment for our surgical residents.

Summary

We are convinced to a high level of certainty that this exercise is preparing our resident staff for the consenting and disclosing process far more than had previously been taught. To help clarify that certainty, this year we decided to test the residents prior to any education and simulation, and they will be tested after all the previously mentioned training activities.

We have been doing this simulation training for two years and every resident who has participated has responded very positively. They are very thankful for the experience. The critique and feedback have been very positive with 100 percent expressing that they felt it is a worthwhile exercise.

"Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences, often immersive in nature, that evoke or replicate substantial aspects of the real world in a fully interactive fashion."[4] We believe this simulation does just that, "replicates aspects of the real world" as close as possible. *About the Authors: Amy J. Goldberg, MD is the Director for Trauma Services and the Residency Program and Charles B. Conklin, BS, MBA, is the director of Risk Management at Temple University Hospital*

References

1. *The Society for Clinical Simulation in Healthcare 2014* (SSH), Web application
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3. Rudolph JW, Simon R, Rivard P, Dufresne R & Raemer D. *"Debriefing with Good Judgment: Combining rigorous Feedback with Genuine Inquiry". Anesthesiology Clinics.* 2007; 25: 361-37
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Table A

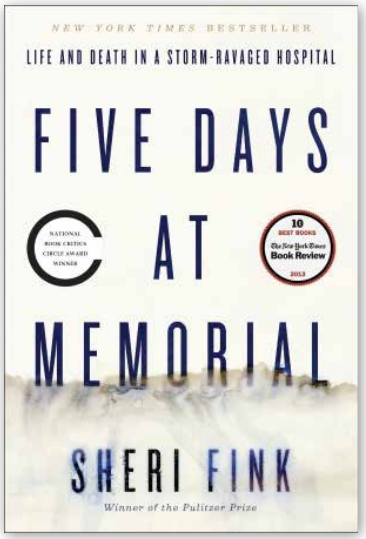
Required Actions in the Initial Consent Session				
		Not Done	**Partially Done**	**Well Done**
1	Explained the procedure to be performed	o	o	o
2	Discussion with patient on laterality for procedure	o	o	o
3	Discussed risks associated with performing this procedure	o	o	o
4	Discussed the benefits of having the procedure	o	o	o
5	Discussed alternative courses of treatment and the risk and consequences of these alternatives	o	o	o
6	Discussed the risks of no treatment being rendered	o	o	o
7	Discussed the potential need for the use of blood or blood products during the procedure	o	o	o
8	Notes on consent form laterality for procedure	o	o	o
9	Had the patient sign, date and time the consent	o	o	o
10	Physician signed, dated and timed the consent	o	o	o
		Not Done	**Partially Done**	**Well Done**
11	Prepared patient to receive the news.	o Entered room in a manner unfitting the news AND physically situated self far away	o Entered room in a manner unfitting the news OR physically situated self far from patient/ family	o Entered the room in a manner befitting the news AND physically situated self at a suitably close distance.
12	Allowed patient to talk without interrupting.	o Interrupted	o Did not interrupt directly BUT cut responses short by not giving enough time.	o Did not interrupt AND allowed time to express thoughts fully.
13	Communicated intention to help	o Did not communicate intention to help via words or actions	o Words OR actions conveyed intention to help	o Actions AND words intention to help
14	Acknowledged patient's emotions/ feelings appropriately	o Did not acknowledge emotions/ feelings	o Acknowledged emotions/ feelings	o Acknowledged and explicitly responded to emotions/feelings in a way to make pt. feel better.
15	Was accepting/non-judgmental	o Made judgmental comments OR facial expressions	o Did not express judgment but did not demonstrate respect	o Made comments and expressions (need not be explicit) that demonstrated respect.
		o	o	o
16	Used words patient could understand and/or explained jargon	Consistently used jargon WITHOUT further explanation	Sometimes used jargon AND did not explain without request from patient	Explain jargon when used without needing request from patient OR avoided jargon entirely
17	Gave patient opportunity to respond: -remaining sensitive to patient's venting -attended to pt's emotions before moving on	o Responded inappropriately to pt's emotional reaction (e.g. no opportunity to vent, cut pt off, became defensive)	o Allowed pt to emotionally respond (vent) BUT did not address /acknowledge response before moving on	o Allowed pt. to express feelings before moving on AND Asked patient if they have any questions.
18	Provided clear explanations/ information	o Gave confusing OR no explanations, making it impossible to understand information	o Information was somewhat clear BUT still led to some difficulty in understanding	o Provided small bits of information at a time AND summarized to ensure understanding.
19	Displayed sincerity towards patient.	o Did not appear sincere in statements and manner.	o Appeared somewhat sincere in statements and manner.	o Appeared completely sincere in statements and manner
20	Collaborated with patient in identifying next steps/plan	o Did not tell patient of next steps/plan.	o Told patient next steps/plan	o Told patient next steps THEN asked patient's views.
21	Maintained professional manner by controlling emotions	o Unable to control emotions; became dismissive, defensive and/ or condescending	o Attempted to control emotions (e.g. only somewhat dismissive, defensive, or condescending)	o Maintained high level of professional manner; no defensiveness, anger, frustration

Table B

Required actions in Disclosing Medical Error				
		Not Done	**Partially Done**	**Well Done**
1	Disclosed error - direct(used the words "error" or "mistake") -prompt disclosure	o Did not directly disclose the error NOR was the explanation upfront	o Did not directly the error OR directly disclosed late in the interview	o Directly disclosed the error upfront.
2	Personally apologized for the error (e.g.: "I am sorry that this happened.")	o Did not apologize for the error	o (not applicable)	o Apologized for the error.
3	Took personal responsibility for the situation	o Took no personal responsibility (e.g. assigned blame to others)	o Took general responsibility as part of organization	o Explicitly stated personal responsibility
4	Assured patient/ family of steps to prevent future such occurrence	o Did not address prevention of future occurrences	o Noted general steps to be taken regarding prevention	o Noted specific steps to be taken regarding prevention
Required actions in obtaining Informed Consent (for Chest Tube insertion)				
		Not Done	**Partially Done**	**Well Done**
5	Explained the procedure to be performed	o	o	o
6	Discussion with patient on laterality for procedure			
7	Discussed risks associated with performing this procedure	o	o	o
8	Discussed the benefits of having the procedure	o	o	o
9	Discussed alternative courses of treatment and the risk and consequences of these alternatives	o	o	o
10	Discussed the risks of no treatment being rendered	o	o	o
11	Discussed the potential need for the use of blood or blood products during the procedure	o	o	o
12	Notes on consent form laterality for procedure	o	o	o
13	Had the patient sign, date and time the consent	o	o	o
14	Physician signed, dated and timed the consent	o	o	o

Book Review
Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital

By Sharon Harwood



What would you do? Can anyone stand in the shoes of and judge those making decisions during disasters when resources and assistance are lost? Expanding on her Pulitzer Prize-winning article, "The Deadly Choices at Memorial," Dr. Sheri Fink wrote the book Five Days at Memorial, recounting the events at Memorial Hospital in New Orleans during the ordeal of Hurricane Katrina and the legal battles that followed. In the book, Dr. Fink examines the public investigation of the treatment choices and alleged euthanasia of patients during the catastrophe and how the event impacted the lives of three healthcare providers. The outcomes described by Fink have greatly impacted the current and still evolving guidelines for triage and treatment of patients in disaster situations.

The book begins with a description of the structural and utility limitations facing Memorial hospital, a 1926 facility built below sea level in New Orleans with a history of flooding. The author then takes us on a journey and introduces us to the many lives involved at Memorial during the five days when the facility was engulfed by the 2005 Katrina aftermath. It is a day-by-day account of events starting with day one - damage, followed by the hope of receding waters. Day two - news of levee breaches and ominous impending flooding and devastation. With a failed city power grid, diesel generators gave partial electricity. Corridors reeked as toilets overflowed and staff smashed windows to let in the air. Violence outside intruded as gunshots were heard and stabbing victims came in to be treated. By the fourth day, generators were not functioning and more than 50 intensive care patients lay in steaming darkness.

Interwoven in the day-by-day accounts, we are given lessons about the emerging hospital practices at the time surrounding ethics committees and ethical decision making, along with the focus of emergency preparedness systems post 9-11 on bioterrorism, not natural disaster.

Early in the medical decision-making process at Memorial, patients with "do not resuscitate" orders and the most critical were placed on lower priority for evacuation. Ultimately 45 patients died, some with high levels of levels of morphine and other drugs. Also, patients of LifeCare, an LTAC company leasing hospital space, were low priority for transfer.

Post Katrina, as bodies were discovered in healthcare facilities, the attorney general's office targeted Dr. Anna Pou, a cancer head and neck surgeon, and nurses Cheri Landry and Lori Budo, who ordered and administered fatal doses of medications, respectively. The New Orleans community and national medical and nursing organizations rallied around these three providers as heroes in extreme conditions. Ultimately, a grand jury failed to indict the three.

The author describes social, legal and ethical issues relevant to the events at Memorial Hospital including seminal legal cases on right-to-die and discontinue treatment; creation of public and medical work groups to develop standards in prioritizing organ donation candidate selection; and the development of emergency response patient triage systems throughout the country. In all of these advances, however, the human element of decision making remains. The details, personal accounts and social history conveyed in this book are outstanding.

Implications for Risk Managers: Even in the best designed emergency plans, drilling for full system failures are difficult. These accounts show the impact of just-in-time decision making, human response to desperation and isolation as well as how medical judgment is clouded by patient categorization. It is both cautionary and instructive for discussions and a valuable read for ethics committees, disaster planning committees and those in or outside of healthcare organizations involved in emergency management and triage design.

Member Profile
Hala Helm Career Grows With ASHRM by Her Side

By Renee Wenger

Hala Helm
JD, MBA, CPHRM, CHC, FACHE, FASHRM and ASHRM Board Member

ASHRM Board Member Hala Helm, JD, MBA, CPHRM, CHC, FACHE, FASHRM, is currently the Chief Risk Officer for the Palo Alto Medical Foundation and executive vice president of Capstone Insurance, LLC. She is responsible for the development and maintenance of the overall risk management program for PAMF and its affiliated medical groups. She says her first job in risk management came to her "by accident." Helm explains the company she was with in early 2000 was forming a captive insurance company and the director asked her to become involved.

"It sounded interesting and I was ready for a change," she says. "So, he hired me and I started as a project manager in risk management; I could not have known less about it. One of the very first things he [director] did for me was to get me involved in ASHRM at the national and chapter levels. It was absolutely so valuable. I could not have been as knowledgeable about RM as quickly without ASHRM. I bought the Risk Management handbook, attended all the conferences and seminars. As my experience level grew, I continued to find higher levels of expertise. I really like that in ASHRM, there does seem to be a place for everyone at every point in the trajectory of their careers. At times, when I was involved in roles that were strictly compliance without the risk management, I've never let my membership lapse, even if I had to pay for it myself."

She adds that as her career grew, ASHRM became a great forum for her to begin to give back by volunteering as faculty and speaker at national conferences and other educational venues. In 2014, she joined the ASHRM Board of Directors.

"Now, as a board member, ASHRM offers me the opportunity to take a place in the leadership and strategy of advancing our profession," Helm says. "It has been satisfying to have a place in ASHRM."

For the past three years, her career has expanded its path from primarily hospitals into working within an ambulatory setting for physicians. She says it has broadened her perspective and given her the insights of physician-led organizations where there is strong emphasis on the patient.

Now, as a board member, ASHRM offers me the opportunity to take a place in the leadership and strategy of advancing our profession.

"When I was in the hospital setting, I wish I would have been more involved with the physicians," she says. "I advise hospital risk managers to form partnerships, even informal, with the physicians and develop those relationships. I've found the physician organizations are more focused on the patient experience, more on the art of healthcare rather than focusing on the business."

On a personal note, Helm says she is celebrating 32 years of marriage to a wonderful husband. They have two sons, a grandchild and three rescue "mutts." An avid runner, Helms says people might be surprised to know she trained in swimming and cycling and finished a triathlon; she laughs that one was enough.

Population Health Management

Where Population Health Management and Risk Collide: Risk Propensity as a Critical Competency

By Jennifer Volland and Ryan Donohue

With the changes in United States health policy over the past few years, transitions of care and population health management have become areas of increased focus. Healthcare organizations are being held accountable with incentives and penalties tied to clinical and patient satisfaction outcomes. A component of population health is to avoid 30-day readmission rates for specific disease conditions and those identified to be most at-risk for incurring health claims. However, there are additional gains that will become realized from a financial, safety and quality of care perspective as part of the population health paradigm shift. Patient 30-day readmission rates are only one piece of the puzzle where a broader lens of the risk being mitigated should be taken when assessing the impact of population health.

There are mutual gains created between an organization and a patient that have yet to be fully recognized. Clinicians within the hospital environment save lives, stabilize acute conditions and provide intervention for necessary procedures. The symbiosis between a hospital and the community is indisputable. Alternately, the hospital environment can be a source of hospital-acquired infections, medication errors, patient falls and events related to ongoing patient care (Levinson, 2010). The likelihood of an adverse outcome increases as the duration a patient resides within the hospital setting becomes longer. The frequency and magnitude of these adverse events is nearly impossible to calculate since often staff lack the understanding of what needs to be reported (due to the incident being an expected outcome or adverse event; the outcome produced only minor harm; the event was not on the hospital's mandatory reporting list; or the incident was not caused by a perceptible error such as medications). A study in 2012 revealed that approximately 86 percent of patient mishaps fail to be entered into hospital incident-reporting databases; 62 percent was due to staff not considering it reportable (Levinson, 2012). Lesser lengths of stay create a decreased timeline for a preventable adverse event to occur.

Population health management success over the next decade will be contingent upon the ability of clinicians to effectively manage the health of an increasing elderly population. More than 10,000 Americans turn 65 each day. From a claims liability perspective, two-thirds of senior citizens have at least one chronic disease. Additionally, 20 percent of individuals over the age of 65 receive care from 14 or more physicians with an average of 40 physician visits per year (Punke, 2014). The challenge in this context becomes clinically serving the aging population while mitigating the need for accessing services. This is the intersection where population health and risk can collide. The perfect storm is when individuals shift from being consumers of wellness and preventative outreach to becoming patients. There is a risk management role at this juncture in directing care processes toward the prevention of hospital readmissions, proactively monitoring for events that can lead to hospital acquired infections (HAIs) and ensuring that patient education and activation is sufficient for self-care with each patient's departure. Without adequate identification of at-risk groups, patients can quickly become lost within the "healthcare maze" through an increased need for services in the ambulatory and acute care settings. Consumers often describe this journey as an endless path of fear and confusion with no clear end in sight (Donohue, 2013).

The Future of Population Health Management

Healthcare system costs in the United States for Alzheimer's and dementia are projected to reach $1.2 trillion by year 2050. There were approximately 15.4 million families and friends providing 17.5 billion hours of unpaid care valued at $216.4 billion for those with Alzheimer's disease in 2012. Examining the community impact, 80 percent of dementia care is provided by an unpaid caregiver (Alzheimer's Association, 2013). The need for clinicians to understand the risk propensity of populations rapidly becomes a requisite with the growing number of families who render eldercare.

Risk propensity is the likelihood for an event to occur—an individual to engage in a behavior, a claim for healthcare services to be incurred or a tendency for something to happen. Identification of subgroupings can focus a clinician on those who are most in need of potential health condition monitoring.

Health Risk Assessment of a Defined Population

Accountable Care Organizations (ACOs) are required to administer a health risk assessment (HRA) for cost control and healthcare claim expenditure avoidance, to provide a physical exam and cover specific blood testing (Mechanic 2010, Carroll & Edwards, 2013). This requirement went into effect with the Patient Protection and Affordable Care Act of 2010. Most relevant to risk management, the HRA must identify chronic

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diseases, injury risks, modifiable risk factors and the urgent health needs of an individual (Staley, Stang, & Richards, n.d.).

HRAs conducted by ACOs fall into one of four levels of maturation. The most basic level examines a population in aggregate without segmentation by demographic groupings. The second level provides clarity through the use of validated tools for understanding risk according to subgroupings such as chronic conditions. The third level shifts from the aggregate population to an individual unit of analysis for direct outreach. The fourth and highest level uses specific demographics to target individuals with a formalized wellness program and can produce a return on investment due to the granularity of information. Program outcomes can be tracked over time for both the population and a specific individual (Volland, 2014). Risk can also be identified by insurance payers prior to claims incurred, where healthcare organizations, clinicians and payers are engaging in partnering of population health initiatives and incentivized outcomes.

Risk Propensity in the New Population Health Frontier

The effectiveness of an individual's wellness plan and choice of service provider resides within the relationship between patient-physician and the ability of an individual to engage in healthy lifestyle behaviors. There is a risk whenever patients seek the emergency department in lieu of a primary clinician. Patients that utilize the ED are more inclined to be admitted (Morganti et al., 2013).

The PPACA Readmissions Reduction Program targets hospital readmission rates within the first 30 days after a patient's discharge to home for designated disease conditions. The disease conditions that became effective for penalties in 2013 are acute myocardial infarction, congestive heart failure and pneumonia. An additional expansion of conditions is being finalized by the Centers for Medicare and Medicaid Services to become effective in 2015, which would include acute exacerbation of chronic obstructive pulmonary disease and patients admitted for elective total hip/total knee arthroplasty (Centers for Medicare and Medicaid Services, 2014).

Individuals who go to the ED and are admitted to inpatient status tend to score an organization lower on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey questions (Sorenson, 2013). All individuals within an organization can impact how patients rate their experiences including food and nutrition services, patient relations and departments such as patient billing. All touch points become sources of influence and any adverse encounters, mislabeled specimens, redraws or breakdowns in process can affect patient ratings.

The ED is area of greater transparency with the advent of social media. Hospitals are placing their ED wait times on forums such as Twitter. It raises the question of where patients may go for care with the increased visibility. Will frail individuals seek services from a facility with slower ED service and treatment?

Starting in 2015, hospitals in the national top quartile of HAIs will see a 1 percent overall cut in Medicare payments with an anticipated average penalty of $208,643 (DHHS, 2009). Payment restrictions on specific HAIs under Medicaid policy began in 2012. The total costs of the top five HAIs have been estimated at $9.8 billion annually, which equates to per-case costs for: central line-associated bloodstream infections at $45,814; ventilator-associated pneumonia at $40,144; surgical site infections at $20,785; *Clostridium difficile* infection at $11,285; and catheter-associated urinary tract infections at $865 (Zimlichman, 2013). While some of these conditions are treated within the inpatient setting, there is a risk for readmission if the patient lacks adequate knowledge of symptoms and where to seek treatment.

Medical management is shifting from the hospital to an outpatient setting for both patient volumes and average lengths of stay. With this transition has come an increase in the frequency of HAIs (Burke, 2003; Stone, Larson, & Kawar, 2002). Hospitalization can be less than the incubation period of a microorganism (developing infection) where the symptoms occur post-discharge. It is estimated that between 12-84 percent of surgical site infections are detected post-discharge with most evident at 21 days after surgery (Collins, A., n.d). Additionally, patients with staphylococcus aureus, vancomycin-resistant enterococci, or *Clostridium difficile,* are 40 percent more likely to have a readmission (Emerson et al., 2012). Given the risk profile, these patients can benefit from additional discharge planning and patient education (O'Reilly, 2012). Coordination and monitoring may be an additional layer of protection by adopting processes that facilitate communication between providers as part of the patient discharge process.

Healthcare reform is focusing on population health and reimbursement models of maintaining wellness. At the crux of population health keeping individuals at the highest level of health possible and strategically balancing risk. Each encounter where health risk or claims can be mitigated benefits the overall population through lower costs and better outcomes. Understanding the risk propensity of populations provides insights for proactive management of individuals and aggregates. This intersection is the new core competency for healthcare leaders and clinicians to understand. Risk propensity has the ability to mitigate the perfect storm where population health and risk collide.

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NEA-BC certification; and recently appointed to the 2014 Board of Examiners for the Malcom Baldridge National Quality Award.

**Ryan Donahue is a thought leader in healthcare specializing in the effects of consumerism. Through his work with National Research Corporation, Ryan has partnered extensively with hospitals and health systems to build consumer-centric healthcare brands.*

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ASHRM Update

Enjoy these highlights of ASHRM's accomplishments in the second quarter of 2014 and take note of some valuable upcoming activities, benefits and events

Education for Success at ASHRM Academy 2014

ASHRM ACADEMY
May 5-8, 2014 • Oak Brook, IL

Nearly 200 education-eager individuals attended the second ASHRM Academy, May 5-8 at the Hyatt Lodge in Oak Brook, Illinois. The luxurious setting, complete with a rejuvenating spa, yoga and lap pool, was ideal for face-to-face learning sessions and rewarding networking. CPHRM Exam Prep Course and PSII were filled to capacity with Module 1: Essentials sold out weeks in advance. Stanford University Medical Network risk consultants presented the Partner Program: Emerging Issues in Risk Management, one of the hottest topics in healthcare today. Advanced topics, such as ACOs and the Emerging Risk Management Imperative plus Implementation Strategies for Communication and Resolution Programs, stimulated dialog. Watch for alerts about next spring's ASHRM Academy 2015.

Healthcare Risk Management Week

SHARING IN THE CARING
ASHRM
HRM WEEK
JUNE 16-20, 2014
E ▪ R ▪ M

HRM Week, held June 16 to 20, proved to be another great ASHRM annual campaign to raise awareness about the critical work of risk management and patient safety professionals. This year's theme – Sharing in the Caring Through Enterprise Risk Management – emphasizes that all healthcare workers play a vital role in patient safety. It's the Sharing in the Caring across the healthcare continuum that impacts patient safety and moves the needle closer to zero preventable serious safety events.

To enhance and encourage HRM Week celebrations, ASHRM developed a communications toolkit, interactive quiz, "Changing the Paradigm: Improving Patient Safety through Patient & Family-Centered Care" webinar on June 18, HRM Week gifts and more to help highlight the skills and contributions of HRM professionals. Also, ASHRM developed a range of scenarios that affect patients, caregivers and healthcare providers. The fliers provided quick tips and are ideal for sharing with co-workers and team members thought the year. Download the fliers and find out more at www.ashrum.org/hrmweek

Join the Journey in 2014 – Submit your "Why" Story Today!

Working in healthcare risk management isn't just a profession. It's a passion. To do what you do takes massive courage, enduring strength, and an inherent, unwavering compassion for patients and their safety.

Throughout 2014, ASHRM will be asking its members, "What's Your Why?" We want to know – in your words – WHY you do what you do every day and WHY you care so much. The compilation of your stories about learning, improving and implementing healthcare risk management best practices; about planning and perfecting strategies; and your memories of celebrating the wins and your lessons from the losses – it's in your Sharing in the Caring that will make us all better healthcare professionals and help improve patient safety.

Join the journey in 2014–Sharing in the Caring through Enterprise Risk Management. It's the next step to destination zero. For more information go to ashrm.org/whystory

SHARING IN THE CARING
ASHRM
ANNUAL CONFERENCE & EXHIBITION
October 26-29, 2014 ▪ Anaheim, CA
E ▪ R ▪ M

Registration Underway for the 2014 ASHRM Annual Conference & Exhibition!


Rich Umbdenstock


Magic Johnson

More than 2,000 engaged attendees will converge on Anaheim, California for ASHRM 2014, Oct. 26-29. As the leading HRM industry conference of the year, ASHRM 2014 continues its legacy of optimal learning, networking and career-building opportunities. ASHRM's 2014 theme, "Sharing in the Caring through Enterprise Risk Management" emphasizes the important role that all healthcare workers play in furthering patient safety.

This year kicks off with the Annual Business Meeting and Opening Keynote featuring American Hospital Association President and CEO Rich Umbdenstock. The conference closes with noted entrepreneur and NBA

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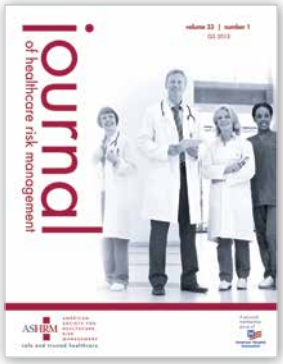
Hall of Famer Magic Johnson. With more than 70 educational sessions over six tracks, myriad events and professional development opportunities, ASHRM 2014 again promises to be an exceptional and rejuvenating experience. Find out more at www.ashrm.org.

2015 ASHRM Leaders Elected

Jacque Mitchell, 2014 ASHRM president, announces the results of the recent elections. Nearly 16 percent of members voted – an increase of more than 250 members from last year! Ann Gaffey is the 2015 President-Elect; Victor Klein and Barbara McCarthy were elected to three-year terms each to the Board of Directors; and Maureen Archambault, Monica Cooke and Kathy Shostek were elected as 2015 Nominating Committee members. The new officers will be sworn in on Wednesday, Oct. 29 during ASHRM's Annual Conference & Exhibition in Anaheim, California. Their terms begin Jan. 1, 2015. Ellen Grady Venditti serves as the 2015 president and Ann Gaffey as president in 2016.

May We Boast? Journal of Healthcare Risk Management Earns International Awards, Again!



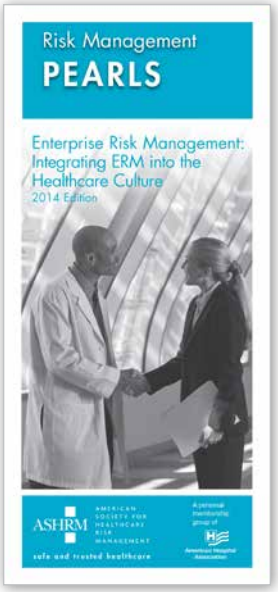
For the fourth year in a row, congratulations are due to the authors, contributors, and Editorial Review Board of ASHRM's Journal of Healthcare Risk Management, whose work has been recognized with another 2014 APEX Award for Publication Excellence in the category of Regular Departments & Columns. In addition, Volume 33, Issue 1 of the Journal also received an Award of Excellence in the print category of Magazines, Journals & Tabloids. That adds up to five Awards over the past four years. APEX 2014, the 26th Annual Awards for Publication Excellence, is an international competition that recognizes outstanding publications throughout the communication and publishing industry. If you'd like to contribute to this stellar publication, you'll find submission guidelines www.ashrm.org.

New Pearl! Integrating ERM into the Healthcare Culture

ASHRM's new Enterprise Risk Management Pearl for Integrating ERM into the Healthcare Culture illustrates how to incorporate ERM concepts and principles in decision-making processes at all levels so that ERM becomes an integral part of the organizational operating process. This ERM Pearl:

- Demonstrates how the risk manager can work to integrate ERM concepts into the culture of the healthcare organization
- Addresses how ERM can be linked with other key business functions, such as strategic planning, internal audit and capital budgeting.
- Incorporates on-going monitoring and refinement of the ERM process, making it a sustainable part of the organizational landscape.

Now available in the ASHRM Online Store. Purchase yours today!



New CPHRMs

Congratulations to these NEW CPHRM Recipients!

April
Karen Hinton
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Amy Dougherty
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