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A risk management tool for the healthcare industry
Perspectives



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Zurich Healthcare Symposium

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Zurich Healthcare Symposium

Zurich held its third annual Healthcare Symposium on April 14-15, 2010. This educational program provides an opportunity for our customers to learn about emerging risk issues in the healthcare industry. The Symposium also brings together risk management professionals from around the country, allowing them to build valuable relationships and share information with their peers.

At Zurich, we value providing our customers more than just basic coverage and services. We believe in building beneficial relationships. One way we do this is by working with our customers to understand the risk environment that affects us both through programs such as the Symposium. This year, we featured topics such as enterprise risk management, the medical home model of care, providing healthcare to a culturally diverse population, and new issues in healthcare litigation. We would like to share the valuable information that was discussed, so please enjoy this issue of Perspectives, which provides a summary of the symposium.



An emerging defense in shoulder dystocia cases is a biomedical engineering defense.

Attorney panel – New issues in liability

Marilee Clausung, partner at Anderson, Rasor & Partners, LLP and Ashley Purcell, partner at Booth Smith & Slover, P.C. discussed recent trends/issues affecting medical malpractice litigation during a panel session moderated by Rob Bartolone, Regional Claims Manager from Zurich. They discussed a wide range of topics:

The first part of the session discussed how technology can be used to help –or harm – the defense of a case. The electronic medical record (EMR) contains more than just notes. It also contains metadata information that allows you to track when and by whom records were viewed, and entries, edits or revisions are made.

Risk managers need to educate themselves about what metadata is. They should talk to and educate internal information technology (IT) staff about this data, and how to use it.

In addition to the data that is in EMR, other systems in use at hospitals contain digital and electronic information that may be pertinent to a lawsuit. These include:

- Key card and transponder data that shows when providers are present at the hospital.
- Use of telemetry to view medical records or diagnostic studies remotely - information on who accessed the information and when, may be discoverable.
- Patient tracking boards, such as those used in the Emergency Department, that can show where a patient is, when studies are done, when they are reviewed, and when orders are written.

- E-mail, both personal and professional, that may relate to care and can be subject to discovery
- Digital phones contain memory banks that can show when and to whom a call was made
- Pagers contain data stamps that show when pages were sent and received

All of these systems can help prove or disprove the testimony of providers. It is important that the testimony and the information from the technology used are consistent.

The panel also discussed other sources of medical information that can be sought by attorneys in a lawsuit. Providers who use blogs to write about care of a patient or even the environment they are working in may find that information is being requested as part of discovery. Many providers think that if they use their own personal computer or journal for keeping notes or logs about professional activities, this is protected from discovery. But this type of information, including that entered into a BlackBerry or similar device, may be discoverable.

The second part of the presentation discussed several issues relating to obstetrics litigation. Following a brief review of new guidelines that standardize the terminology and definitions used in fetal heart rate monitoring published by the American College of Obstetrics and Gynecology (ACOG) and the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN), they turned to a discussion of causation defenses for obstetrics cases.

Hospitals can help defend birth injury cases by showing evidence that the injury was not due to negligence. This can include Apgar Scores, cord blood gases (both arterial and venous), brain MRI studies, and placental pathology studies. It is important to determine if there was a metabolic disorder or genetic causes that existed before labor.

It may not be practical to obtain these tests after each delivery. Cord blood gases need to be done immediately after delivery, but some physicians are reluctant to order these because they may not be paid for by insurers. Hospitals can develop criteria or checklists that remind staff to draw cord blood in certain circumstances. For placental pathology exams (preferably by a specialist in this area rather than the hospital pathologist), the hospital can develop criteria for when such exams should be performed.

The panel also discussed the importance of the expert witness for an effective defense. The expert needs to be articulate and be able to withstand cross-examination. Attorneys should develop new, fresh experts rather than relying on the same pool of “tried and true” experts. Experts in several specialties may be needed, including a geneticist, perinatologist, placental pathologist, neonatologist and obstetricians.

Many hospitals and insurance companies are now using highly experienced attorneys from across the nation to defend these cases. These attorneys can assist in defense by obtaining highly qualified experts and doing quick record reviews, identifying issues, and co-managing the defense at trial. These attorneys can also successfully challenge plaintiff’s economic experts to help mitigate damages.

Another topic discussed was the defense of shoulder dystocia cases. They have been difficult to defend, and seen almost as strict liability cases. An emerging defense to these cases is a biomedical engineering defense. Dr. Michele Grimm, from Wayne State University testified that “natural forces of labor” - the uterus - is the cause for shoulder dystocia. Her testimony as an expert witness (she is not a physician) was successfully tested in a liability case and upheld on appeal. This testimony has resulted in obtaining not guilty verdicts.



The medical home model is a vision of primary healthcare as it should be.

Transforming healthcare – The medical home

As the cost of healthcare in the US continues to rise, there has been growing interest in the concept of the Patient Centered Medical Home (PCMH) as a way to provide cost-effective quality care. A panel of experts representing important stakeholders in the healthcare industry discussed this issue.

Terry Noetzel, a principal with Deloitte & Touche, LLP, provided an overview of some of the issues facing the healthcare industry which support the need for a PCMH model. Although a large proportion of the population has a chronic condition requiring coordinated medical care, under the current system physicians do not have the tools or incentives (including reimbursement) to address complications arising from chronic conditions. Employer healthcare costs are increasing, diverting moneys that could be applied to enhance global competitiveness. Regulators and policymakers see a disconnect between incentives, the management of chronic conditions, and overall healthcare system effectiveness. The medical home model is meant to address some of these issues. The goal of a medical home is to provide a patient with a broad spectrum of preventive and curative care over a period of time, and to coordinate all of the care the patient receives. Although this model can reduce overall costs, there are roadblocks to its implementation.

Dr. Douglas Henley, Executive Vice-President/CEO of the American Academy of Family Physicians (AAFP) presented the primary care physician point of view. He said the medical home model is a vision of primary healthcare as it should be a framework for organizing systems of care.

It uses team-based care while maintaining the important patient-physician relationship. The team is comprised not just of physicians, but nurse practitioners, physician assistants, nurses, care coordinators, nutritionists and others. All members of the team need to work at the top of their license.

Under the PCMH model, the patient enters a medical home through a physician directed team that provides primary, chronic, preventive and acute care. Evidence based referrals are made to specialists and sub-specialists, to institutions, such as hospitals and long-term care facilities, and to community services, such as pharmacies, hospices and home healthcare providers. Done correctly, the PCMH will reduce visits to specialists and hospitalizations.

There are many challenges to developing the PCMH. One of the biggest is the declining number of primary care physicians. There has been a 50% decrease in the number of people choosing primary care residency. Having sufficient numbers of primary care physicians is important. As the number of primary care physicians increases, the cost of care goes down and quality of care goes up.

There is also a lack of incentives – and payment – for care management. Under the current system, primary care physicians are paid significantly less than specialists and only 5% of all healthcare dollars go to primary care. The ideal payment system would be a blended payment consisting of updated fee for service payments, positive incentives for quality improvement and performance assessment, and per member / per month care management fee to be paid to the PCMH.



Dr. Jay Faith, the Medical Director, Primary Care and Community Health, Swedish Medical Center, provided perspective from the hospital side. Swedish is a three-hospital, not-for-profit health system. It has 2,500 physicians on staff, 500 of whom are employed by the hospital.

When Swedish opened a new clinic in one of its community hospitals, it did so under a PCMH model. It worked with two insurance carriers to develop a primary care capitation system – a flat per member per month fee – for payment. Physician incentives are based on quality measures, such as following national guidelines for screening, lowering blood pressure and keeping patients out of the ER. The program has been open a year, and has been successful.

Dr. Faith discussed the need for the hospital to better coordinate the transition between the hospital and out-patient setting. Swedish uses care navigators to improve these transitions. They contact the primary care physician to get information about the patient when he/she is admitted. They provide patient education, and make sure the patient understands what he/she needs to do before being discharged. They make sure there are a primary care provider and a follow-up appointment for follow-up. Patients are also called after discharge to see if there are any problems.

Mark Casmer, Senior Director at the Medical Advantage Group (MAG), provided perspective from the third party payer. In Michigan, Blue Cross/Blue Shield is the largest payer and insures about half of the state. It started to change reimbursement to physicians through an incentive program, moving some money out of the fee-for-service structure and into incentives. As more of the physician's reimbursement is based on quality rather than quantity, physicians will need to provide care in a more coordinated fashion to survive. It is hard to implement this type of system, unless most of the payers in a service area participate since multiple payment structures add significantly to the administrative burden.

Mr. Casmer noted other actions that can help make a PCMH successful. Measurement and change efforts should focus on communities of caregivers rather than individual practitioners. Payers need to be partners, not adversaries or controllers. Physician organizations should help create system change, and not just react to prescribed controls.

The panel agreed that hospitals will need to embrace the PCMH model in the future. CMS is studying bundled-payment systems, in which hospitals will be reimbursed a set amount for a particular condition or procedure, regardless of how much care is provided. This model requires the hospital and its physicians to better coordinate care. Hospitals that can work with PCMH models of care will be better able to meet the expectations of payers and patients.

Cultural issues can arise not just because of language difficulties, but because of cultural beliefs.

Cultural diversity

Amy Wilson-Stronks, a principal investigator with The Joint Commission of the report Hospitals, Language, and Culture study healthcare disparities, and Marilyn Michel, Healthy House discussed cultural diversity in healthcare.

The presentation covered topics such as defining cultural competence in the context of patient safety and how to establish a proactive approach to mitigate cultural misunderstandings and improve patient-provider communication.

They noted that risk managers are “change makers” in their organizations, and can help drive them to make changes to improve delivery of care in a culturally diverse environment.

Cultural issues can arise not just because of language difficulties, but because of cultural beliefs. A case scenario was presented to show how misunderstandings can arise. A patient who was having abdominal pain believed this was due to a hex put on him by his neighbor, while the hospital staff believed he had appendicitis. The patient was very fearful of the hex and was not able to focus on or understand his clinical needs, and wanted to see a native healer. The physician wanted to perform testing and surgery. In order to ensure proper treatment is provided, the hospital staff needed to understand the patient’s cultural beliefs and fears so they can work with them. That could be reassuring the patient that he could see a native healer after he had the medical treatment.

Ms. Mochel then discussed how hospitals can work with patients with different cultural beliefs. In California, a hospital began a program to identify healers in their communities and invite them into the hospital. This provided information on what roles healers and physicians have, and to develop understanding of how each can play a role in providing care to patients. Over time, relationships were developed and an active program was established. The hospital and the healers worked together to meet the cultural needs of the patient population in their community, and patients became more trusting and accepting of the services the hospital provided.

The presentation also covered health literacy. People receive information in very different ways and healthcare providers need to be cognizant of cultural and language differences. These differences have a significant impact on patient care and treatment, and in many cases outcomes. Literacy does not merely affect the poor or non-English speaking patients. The Joint Commission (TJC) published a report that 80% of hospitals experience frequent language issues. A new guide to providing assistance on literacy/language and cultural issues will be issued in the near future. Updated TJC standards require that patients receive information in a way they can understand. This can be done using bilingual hospital staff, contract staff or trained interpreters for this purpose.

There is a difference between interpreters, who are used for oral communication, and translators, who are used for written communication.

Document translation needs to consider and reflect the culture of the patient. In some instances it may not be possible to provide a word for word translation. English documents need to be reviewed and simplified so that an accurate translation can take place. The goal is to “Trans-Adapt” in order to translate documents to make them understandable. It is the responsibility of the physician, not the interpreter, to assure that the patient and family understand what is being said.

TJC is adding additional, new requirements around language proficiency. They include the following:

- The Hospital is required to identify patients’ oral and written communication needs, including the patients “preferred” language.
- The hospital defines staff qualifications (including volunteers) to provide interpretation. The hospital needs to ensure the interpreters’ proficiency.



Enterprise Risk Management

Enterprise Risk Management (ERM) is a risk management tool that has long been embraced by the business community, but only recently and on a limited basis by the healthcare community. Mary Gardner, VP of Business Resiliency for Zurich, opened a presentation on ERM that included an overview of this risk management approach and how it is applied to Zurich's business model. Peggy Nakamura, Chief Risk Officer and Associate Counsel for Adventist Health, continued the presentation from a healthcare provider point of view.

ERM is a broad approach to analyzing the risks to which an entity may be exposed. As Ms. Gardner noted, ERM seeks to uncover risks from day-to-day operations as well as emerging risks and unexpected events. Companies that employ an ERM model cultivate active risk management by engaging everyone, from the entry-level employee to the Board of Directors member, in the process of identifying potential risks. Effective ERM couples a strategy for minimizing those risks with the monitoring of interventions in order to achieve desired business outcomes.

ERM evolved from the traditional focus on managing a specific risk with a specific intervention (risk transfer through insurance) to a top-down and bottom-up approach that analyzes an entity's overall risk profile. Looking to the future, ERM will treat all risk categories equally regardless of whether they are insurable.

For those businesses which compete in the global arena, there is increasing pressure to implement ERM as the model for their risk management program. Factors such as corporate failures (Enron, recent credit crisis), regulatory actions (Sarbanes-Oxley) and industry initiatives have underscored the need for an ERM approach to risk management. In 2008, Standard and Poor's (S&P), a debt rating agency, identified ERM as an explicit, measurable element in determining a company's rating. S&P requires companies to demonstrate their ability to incorporate risk information as part of their strategic decision making process in order to score well on the S&P rating assessment.

In a time of crisis, a risk manager must have a clear understanding of exposures across all aspects of the business. By creating a Total Risk Profile (TRP), that understanding will be achieved. An important element to the profiling process is communication that is both vertical and horizontal.

A risk profile enables an organization to categorize risk into four types of exposures:

- Strategic risks - Consist of threats to a company's viability
- Operational risks - Involve adverse unexpected developments related to internal processes, people and systems
- Financial risks - Involve risks associated with accounting
- Market risks - Those changes in the market that may affect a company

Education is the key to integrating an ERM concept into a facility's culture.



A sophisticated risk management program combines resilience in handling exposures with an ability to respond by making better informed decisions. That applies lessons learned to mitigate risk and maximize opportunity.

Turning to the healthcare arena, Ms. Nakamura noted that its complex nature had a significant influence on ERM. She cited factors such as complicated technology, powerful drugs, unclear lines of authority, varying physical settings, diversity of patients, staff and physicians and medical professional liability expense as deterrents to adoption of this model for risk management in the healthcare industry. Other barriers to ERM include departmental silos, lack of accepted risk metrics, lack of senior management support and difficulty in demonstrating the value of ERM over traditional risk management approach.

Despite these obstacles, Ms. Nakamura stated that she believes implementation of an ERM program is an achievable goal. The first step on what promises to be a long journey is to identify and engage a senior level executive champion in the ERM concept. Next, a task force should be created to facilitate the development of an ERM program. They should be charged with reviewing both the organization's strategic plan and risk identification tools. An annual review of the strategic plan and risk identification is critical to developing an ERM program.

It was emphasized that education is the key to integrating an ERM concept into a facility's culture. She concurred with the notion that ERM is a process that requires a top-down

commitment to be successful. In defining ERM for an organization, Ms. Nakamura suggested that consideration be given to the organization's risk appetite, its culture, mission, values and vision. Once those steps have been taken, the next phase is to establish an ERM committee, identify the process at the management level for risk identification and develop a timeline. The timeline should take into consideration the organization's strategic planning cycle, the budget cycle, board meetings, senior management meetings and department director meetings. Doing so will facilitate goals and objective setting.

At this point in time, the ERM model is taking shape within the organization's operations. To continue the process of implementation, it is vital to have a clearly defined vision of the role ERM plays in the business. There needs to be a clear risk framework with regard to identification, assessment, evaluation and monitoring. In addition, to complement the top-down approach, a bottom-up participation in risk identification is invaluable in engaging all stakeholders.

In summary, successful ERM implementation depends upon several factors. Ms. Nakamura cited knowledge of organizational culture and the process for introducing new initiatives and programs as critical factors. Keeping all stakeholders informed and educated on an ongoing basis is also essential. Lastly, avoiding complexity while being flexible will bolster the organization's ability to establish and nurture an ERM program.

“When you’ve seen one way of managing quality, safety and risk management – you’ve seen one way of managing quality, safety and risk management.”

Managing risk, quality or safety: What’s the difference?

The Symposium concluded with a presentation by Mark R. Chassin, MD, MPP, MPH, President of The Joint Commission (TJC.) Dr. Chassin stated “When you’ve seen one way of managing quality, safety and risk management – you’ve seen one way of managing quality, safety and risk management.” These areas are interrelated but the puzzle contains many pieces – root cause analysis, performance measures, peer review, malpractice claims, to name a few – which can lead to lost opportunities for improvement if not properly aligned and integrated.

According to Dr. Chassin, there has been a great deal of progress in the last ten years on the quality and patient safety front, but despite our best efforts “opportunities for problems” still exist through misuse, under use, and overuse of the system. With the introduction of 35-38 million newly insured individuals into the system through the recently passed Health Insurance Reform Bill, the problem of overuse will only increase.

Dr. Chassin stressed that with transparency comes visibility of problems and stakeholders demanding excellence in unprecedented ways. He recommended that the audience visit the website deadbymistake.com to see firsthand the proof of this increased demand for excellence.

Furthermore, he commented on how far TJC has come on quality issues. In 2000, The Joint Commission had few measures of quality and no national data collection or reporting. Today, all that has changed. Following the gathering and publishing of data, there has been an

improvement in the percentage of acute MI patients arriving at TJC accredited facilities who received aspirin on arrival to the ED and beta blockers on discharge. Surgical indicators significant improvements since the first full year of reporting in 2005.

The quality landscape is constantly changing for hospitals. Dr. Chassin indicated that because quality improvement resources are scarce, and TJC strongly influences how those resources are used, the TJC has an obligation to maximize the health benefit of their measures and standards. He said that the main barriers to achieving major durable improvement include 1) a lack of capacity to execute robust process improvement (RPI) and 2) healthcare organizations’ failure to establish a safety culture. The remainder of this presentation focused squarely on the topics of achieving these two aims.

Robust process improvement

How have other organizations outside of healthcare achieved “robust process improvement”? Examples cited by Dr. Chassin include Lean, Six Sigma, and change acceleration. He stated that he believes that these processes, when applied to our toughest safety and quality problems, are equally effective, address critical failings of current QI and appeal to physicians and other clinicians. He also discussed high reliability organizations (HRO) which manage serious hazards extremely well. HROs have a set of operating and management principles and tools as well as a particular culture that allow them to achieve high reliability. Achieving high reliability in healthcare will be a long road with RPI as a vitally important vehicle for getting there.

According to Dr. Chassin, critical components of RPI include measuring reliability, identifying root causes, targeting interventions and sustaining improvements over time. He also pointed out that it is important to be aware that a best practice in one organization may not work in another organization. Improvement most often fails because an organization failed to accept and implement a good solution. An organization must be able to assess resistance to change. There are typically three types of resistance – technical, political and cultural. Each type requires a different approach to overcome the resistance.

Dr. Chassin stated that there is no plan to require adoption of RPI by accredited organizations. However, he did report that TJC has adopted it and is aggressively pursuing training and internal capacity to apply RPI tools. With adoption of Lean, Six Sigma, and change acceleration, TJC is rapidly changing its culture and focusing on customers, simplifying processes and reducing costs.

Safety culture

Close calls or “free lessons” as Dr. Chassin calls them, are a critical barometer of the safety culture in an organization. In a punitive organizational culture, free lessons will not surface for fear of punishment. In a bureaucratic culture, the process is celebrated, not the opportunity for improvement, and in a high reliability organization the reaction will be the same as if an adverse event had actually occurred.

According to Dr. Chassin, the three interrelated imperatives of a safety culture are trust, reporting and improvement. A culture where trust is established does not mean there is a blame-free culture. Rather, it requires separation of blameless errors from egregious ones, establishment of a code of behavior, and uniform assessment of errors.

Dr. Chassin identified four questions to ask every time there is a decision to be made on error-associated discipline:

1. Was harm intended
2. Was there evidence of illness or substance abuse
3. Was there departure from agreed upon safe practices (if yes, were the protocols available, intelligible, workable, correct, in routine use, were there mitigating circumstances)
4. Would another person with same training/ experience behave in the same way in similar circumstances?

The future

Dr. Chassin wrapped up his presentation by introducing the audience to the Joint Commission Center for Transforming Healthcare. This initiative was begun in 2009 with the collaboration of some of the nation’s leading hospitals and health systems with the aim to solve healthcare’s most critical safety and quality problems through dissemination of targeted solutions to healthcare’s complex problems. The first project to be addressed was hand hygiene followed by hand-off communication and wrong-site surgery. Although these projects are still underway, the projects’ initial information has already been posted at: <http://www.centerfortransforminghealthcare.org/>

Dr. Chassin left the audience with a question he called The Big Challenge – Can we transform healthcare into a high-reliability industry – with rates of adverse events and breakdowns in safety processes comparable to the best high reliability organizations in the world?

There is growing evidence that an integrated program results in increased patient safety, satisfaction and efficiencies.

Risk management, patient safety and quality

For many years risk management and quality functions within a healthcare organization operated independently. When the patient safety movement began gaining momentum, it was often incorporated into the risk or quality department. Over time organizations have seen where risk and quality functions have overlapped - which is primarily in the area of patient safety. This has evolved into the concept of integrating risk, quality and patient safety functions. A number of benefits can be realized from integration of these three areas. One such benefit is a greater opportunity to influence the culture of safety throughout an organization as well as more efficient utilization of resources stemming from less duplication of efforts. A frequently cited benefit is improved communication within the organization.

Three risk managers from very different organizations shared stories of how their organizations integrate these functions. There are a number of different models on which to base a collaborative program which the following information will show.

Nancy Bork is the Director of Risk Management at Edward Health Services Corporation in Naperville, Illinois. The system includes a 309 bed community hospital, a free standing emergency department, a 92 bed free standing psychiatric hospital and two urgent care facilities. Nancy reports to the VP General Counsel. They do not have a designated patient safety officer and there is a risk management liaison at each of the off campus facilities. Risk, quality and patient safety

plans are integrated into one plan. Strategies to support team collaboration include having risk management and clinical excellence occupy the same physical space. They meet as a group on a monthly basis and share projects.

A daily unusual occurrence summary is distributed to a multidisciplinary group and monthly board reports combine information and are not fragmented, individual department reports. These reports are often centered around various themes such as falls, retained foreign bodies, and performance improvement efforts. A key to effective collaboration is to delineate accountability so that each department knows the functions for which they are responsible and accountable. They have also brought a patient in to tell their story which has proved to be an effective approach. They involve staff in the RCA process as appropriate.

Sue Ullrich is the Manager of Quality/Patient Safety and Risk at Campbell County Memorial Hospital in Gillette, Wyoming. Campbell County is a tax supported organization that is DNV accredited. It is governed by a publically elected board and all board meetings are televised. The full service hospital is licensed for 90 beds and the long-term care facility is a 150 bed facility. There is an affiliation with Wyoming Orthopedic and Rehabilitation Institute and several clinics. The hospital is designated as an area trauma hospital by the State of Wyoming. Ms. Ullrich reports to the CEO. The department staff consists of two additional RNs, a department secretary and the Utilization Review Nurse.



The Medical Staff Coordinator reports to the Quality/Safety Department. The department plans are separate. Sue also chairs the Quality Committee which is a board committee. Primary responsibilities of the department include maintaining voluntary accreditation, meeting CMS standards, physician quality activities (including peer review and data collection for credentialing), incident reporting system and response, conducting RCAs and FMEAs, core measure data abstraction and improvement efforts. There is longevity in the staff and they are crossed trained.

Lori Chabot is Director of Risk Management at Exeter Health Resources in Exeter New Hampshire. Exeter is a not-for-profit 100 bed community hospital which services 38 towns in the New Hampshire seacoast region. The organization also includes Core Physicians, Rockingham Visiting Nurse Association and Hospice, a health and fitness center and a 26 bed sub-acute, rehabilitation facility. Risk Management reports to Quality Management and there is no designated Patient Safety Officer. Lori is a graduate of the ASHRM Patient Safety Foundation Fellowship Program which she stated has been very helpful.

She receives all incident reports. Patient Safety is viewed as an overlap between Quality and Risk Management and functions for all three areas are delineated. Lori provides orientation for staff and physicians providing them with a reading list and DVD list to facilitate further education. A case review, reported through quality, is conducted every Tuesday morning. All staff who was involved are invited including physicians, ancillary staff and environmental staff. State statutes are discussed at the beginning of the meeting and the methodology to be used for reviewing the case is presented. Attendees from the outside sign a confidentiality agreement. A Best Practice Committee and a Pediatric Practice Committee have been implemented as a result of the case reviews. Other strategies used to encourage sharing of information are to encourage storytelling and family meetings.

Each organization must decide the best model on which to build their patient safety program. Although with any model the evolution of a solid program takes time, there is growing evidence that an integrated program results in increased patient safety, satisfaction and efficiencies.

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