forum
news of the american society for healthcare risk management

Q2 • 2014

Letter from the Chair

This year I am proud and pleased to greet you as the Chair of ASHRM's eNewsletter Task Force. Although I have volunteered with our local chapter in Oregon for six years, this is my first experience volunteering with ASHRM, and I appreciate the opportunity. I also want to thank the excellent volunteers who make up the Task Force this year including Kathleen Barton, Mary Bollwage, Marie Burdett, Charles Conklin, Clara Rosalia Flora, Jennifer Groszek, Sharon Harwood, Kimberly Hathaway, Anne Huben-Kearney, Anne Justice, Sharon Moon, David Murray, Laura Norton, Josefina Ortiz, Victoria Pruitt, Ann Marie Swindler and Theresa Vander Vennet. Our Staff Liaison is Mary LaRusso.

In 2014, ASHRM is asking its members "What's Your Why?" We are being encouraged to share our stories about work and what makes it meaningful. I find that it is hard to write about because there is so much that we cannot share out of respect for people's privacy. The most meaningful and personal moments in our jobs are ones no one else will ever know about. It can make casual conversation lonely sometimes, but there is a sense of honor that comes with that integrity and that makes the work meaningful.

For another thing, it is so difficult to identify the wins and losses because every memory is a combination of both. We are the safety and improvement people. We are constantly challenging ourselves and everyone around us to do better. It can make the day exhausting, but there is a sense of commitment that comes with that focus on excellence and having commitment to one's work makes it meaningful.

Finally, in the end, I know that my stories are not just mine. There isn't a goal I've met or a good outcome I've created that did not involve at least a dozen other people I rely upon every day. The ones who take a moment from their impossible workload to give me their most precious possession – their time. The ones who reach out a hand when I've gone off track. The ones who find it in their hearts to forgive and move on.

Why do I care so much? Because they do. Because every single person I work with shows up every day with one thought – what can I do to help?

My "whys" – are honor, commitment, community. I feel very, very lucky to have this job and to work with the people I work with daily. Just the experience of writing and thinking about work and what it means has been a good reminder that I'm in the right spot for the right reasons. I wish the same for you.

Sincerely,

Renee G. Wenger JD, RPLU, CPHRM

inside

ASHRM AMERICAN SOCIETY FOR HEALTHCARE RISK MANAGEMENT
safe and trusted healthcare

American Hospital Association®

155 N. Wacker Drive | Suite 400 | Chicago, Illinois 60606
TEL (312) 422-3980 | FAX (312) 422-4580 | e-mail ashrm@aha.org | www.ashrm.org

Patient Safety

Your Emergency Department Can Achieve High Reliability and Safety with Physician Sign Out

By Drew Fuller, M.D.

It's 11 p.m. Do you know how your ED physicians Sign Out their patients during a shift change?

If not, you are not alone. A poll conducted during the Safer Sign Out presentation at the ASHRM 2013 annual meeting highlighted that fewer than 15 percent of respondents were aware of any formal protocol for their ED. Moreover, only 17 percent thought their hospital's practices were "Safe/Reliable" and no one answered that they were "Very Safe/Reliable." (>50 respondents). Other studies support similar results.

This is not surprising. Until recently, few institutions had taken steps to assess or standardize the practice in the ED or other high-risk areas for physician handoff communications despite the Joint Commission's request to do so through the 2006 National Patient Safety Goal (2E).

According to a recent assessment by the Emergency Medicine Patient Safety Foundation (EMPSF), most EDs have no formal policy or structure for this risky process. Even if a policy was claimed or identified, most had low levels of reported compliance and few had any reliable method for performing quality assurance of the process.

Why does it matter?

"Sign Out is one of the most dangerous procedures in the Emergency Department," (*common training mantra)*

The stakes are high and so are the risks. The Joint Commission notes that up to 80 percent of serious medical errors involve miscommunication during a handoff. Cheung et al reported in the American College of Emergency Physician's whitepaper, "Improving Handoffs in the Emergency Department," that up to 24 percent of ED malpractice claims involve an issue with handoffs.

EDs are by their nature high-risk environments that are vulnerable to errors and adverse events. Production pressures, multitasking, rapid turnover and interruptions are just a few of the many routine factors that can significantly contribute to miscommunication. Combine that with the risks in any handoff and the hazard potential adds up.

Your EDs Sign Out thousands of patients a year.

Whether done formally or not, EDs Sign Out thousands of patients a year. Data from several of the Mid-Atlantic hospitals showed that the average community hospital with 40,000 ED visits could Sign Out over 2,000 patients a year.

What usually happens in EDs for Sign Out?

Typical practice for Sign Out is usually limited to a conversation between the two physicians. This type of "verbal note taking" approach has been shown to have relatively high rates of data loss. In addition, the practice can be unstructured, rushed, highly variable and fraught with potential for lapses, delays or miscommunication. Some have termed these "Hopeful Handoffs" because they too often rely on hope rather than proven best practices to bring high reliability to the transition of care.

Other reported strategies for ED Sign Out include:

- "We Round" in which doctors "round" on the patients being Signed Out, however, physicians report low rates of compliance and resulting dissatisfaction.
- "No Sign Out" approach claims that the physicians overlap shifts to avoid the need to Sign Out. It is difficult to see how this is possible when some patients may be in the ED for a prolonged period (e.g. intoxicated, complicated or psychiatric patients), which could lead to covert and unsystematic Sign Outs.
- "Start over" technique. This can have benefits but has questionable practicality, effectiveness and compliance.
- "EHR" tool. Some EHRs may have a tool but few report their effectiveness. There may be potential in the future but many physicians have expressed frustration and concern.

With many of these strategies, it may not be possible to assure that important safeguards are in place such as using a recorded reference/checklist tool or knowing whether there is any communication with the patient and nurse. In addition, the strategies are difficult to assess through QA measures.

Seeking a better Way.

Having a high-risk process in a high-risk environment demands a high-reliability solution. The Safety Leadership Group of Emergency Medicine Associates (Germantown, Maryland), the largest provider of emergency physician services in the Mid-Atlantic, committed to developing an effective and efficient solution. Using recommendations from the American College of Emergency Physician's Quality Improvement & Patient Safety (QIPS) workgroup, as well as feedback from more than 100 practicing physicians, safety specialist, executives and nursing leadership, a process was developed, implemented, refined and shared nationally.

continued on page 3

continued from page 2

The result was a simple, practical process that uses a recordable communication form/checklist for important details with the physicians connecting with the patients and nurses via bedside rounding. In addition, there is a built-in QA tool for monitoring important components.

Safer Sign Out was initially implemented in three states and Washington, D.C. These hospitals represented a wide spectrum of 11 different community healthcare systems including Johns Hopkins (Sibley), MedStar (Montgomery), University of Maryland (Charles Regional), HCA (Reston), Adventist Health, Inova, Novant and VHA (Calvert Memorial).

The Safer Sign Out process was quickly supported and listed by ACEP's QIPS section as well as the Maryland Patient Safety Center. The Emergency Medicine Patient Safety Foundation (EMPSF) further refined the tool and advanced it nationally through a dedicated website SaferSignOut.com where hospital leaders and physicians can download educational and implementation resources. In addition, EMPSF is offering advanced educational tools and consulting services. Several large health systems regionally and nationally are now planning implementation of SSO.

97 percent of surveyed ED nurses believe it is "Important" to "Very Important" for the physicians to share details of their Sign Out with the nurse team member

National Recognition.
The American Medical Association's Handoff Resource webpage and the AHRQ's Patient Safety Net have highlighted and listed Safer Sign Out. National articles have been published in AMNews (AMA Newspaper), ACEP News, Urgent matters and ED Management. All of these sources are available on SaferSignOut.com.

The Wall Street Journal reported about Safer Sign Out in a December 2013 issue of Market Watch, bringing it to the attention of patients and the general public.

Is it Effective?
A recent national assessment by EMPSF showed impressive results. Preliminary analysis of Safer Sign Out found close to a three-fold increase in physician Sign Out Safety scoring and low safety scores were nearly eliminated. In addition, SSO sites showed that physician satisfaction (of Sign Out practices) was nearly double the national average, supporting the belief that physicians will embrace standard or structured processes. Efficiency in utilization was key with physicians reporting that SSO only added approximately three minutes to the average Sign Out of one to three patients.

Risk Management and SSO
Insurers such as Beta Health Pro are encouraging adoption by offering premium discounts up to 2 percent for institutions implementing Safer Sign Out.

Questions to ask your ED leadership
- Do you have a formal protocol for Sign Out?
- Are patients **EVER** in the ED without an assigned physician?
- Do you have a recordable checklist/communication tool?
- Do you round on the patient? Can you demonstrate compliance?
- Is the Sign Out routinely communicated with the nurse? Why or why not?
- Do you have a formal QA process? How does it work?

Advice for improving safety in ED Sign Out:
- Don't rely on the **"Hopeful Handoff"**
- Have your ED group **PROVE** they have a good system
- Don't accept the **"We Don't Sign Out"** method
- Encourage use of a system that use proven best practices:
  - A recordable **Checklist & Communication Tool**
  - Connects **doctors** with nurses and patients
  - Has demonstrable **QA**

Safer Sign Out is a simple, frontline, physician-developed solution that is based on evidence, best practices and expert consensus. It has shown to improve physician-reported safety and clinician satisfaction as well as problem with patient satisfaction.

Access to the complete toolkit is available on **SaferSignOut.com.**

Risk Management

Creating and Implementing a Physician Practice Risk Management Program

By Heidi Harrison

Due to changes in healthcare coverage and reimbursement, hospitals and healthcare systems are acquiring physician practices. In this article, I will share one journey in developing a physician office practice risk management program. This example depicts a system that is self insured for professional liability. The rate of adding practices to our organization has been very rapid. We have spreadsheets to track individuals as well as practices to ensure that all parties are included in our program. We have three categories of practices: acquisition of running practices, creation of new practices and existing practices/clinics.

Ideally, prior to purchase/acquisition, there would be a risk assessment performed to evaluate the care/services and identify liability concerns and opportunities for improvement. Such an assessment should include a rating scale, which allows an objective analysis of each practice. Even if this is done after acquisition, it is a great tool for identifying issues and planning for needed improvements. Once the risk assessment is completed, an action plan including deadlines for completion will ensure that improvements are addressed in a timely fashion. A follow-up visit should be conducted to ensure improvements were adopted and incorporated into the practice.

The top deficiencies noted were a lack of tracking tests and an absence of patient follow-up. Since missed or delayed diagnosis is the highest volume category of claims associated with physician practices, addressing these deficiencies with a standardized process should reduce such occurrences.

Once acquired, practice staff should go through employee orientation. The physicians need a different, separate orientation. A part of this should include an overview of the risk management program. This allows the physicians to meet their risk and, in some cases, the claims manager. Although many physicians would rather pick up the phone and speak directly with a risk manager, there are some who also want written references to review. Physicians are also trained in using bullet points plus a short brochure or flier can serve as a brief risk management overview.

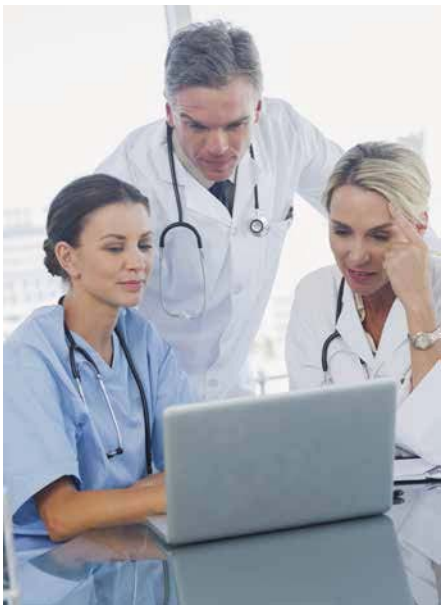
One liability concern identified is that some practices have a few policies and procedures in place but most do not have a comprehensive practice manual for use by the physicians as well as practice management. Creating and implementing such a manual, hard copy as well as online, quickly became a priority. Our goal was to promote standardization for patient safety and minimize liability. As a first step, we created a draft table of contents outlining what we felt was most appropriate to be included in this manual. We identified existing patient-related policies that were applicable in the ambulatory environment including such topics as advance directives and informed consent. Next, we used the published statistics of the highest volume drivers of physician practice claims and lawsuits to pull together general references on specific subjects such as communication. We initially shared this manual with some users to gain feedback about the contents, and made adjustments based on their recommendations.

> In order to sustain risk awareness, we knew that continuing education on minimizing risks and addressing liabilities would be needed.

In order to sustain risk awareness, we knew that continuing education on minimizing risks and addressing liabilities would be needed. By and large, physicians just want to treat patients. They do not want to spend their time performing business or administrative functions. Capturing and keeping their attention to learn about risk reduction strategies can be a challenge. We explored developing continuing medical education (CME) classes ourselves and also evaluated several vendor products. Some of the vendor education and testing focused on specific agencies and their functions versus concepts important to physicians in terms of risk mitigation in practice. Ultimately we chose an online software vendor to provide these classes. Unfortunately, the content is very dry. Hopefully in the future, someone will add entertaining touches. To ensure course completion, we have made these classes easily accessible online and mandatory for all our insured physicians. As we bring practices into the fold, we add them to our list of ambulatory/outpatient areas to be included in our Environment of Care and safety rounds schedule. For those organizations that have or are physician practices as a separate entity, you will need to initiate these types of rounds.

continued on page 5

continued from page 4



There is wide variation in the practice of healthcare risk management among healthcare organizations and settings based on the structure in place as well as the skills of the risk manager and the needs of the organization. Some risk managers focus on data analytics based on events reported; some focus on quality using defined metrics and methodologies; some are responsible for patient safety; some manage the insurance portfolio including claims; and, more often than not, risk managers are involved in a combination of such activities.

We discussed risk management in an ambulatory environment with our colleague Michael Lloyd, who has risk management experience in inpatient and ambulatory settings. He identified the following key areas of difference in the ambulatory settings compared to inpatient:

1. Working more directly with physicians versus administrators, physicians call with a focused problem and need immediate advice
2. Encountering a wider variety of issues
3. Experiencing fewer germane regulations and structure
4. Having fewer resources such as clinical decision support and performance improvement.

Michael's wish list for ambulatory environments includes one standard of care based on evidence-driven protocols, regardless of the setting. We lamented how physicians often resist checklists and alerts, often describing them as "cookbook medicine." However, these tools are being implemented to support patient safety, despite physician reservations. A few other wishes are for standardized error taxonomy, incident/event reporting and claims statistics reporting to allow for comparisons.

This example is one organization's journey in adding multiple physician practices to their self-insurance portfolio. Risk managers in this situation will have a learning curve to acquire additional knowledge related to risks associated with physician office practice, but risk mitigation concepts apply in any setting. One of the differences I have identified is that physicians often react in anger to patient complaints and allegations related to their care, and may even ask about retaliation against the patient/plaintiff. Physicians have many years of education and many were trained as "captains of the ship" versus working in teams. What may be helpful in getting physicians on a different page is explaining that patient concerns are frequently not about the medicine involved but about communication and sometimes negative outcomes, which are inherent risks or known complications. Physicians as well as healthcare providers need information about how the legal process works and the knowledge that risk management is available as a resource to support them as needed.

I believe that we all cherish the sharing of information, ideas and methodologies, and I hope that you find this article helpful. My thanks go to Michael for contributing his renowned two cents.

References

Bernstein, Maurice MD. & Capra, Doug. (2011, January 11). Better communication leads to better care. *American Medical News*. Retrieved April 2014, from http://www.amednews.com/article/20110131/profession/301319955/5/#1#1

Cohen, Jeffrey, MD. FACS, FASCRS., Orlando,Rocco III, MD., Kelly, Kevin MPH. & Diastasio, Susan, MBA. (2013, January – February) A Results-Driven Risk Management Program: One Surgical Group's Success Story. *Physician Executive Journal of Medical Management: American College of Physician Executives,* 45-50.

Martin, Keith L. (2011, February 23). Arm Yourself Against Malpractice: Proper communication is one of your biggest weapons against plaintiffs' attorneys. *UVA Physicians Practice*, 21.

Williams, JD. *Physician, Protect Thyself, 7 Simple Ways NOT to Get Sued for Medical Malpractice*. Pensacola, FL:Margol Publishing, LLC .

Enterprise Risk Management
The Challenge of Preventing and Defending Against Allegations of Decubitus Ulcers

By Peter Chidichimo, MS PT

Plaintiff's attorneys have found fertile ground in lawsuits that focus on allegations of failure to prevent and treat decubitus ulcers, also known as pressure ulcers or bedsores. Defending against these lawsuits is often made difficult by incomplete or insufficient documentation, compounded by the challenge of identifying patients at risk and implementing protective measures.

The risk of developing decubitus ulcers is not limited to patients nearing end of life. Any condition causing or leading to prolonged immobility can place a patient at risk. Common examples seen in many malpractice suits include paralysis, coma, cancer, stroke, renal disease and others. Therefore, it is crucial to identify patients at-risk and develop, as well as implement, a proactive plan of care. Research suggests that for patients requiring wound care, quality of life is especially impacted by pain, change in body image, odors or mobility.

Much of the success in prosecuting these lawsuits may be based on the public's general unease with nursing homes, which is further fueled by negative headlines of alleged abuse and neglect.

Much of the success in prosecuting these lawsuits may be based on the public's general unease with nursing homes, which is further fueled by negative headlines of alleged abuse and neglect. While there may be cause for concern with any institutional care, there is a misperception regarding how problematic it can be to prevent skin breakdown in certain patients.

An added burden exists where there is a regulatory presumption (e.g. Department of Health code) indicating that a person who enters a nursing home without decubitus ulcers "should not develop them," unless they were unavoidable following appropriate preventive measures. In essence, the record must show that all reasonable measures were taken to prevent such ulcers and any breach in the record can be problematic to defend against. In addition, on the federal level, Center for Medicare and Medicaid Services regulations also place a burden on nursing homes to prevent decubitus ulcers.

First and foremost, skin – an area of roughly 20 square feet – is, the largest organ in the body. Skin is ever-changing. It consists of numerous components including water, protein, lipids and various minerals and chemicals. Our skin has a vital function – to protect us from infections and other invaders.[4] Healthy skin will regenerate approximately every 27 days. Proper care is essential to maintain the vitality of this protective organ.

Like any other major organ, however, skin is susceptible to failure, especially near the end of life. Through aging, illness or prolonged immobility, we can lose the ability to regenerate skin as well as to maintain appropriate skin care. Plus, physiologic changes that occur as a result of advanced age, disease progression or impending death can adversely affect the skin. The body may react by shunting blood away from the skin to vital organs, resulting in decreased skin perfusion and a reduction of the normal metabolic process. This results in decreased tolerance to external insults including pressure. These physiologic changes may be unavoidable and occur despite appropriate interventions. Minor insults, such as blisters and skin tears, can lead to major complications including pressure ulcers and infection. These chains of events can be difficult to reverse and are often difficult to predict.

Contrary to popular belief, not all pressure ulcers are avoidable. An expert panel was established in 2007 to formulate a consensus statement on Skin Changes at Life's End. The panel consisted of 18 internationally recognized stakeholders including clinicians, caregivers, researchers, legal experts and others. The inaugural forum was held April 2008. The panel discussed the concepts of skin failure and other end of life changes. As a result of the panel's discussion, certain recommendations were proposed.[3]

The responsibility for assessing, preventing and monitoring decubitus ulcers is typically a responsibility of the nursing staff. The SCALE panel recommends that the plan of care be clearly documented and reflected throughout the entire medical record. Charting should record the patient's clinical condition including comorbidities, risk factors, significant changes and interventions. Facility policies and guidelines for record keeping should be followed closely and updated regularly. The impact of interventions should be assessed and revised as appropriate. The record should include the location, staging and photos of any new ulcers, as well as relevant lab values, especially albumin levels. Documentation is critical in defending against allegations of causing or failing to prevent decubitus ulcers.

continued on page 7

continued from page 6

A plan of care should be implemented on a timely basis. Intervention may include turning and re-positioning the patient at regular intervals, avoidance of pressure points, use of a special mattress, use of adaptive devices, proper nutrition and physical therapy. Caregivers need to be especially cognizant of the warning sign of unintended weight loss, which could be a sign of poor nutrition and can contribute to ulcers or delay healing of existing ulcers. Patients should be monitored regularly and encouraged to eat well, be properly positioned for eating and provided with supplements if necessary.[4] A comprehensive skin assessment should be performed regularly. Special attention should be given to bony prominences, such as the sacrum, coccyx, ischial tuberosities, trochanters and heels. The skin or wound should be described in detail, especially at admission, discharge or transfer. The plan of care needs to address pressure, friction, moisture, nutrition and immobilization. For successful implementation, the plan of care must be matched with the facility's resources (equipment and personnel).

When a patient experiences SCALE, tolerance to external insults such as pressure decreases to such an extent that it may become logistically impossible to prevent skin breakdown and the possible invasion of the skin by microorganisms. Incontinence complicates care due to moisture, as does a compromised immune system often seen in patients with advanced stages of cancer or those receiving palliative care. Patients with dementia or mental illness might not understand the purpose of appropriate interventions. Professional liability claims specialists, who review lawsuits against hospitals and nursing homes, note that patient compliance also can be a factor. Patients may be uncooperative with the plan of care and even combative with the nursing staff. Some patients refuse to cooperate with frequent position changes, to participate in PT or to take prescribed supplements designed to aid with nutrition. Other compliance issues identified include refusal to take medications, consuming foods outside the prescribed diet (i.e. diabetic diet) and wearing inappropriate footwear (i.e. tight-fitting, trendy sneakers are popular among younger patients, according to Daniel Stone, a Risk Manager at Coler-Goldwater Nursing and Rehabilitation Center in New York City.)

If a patient does develop a decubitus ulcer, it is important to identify the stage of the ulcer as well as record its size and appearance at regular intervals. Appropriate referrals may be necessary for wound care, infectious disease consultation or surgical intervention. Many facilities use a wound-care team that consists of specially trained nurses, physicians and wound-care experts who are dedicated to treating decubitus ulcers.

It is important to communicate regularly with the patient and family regarding care goals, interventions, and responses of skin care.[1] Based on discussion, the terminal patient may choose comfort or maintenance as opposed to debridement, a colostomy for incontinence, or other aggressive measures. It may be appropriate in some cases for comfort to be the primary goal, even though it may conflict with best skin care practices. The patient and family should have an understanding that skin compromise may be an unavoidable part of the dying process.[3] This understanding has the potential to defuse the perception of distrust and neglect surrounding long-term facilities. Through educating patients and families that skin conditions are sometimes a normal part of the dying process, there is less potential for assigning blame, and a greater understanding the skin compromise may be unavoidable.[1] Collaboration and communication with the patient and family should be ongoing and even extend to others involved such as healthcare professionals, healthcare administrators and payors. Preventive care measures should extend across all facility departments and specialties including outside healthcare providers.

In summary, the prevention of decubitus ulcers in the physically compromised patient is an ongoing challenge to the clinical staff assigned to such patients. The challenge is particularly difficult where physiologic changes make the development of such ulcers inevitable. Documentation in the clinical record is imperative, as is ongoing communication with the patient and family about skin changes related to the disease process and what the current goals of care should be – restorative or comfort focused.

Legally defending these cases can be problematic owing to occasional breaches in the continuity of the clinical record, timeliness of preventive measures or intervention plus the added burden of state and federal regulatory violations.

References

1. Sibbald, R. Gary , Krasner, Diane L. & Lutz, James. SCALE: Skin Changes At Life's End. Retrieved April 23, 2014, from http://www.medscape.com/viewarticle/715497_1
2. WebMD. Skin Problems and Treatments Health Center. Retrieved April 23, 2014 from http://www.webmd.com/skin-problems-and-treatments/picture-of-the-skin
3. Keefe, Sandy. (September 6, 2011), Skin Changes at End of Life. Advanced Healthcare Network for Nurses. Retrieved April 23, 2014 from http://nursing.advanceweb.com/Regional-Content/Articles/Skin-Changes-at-End-of-Life.aspx
4. Quality Insights Pennsylvania. Pressure Ulcer Reduction Resources. Retrieved Apri. 23, 1014 from http://www.qipa.org/Materials/Patient-Safety/pressure-ulcer.aspx)

Member Profile: Jacque Mitchell RN, BSN, CPHRM, FASHRM, ARM

Jacque Mitchell RN, BSN, CPHRM, FASHRM, ARM and 2014 ASHRM President

By Renee Wenger

Congratulations to Jacque Mitchell, ASHRM's president for 2014! Jacque serves as risk manager for Sentara Norfolk General Hospital in Norfolk, Va. This is Sentara's flagship hospital with 560 beds, a large trauma center and an attached medical school. Jacque handles all claims and risk management duties. She has been active in education and leadership in her healthcare system, and is a past president of the Virginia chapter of ASHRM.

After obtaining a Bachelor of Arts in psychology from the State University of New York at Binghamton, Jacque began her career in 1975 at a Midwestern hospital. It was from that experience that she learned a great deal about how to staff a hospital. She also discovered that she wanted to work with people through the profession of nursing. Entering nursing school at Southern Illinois University, she obtained her bachelor's in nursing in 1986. After graduating from nursing school, Jacque worked for a small community hospital where she began assisting with certain risk management projects. She found that she liked doing risk management. In particular, she felt that writing policies helped her learn about why we do what we do. In 1988, she and her husband moved to Virginia, where she guided nursing students from Norfolk State University through their clinical experiences in hospitals, daycares and clinics, until a position became available for a new Risk Management Department start-up. She says that she read everything she could on the subject of risk management and built a small department. For the next eight years, she furthered her expertise through her collaborations with other departments such as utilization review, workers compensation, infection control and others. Jacque came to her current job in 1992.

Jacque says she "loves" doing risk management. She enjoys seeing the great things that are done by risk managers every day and appreciates seeing the changes over the years. When she began her career in risk management, the majority of her work involved managing claims. Now, less than 10 percent of her duties involve claims. She celebrates the shift from a reactive to a proactive culture, which, in her opinion, has produced better outcomes and fewer claims.

When asked about this year's ASHRM theme of Sharing in the Caring Through Enterprise Risk Management, Jacque said that her "Why?" is the interactions she has with patients and families. She loves being able to bring patients, families and providers together and empowering patients to ask the questions they need to ask. She believes this creates better resolution for patients and families, and increases collegiality with providers.

There are three goals that she has identified for ASHRM this year. First, she wants to focus attention on patient-centered healthcare. She believes in involving patients and families in care and treatment. She thinks we can learn from patients who know about their own health and bring a different perspective to the discussion. She asserts that the next evolution of "getting to zero" is encouraging patients to speak up and participate.

Jacque said that her "Why?" is the interactions she has with patients and families. She loves being able to bring patients, families and providers together and empowering patients to ask the questions they need to ask.

Jacque expressed excitement at the second goal – helping to finish ASHRM's second white paper, which should be out soon and is available to all ASHRM members. As you may recall, the first white paper dealt with identifying and defining serious safety events. This paper will cover harm levels and deviations from normal. Together, they help us talk across systems.

Her third goal is to prepare current risk managers to mentor the next generation, so when opportunities arise, they will be ready to step up. She estimates that it takes at least two years to mentor someone to the point where they can function on their own. She adds that she is impressed with the quickness of young professionals who seem to be much more familiar with risk managers and what they do than we once were.

As for her personal time, Jacque says that her children are all raised, but she still has three "dependents" at home – her poodles. And as she reminded me, "Every day is a different day." We look forward to Jacque's compassionate, inclusive and caring leadership this year.

ASHRM Update

Highlighted Accomplishments - First Quarter 2014 and Upcoming Events

National Patient Safety Awareness Week & Patient Safety Portal
"Sharing in the Caring through Enterprise Risk Management" was ASHRM's theme for National Patient Safety Awareness Week 2014. The goal was to draw attention to the vital role that all healthcare workers play in furthering patient safety. Although patient safety is a top priority every day, this designated week provided an extra opportunity to learn and collaborate about eliminating and minimizing serious safety events.

ASHRM's Patient Safety Portal provides lots of practical strategies, tips and resources for providers to use to create a culture of patient safety. The online Portal attracted a lot of viewers during National Patient Safety Awareness Week 2014: A total of 2,136 people viewed the Patient Safety Portal; about 500 took the Interactive Quiz; nearly 200 watched the video; and more than 900 viewed the Patient Safety Core Topics and Tips. Both Topics and Tips and The Interactive Quiz were very popular—capturing 42% and 25% of total viewers respectively.

An additional eblast campaign generated a high level of interest for hot topics such as readmissions and adverse drug events. We are happy to report that the HRM community was very engaged in ASHRM's National Patient Safety Awareness Week 2014 campaign.

As a leader in patient safety education and advocacy, ASHRM's goal is to offer risk management professionals a "full circle," organizational framework for employee participation. ASHRM believes that this approach is the best practice for achieving desired patient safety outcomes.

You can find videos, checklists, fliers, programs, publications and more support on ASHRM's website at www.ashrm.org. Simply go to the Patient Safety Portal.

New Pearls – Risk Management Pearls for Medication Safety: Part I and Part II

Although medications are intended to benefit patients, the medication-use system is a potentially high-risk and error-prone component of the healthcare delivery system in both inpatient and outpatient delivery systems. These two booklets summarize medication error-prevention strategies and practices that are effective in reducing and eliminating patient harm. They are popular with our membership and sales continue to rise. For more information, go to www.ashrm.org.

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

ASHRM Academy
ASHRM Academy, held on May 5-8 in Oakbrook, Illinois, attracted nearly 200 attendees. It was an exceptional learning experience in an intimate forum at a luxurious, resort-like hotel, complete with nature walks and yoga. Risk managers learned and connected with other engaged healthcare professionals, taking their HRM skill set to the next level. Attendees had the opportunity to earn the HRM or Patient Safety certificate; take the CPHRM Exam; and attend our Partner Programs to earn up to 13 ASHRM credit hours that could be applied toward FASHRM, DFASHRM or CPHRM status.

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

HRM Week
Healthcare Risk Management (HRM) Week is June 16-20, 2014. This is ASHRM's annual campaign to raise awareness about the critical role risk management and patient safety professionals play in eliminating and preventing and serious safety events. The theme for this year's event is "Sharing in the Caring through Enterprise Risk Management." ASHRM offers strategies and resources for all workers in furthering patient safety. Many of these are aligned with the Partnership for Patients campaign. There's also an exciting new collection of promotional products (for purchase) to give to staff throughout your organization. These colorful items are visual reminders for the "Sharing in the Caring" of patients. For more information, go to www.ashrm.org. Don't miss the HRM Week webinar on June 18, "Changing the Paradigm: Improving Patient Safety through Patient & Family-Centered Care."

continued on page 10

continued from page 9

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

Save the Date: ASHRM 2014 Annual Conference & Exhibition
Join ASHRM at the 2014 Annual Conference & Exhibition, October 26-29, in beautiful Anaheim, California. The "Sharing in the Caring though Enterprise Risk Management" momentum continues. Attendees will experience optimal learning and career-building as they network with 2,000 healthcare professionals to gain deeper knowledge about claims and litigation; enterprise risk management; patient safety; and preventative strategies. Thought-provoking keynote speakers and 70 concurrent educational sessions across six tracks are sure to keep you in the know. Register now at www.ashrm.org./annual

We'll see you in Anaheim!

ASHRM 2015 Leaders Election – Call for Nominations
The ASHRM election process is critical to the success and growth of our society. ASHRM members nominate leaders to enable ASHRM to achieve its vision and mission with a president-elect, three members to serve a three-year term on the Board of Directors, and five members to serve a one-year term on the Nominating Committee. For more information, go to www.ahsrm.org.

ASHRM 2015 Research Grants – Call for Letters of Intent
The ASHRM 2015 Research Grants program seeks to stimulate research on healthcare risk management and patient safety issues, as well as support research projects that are either quantitative or qualitative in nature. The deadline was May 2, 2014. For more information, go to www.ahsrm.org.

Spotlighting HRM Projects at the 2014 ASHRM Annual Conference & Exhibition
Members and non-members have been asked to share their exceptional success stories with their risk management colleagues. Also, submitted poster presentations will be presented to colleagues at the annual conference, October 26-29 in Anaheim, California. They were grouped by the following topics:

- Decreasing/eliminating preventable serious safety events
- Decreasing/eliminating hospital-acquired conditions and readmissions
- Improving quality
- Enhancing patient safety
- Implementing Just Culture innovations

After the annual conference, the poster presentations can be viewed at www.ashrm.org.

New CPHRMs

Congratulations to these NEW CPHRM Recipients!

January
Jeffrey Winecoff
Osagie Ebekozien
James Keeler
Wendy Whelan
Cathleen Smith
Tammy Redmond
Lynn Schuster
Kassie Dye
Angela Sutherland
Fadwa Abu Mostafa
Alicia Fredella
Deborah Gordon
Giselle Krieger
Thomas Tscherning
Michelle Swift
Nolana Daoust
Christian Holland
Tami Mays
Peggy Woodward
Rebecca Stegall

February
Joelle Khysho
Khalil Rizk
Jan Hickey
Patrick Pyle
Beth Chow
Lizzette Rodriguez
Shannon DelChamps
Patti Hartsfield
Brian Murphy
Lisah Carpenter
Patricia McKeon
Leesa Deal
Barbara Hansen
Paul Mersiovsky
Julie Radford

March
Janice McDonald
Dorothy Totah
Michael Valentine
Betsy Castillo
Jill Deimerly
Teresa Simpson
Joseph Rectenwald
Shelby Quinn
Donna Dallis
LeAnn Keester-Moran
Connie Bellamy
Rita Bunch
J. Hopkins
Patrice Hirning

The Certified Professional in Healthcare Risk Management (CPHRM) is the premier credential for the risk management profession. For more information on the credential, and a complete list of recent CPHRM recipients, visit www.ashrm.org/cphrm.

Meet Your ASHRM Staff

Kimberly Hoarle
MBA, CAE
Executive Director

Matthew B. Hornberger
MBA, CAE
Associate Executive Director

Marcia Cooke
RN-BC, MSN
Director, Education & Research

Mary LaRusso
Director, Marketing & Communications

Katie Carlson
RN, MSN, MHA
Senior Education Specialist

Shaun O'Brien
Multi-Media Specialist

Grecelda Buchanan
Program Coordinator, Meetings & Education

SHARING IN THE CARING

ASHRM

Annual Conference & Exhibition

October 26-29, 2014 ▪ Anaheim, CA

E ▪ R ▪ M

Save The Date!

Join the American Society for Healthcare Risk Management (ASHRM) at the 2014 Annual Conference & Exhibition, **October 26-29 in beautiful Anaheim, California**. Register by Oct. 2 to save up to $250 with the Early Bird Discount!

ASHRM 2014 will feature:

- **More than 70 educational sessions**
- **Dynamic keynote speakers including:**
  - AHA President and CEO Rich Umbdenstock
  - Basketball legend and entrepreneur, Magic Johnson
- **Education tracks including:**
  - Claims and Litigation
  - Healthcare Operations
  - Legal and Regulatory
  - Clinical/Patient Safety
  - Risk Financing
  - Leadership

Scan the QR code to learn more about the ASHRM Annual Conference & Exhibition, visit www.ashrm.org/annual, or call (312) 422-3980.

Register by Oct. 2 to save up to $250 with the Early Bird Discount! Watch your email inbox for updates or visit www.ashrm.org/annual.

See you in Anaheim!