CHAPTER

1

DEVELOPMENT OF A RISK MANAGEMENT PROGRAM

JANE J. McCAFFREY, SHEILA HAGG-RICKERT

LEARNING OBJECTIVES

- To be able to describe the key elements necessary to have a successful risk management program
- To be able to discuss three barriers for successful risk management program development and provide at least one strategy for overcoming each
- To be able to discuss one nonclinical area of related risk for a health care organization
- To be able to identify the various organizational structures that can be successful in implementing a risk management program

Organizations and individuals have always sought ways to identify and reduce the risks that threatened their existence. In primitive agrarian societies, where families and villages produced barely enough to meet their most basic needs, the loss of a year's harvest, whether to forces of nature or to the plunder of warring tribes, surely spelled disaster. The attempts of such cultures to protect their food supplies and other necessities of life from destruction by fire, flood, and theft represent history's earliest risk management efforts. As societies developed into industrialized economies, individuals and organizations continued to seek ways to understand and anticipate the risks associated with such perils in an attempt to protect valuable property from such threats, ultimately establishing mechanisms for transferring the financial consequences of such losses through policies of insurance.

Despite the age-old concern with protecting assets from the risks associated with **accidental losses**, **risk management** has existed for only about fifty years.[1] Health care risk management in its present form did not really begin to emerge until the **malpractice** crisis of the mid-1970s, when hospitals and other health care entities experienced rapid rises in claims costs, and subsequently insurance premiums, and witnessed the exit of several major medical professional liability insurers from the market.[2] This crisis formed the basis for health care entities to develop the first risk management programs. The **American Society for Healthcare Risk Management** (**ASHRM**; formerly known as the American Society for Hospital Risk Management) was established in 1980 in response to this developing interest in risk management among health care organizations. Over the years, health care risk management has moved from a discipline focused almost exclusively on medical professional liability issues to a profession concerned with all of the risks associated with accidental losses facing a health care organization.[3] In addition to hospitals, managed care organizations, long-term care, and **ambulatory care**, other providers of health care have come to realize the value of effective risk management and have developed formalized programs.[4] Increasingly, risk management is moving toward the concept of enterprise risk management and considering the myriad of complex legal, regulatory, political, business, and financial risks facing health care organizations. As risk management moves toward this more strategic orientation and risk management professionals prepare themselves for new roles as **chief risk officers**, such factors as diverse work experience, higher education, and broad-based business, financial, and technical skills will be valued in health care risk management professionals more than ever before.[5] Another recent development in risk management has been the return focus on **patient safety**.

The patient safety movement was prompted in large part by the 1999 publication of *To Err Is Human: Building a Safer Health System,*[6] which articulated the findings of an Institute of Medicine study of the devastating consequences of widespread medical **error** in the nation's hospitals. Risk management professionals who had long had **primary** responsibility for investigating, analyzing, and maintaining data regarding adverse patient **incidents** joined with colleagues from performance improvement, health care administration, and a variety of clinical disciplines in an attempt to systematically identify the

underlying causes of medical errors in their organizations and to design and implement effective interdisciplinary organizationwide patient safety programs.

KEY CONCEPTS

- Risk management as a discipline is focused on all risks of an organization.
- An effective risk management program incorporates several building blocks, including key structural elements, sufficient scope to cover all organizational risks, appropriate risk strategies, and written policies and procedures.
- Risk management as a process uses a five-step management decision-making model.
- Risk management programs protect organizational assets through the delivery of safe patient care.
- Risk management program responsibilities vary in terms of organizational structure, size, scope of services, available resources, management commitment, and location.

RISK MANAGEMENT PROGRAM DEVELOPMENT

Whatever the health care setting or the sophistication of the risk management professional, an effective risk management program requires certain elementary building blocks: key structural elements, sufficient scope to cover all applicable categories of risk, appropriate risk strategies, and written policies and procedures. This chapter focuses on these building blocks, giving the novice risk management professional guidance in developing a comprehensive risk management program and providing the experienced risk management professional with a program overview that may be used as a self-assessment guide.

Developing a comprehensive risk management program depends on addressing several specific considerations. An effective risk management effort is built on key structural elements that enable the risk management professional to develop and enforce a risk management plan and enact the necessary changes in organizational policy. The program must include a defined scope of risks to be managed, including an examination of the risks associated with patients, medical staff, employees, governing bodies, property, automobiles, and other risks that subject the health care organization to potential liability or the threat of **loss**. Risk management strategies represent the mix of techniques employed to prevent or reduce potential losses and preserve the organization's assets.

The final building block is a set of written policies and procedures that ensures program uniformity and consistency and assists in communication of the program to affected parties. This chapter describes how each of these four important considerations contributes to an effective risk management program.

KEY STRUCTURAL ELEMENTS OF THE RISK MANAGEMENT PROGRAM

The exact structure of a health care organization's risk management program depends on the size and complexity of its functions and the scope of other services that it offers. Several key structural components are necessary for any health care risk management program to succeed. Whether an entity is just beginning to organize its risk management program or is seeking to revamp or expand an existing program, attention to these structural factors will help ensure that the program has a solid foundation.

Authority

The risk management professional in a health care organization must maintain sufficient authority and respect to enact the changes in clinical practice, policies and procedures, and employee and medical staff behavior that are necessary to fulfill the purpose of the risk management program. The risk manager must deal on a daily basis with highly sensitive and confidential information that directly affects the organization's public image and financial status. The risk management professional is responsible for coordinating risk management activities with members of the medical staff and outside parties and with managers and employees at all levels of the organization. For these reasons, the risk management professional's position should be relatively high in the organizational hierarchy. Ideally, the risk management professional should report directly to the CEO, or at least to another member of the senior administrative management team. Risk management professionals whose positions rank below the department manager level on the organizational chart will almost certainly face difficulty in dealing authoritatively with medical staff, nursing administration, and department managers. They may also have difficulty gaining access to senior management and representing the organization in its relations with insurers, attorneys, and other outside parties involved in the risk management process. In many nonhospital health care organizations and in smaller hospital facilities, the designated risk management professional may serve primarily as a senior manager or clinician and devote only a relatively small percentage of work time to risk management activities. Under such a model, risk finance and insurance program administration are typically handled by the organization's finance department, workers' compensation programs are managed by human resource personnel, and safety programs are developed and overseen by a facility or maintenance manager. Although this division of labor might be efficient for apportioning the workload required for a successful risk management effort, it creates special challenges when establishing ownership of the risk management function and creating an identity for those activities that comprise risk management. Such part-time risk management professionals, especially those who view their risk management

responsibilities as subordinate to their other job duties, might find it difficult to acquire the wide range of expertise necessary to adequately fulfill their risk management obligations and to stay abreast of rapidly changing and often complex legal and regulatory developments affecting the field.

Visibility

The risk management professional should be highly visible in the health care organization. No one individual can perform every function of a comprehensive risk management program single-handed, even in the smallest health care facility. Therefore, it is necessary for the organization's risk management professional, through consciousness-raising, education, and communication, to foster an awareness of risk management practices and techniques among senior management and the governing body, medical staff members, and employees at all organizational levels. The risk management professional's position should be structured to enhance opportunities for interaction with others through service on appropriate committees, participation in educational activities such as employee orientation and staff in-service offerings, and access to organizationwide communication mechanisms.

Communication

As health care facilities have merged into alliances and networks and acquired physician practices, clinics, and managed care organizations to form integrated delivery systems (**IDS**s), additional issues relating to potential liability, insurance coverage, claims management, and loss control have emerged. To anticipate risk management pitfalls and opportunities in this environment, the risk management professional must be an insider who is provided with information on proposed mergers, acquisitions, and joint ventures early in the due diligence process. Equipped with such information, the risk management professional is in a position to advise senior management on the risk management implications of various new business arrangements, many of which can be substantial but are frequently overlooked by executives not attuned to risk management issues and specific insurance requirements.

Coordination

Because of the wide range of risk management functions and the diversity of activities necessary for a successful risk management program, the health care organization should establish both formal and informal mechanisms for the coordination of the risk management program with other departments and functions. To adequately integrate and coordinate risk management with other functions, the risk management professional needs to establish reporting and communication relationships with key individuals within the organization:

- The *chief executive officer* (**CEO**) provides a vital link to the entity's governing board and medical staff and establishes the necessary support for the risk management program. The CEO serves as the key decision maker for many activities crucial

to the risk management program, such as authorizing the settlement of larger claims and establishing insurance limits. Furthermore, the CEO often heads the team of senior managers responsible for the development of new business opportunities, mergers, and acquisitions.

- The *chief financial officer* (**CFO**) may have multiple risk financing responsibilities and provides valuable information for the risk management program. These functions include establishing limits on **self-insured retentions** or trusts, monitoring the financial operations of captives, and overseeing the performance of actuarial analyses. In some organizations, the CFO is the primary purchaser of insurance coverages and must therefore rely on information provided by the risk management professional to make appropriate decisions regarding risk financing activities on behalf of the organization.
- The *performance improvement* or *quality management director* serves as an important source of information regarding adverse clinical events occurring within the facility that have potentially serious risk management implications. The risk management standards promulgated by **The Joint Commission** (until 2007 known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) emphasize the interdependence of risk management and performance improvement activities.[7] Both the development of proactive patient safety initiatives and an effective root cause analysis process for post-occurrence **sentinel events** depend on the active leadership and close coordination of the risk management professional and performance improvement director. The performance improvement director may also be able to assist a risk management professional who lacks clinical training in interpreting and analyzing information contained in medical records, and in providing clinical loss prevention services.
- The *patient safety director* or *officer* is responsible for systematically analyzing the sources of human error and systems issues that affect patient care. Patient safety directors or officers may report to the risk management professional or performance improvement director or to senior management in a health care organization. Patient safety directors or officers are very involved in the development of clinical risk management loss prevention initiatives.
- The *compliance officer* guides the development of policy and staff education efforts related to legislative and regulatory initiatives such as **HIPAA**, Sarbanes-Oxley, and Medicare fraud and abuse prevention.[8]
- The *infection control practitioner (ICP)* provides information on patient infections that might give rise to liability claims and can assist the risk management professional in understanding infection control protocols aimed at reducing the frequency and severity of hospital-acquired infections and establishing guidelines for coping with AIDS, tuberculosis, and other communicable diseases.
- The *safety officer* may have primary responsibility for, or assist the risk management professional in, performing fire safety, hazardous materials management, emergency preparedness, and employee safety activities in compliance with Joint Commission standards. The safety officer usually chairs the organization's safety committee, which serves as a vital source of risk management information and organizational problem solving.

- The *patient representative (*or *ombudsman)* relays information regarding patient complaints and works with patients and families who have experienced difficulties with the organization or specific staff members to reach satisfactory resolutions of their concerns. Patient representatives, whether employees or volunteers, must be trained to recognize and appropriately manage risk management concerns that arise in the course of their activities and to relay information to the risk management professional.
- The *employee health nurse (*or *workers' compensation coordinator* or *personnel director)* may, in some organizations, manage the daily operational aspects of the facility's workers' compensation program and provide claims and injury information to the risk management professional. Often this individual is instrumental in developing transitional return-to-work and other injury management programs. The risk management professional in some health care organizations is personally responsible for the operation of workers' compensation programs but must nonetheless coordinate activities with the human resource director and various line managers.
- The *health information manager (*or *medical records director)* notifies the risk management professional of requests from attorneys for medical records that might signal initiation of legal proceedings or claims. The health information manager also develops policies and procedures relating to the documentation of patient care activities, patient confidentiality, and appropriate release of information and ensures the organization's compliance with HIPAA privacy requirements.
- The *medical director (*or *chief medical officer)* serves as a liaison between the risk management program and the medical staff and assists the risk management professional in "selling" risk management to physicians. The risk management professional must also work with the medical staff services professional to ensure that the organization's medical staff appointment, credentialing, privileging, and disciplinary procedures are conducted in accordance with sound risk management practices.
- The *patient accounts representative* works with the risk management professional to identify patient complaints and concerns that surface during the billing and collections process. Such concerns may be based on perceived patient care problems. They hold the potential for becoming liability claims if collection efforts are vigorously pursued.
- *Nursing and departmental managers* offer the risk management professional the technical and clinical expertise necessary to identify and analyze potential patient care risks and assist with the investigation of liability claims and incidents. Middle management personnel also play a crucial role in building and maintaining support for the risk management program and in educating and raising the risk management consciousness of employees within their areas of responsibility.
- The *education director (*or *in-service program coordinator)* assists the risk management professional in identifying staff education needs pertaining to risk management and in planning, organizing, and presenting orientation and in-service education programs.
- The *human resource director* maintains responsibility for developing effective job descriptions and performance appraisal processes, employee background checks and competency testing, verification of licenses and certifications, and maintenance of a

drug-free workplace, all of which are crucial to the prevention and defense of medical professional liability actions. In addition, the human resource staff generally take the lead in preventing and managing claims and complaints related to issues such as alleged sexual harassment, discrimination, and wrongful termination.

Accountability

Just as risk management professionals need sufficient authority to perform assigned functions, they should be held accountable for that performance. Every health care organization's risk management professional, including those in small institutions that have job duties in addition to risk management, should have a written job description that outlines key risk management responsibilities. Annual performance appraisals assessing the risk management professional's achievement of specific, measurable risk management goals and objectives should be conducted to gauge and document the individual's effectiveness. The risk management professional should submit an annual report to senior management and the governing body that summarizes claims, insurance, and risk management program activities and documents the progress made toward the attainment of established goals.

SCOPE OF THE RISK MANAGEMENT PROGRAM

The purpose of a health care risk management program is to protect the organization against risks associated with accidental losses, regardless of the cause. One of the building blocks of an effective program is sufficient scope to cover all potential sources of risk. Although many risk management professionals focus on the medical professional liability aspects of health care risk management, the discipline extends into many other areas that are equally important to the survival of the modern health care organization. Defined broadly, health care risk management is concerned with a tremendous variety of issues and situations that hold the potential for liability or casualty losses for the organization. To be truly comprehensive, a risk management program must address the full scope of the following categories of risk:

- Patient care–related
- Medical staff–related
- Employee-related
- Property-related
- Financial
- Other

Patient Care–Related Risks

Over the course of the last several years, U.S. health care institutions and practitioners have once again experienced a "malpractice crisis" evidenced by rising jury verdicts,

settlement amounts,[9] insurance premiums,[10] dwindling insurance availability due to carrier withdrawals from the medical malpractice market,[11] and the imposition of more stringent underwriting criteria.[12] The reduction in insurers' investment income resulting from the general economic downturn in the early part of the twenty-first century and the huge unanticipated insurance losses associated from the terrorist attacks of September 11, 2001, only served to exacerbate the worsening trends for health care medical professional liability insurers and their insureds.

Given the substantial proportion of total health care risk management costs associated with medical professional liability claims and insurance premiums and the current national focus on patient safety issues, it is not surprising that most health care risk management efforts begin with patient care–related issues. Patient care or clinical risk management, including information gathering, **loss control** efforts, medical professional liability risk financing, and claims management activities, forms the core of most health care risk management programs. Although most patient-related risk management activity focuses on direct clinical patient care activities and the consequences of inappropriate or incorrectly performed medical treatments, other important patient-related issues also confront the risk management professional, including the following:

- Confidentiality and appropriate release of patient medical information, especially in light of HIPAA and other privacy requirements
- Protection of patients from abuse and neglect and from assault by other patients, visitors, or staff
- Securing appropriate informed patient consent to medical treatment
- Nondiscriminatory treatment of patients, regardless of race, religion, national origin, or payment status
- Protection of patient valuables from loss or damage
- Appropriate triage, stabilization, and transfer of patients presenting to dedicated emergency departments (DEDs)
- Patient participation in research studies and the use of experimental drugs and medical procedures
- Utilization review decisions related to the timing of patient discharges and the provision of medically necessary services under various third-party managed care arrangements
- Access to care concerns

Medical Staff–Related Risks

Closely aligned with patient care–related risk management issues are those experienced by medical staff and other clinically privileged practitioners. Many, if not most, of the

potentially serious occurrences related to the delivery of clinical patient care involve a facility's medical staff. It is imperative that the health care risk management professional include physicians in clinical loss prevention and claims management programs and elicit their support for overall risk management activities. Risk management concerns that stem from the unique relationship between a health care organization and its medical staff merit the risk management professional's particular attention. Of special importance are the following:

- Medical staff peer review and performance improvement activities and maintaining the confidentiality and protection of the data generated through such peer review processes
- Medical staff credentialing, appointment, and privileging processes
- Medical staff disciplinary proceedings, due process considerations, and potential allegations of antitrust and restraint of trade
- Identification and treatment of impaired physicians and other credentialed providers who pose a threat to patient or employee safety
- Business arrangements and financial incentives to physicians that might have fraud and abuse or other implications under federal Medicare regulations[13]
- Physician gatekeeper obligations and incentives under various managed care plans

In this era of expanding legal theories of corporate liability and vicarious liability, the activities of the medical staff are often deemed the activities of the health care organization. It has become increasingly difficult for defense attorneys to persuade judges and juries to distinguish between the institution and its independent contractor physicians. As physicians become business partners with health care entities and assume ownership interests in new ventures, and as hospitals and other organizations purchase or assume management of physician practices, the distinctions become even more blurred.

Employee-Related Risks

Several issues relating to the employment of personnel deserve the health care risk management professional's attention. Of obvious importance is maintaining a safe work environment for employees, reducing the risk of occupational illness and injury, and providing for the treatment and compensation of workers who suffer on-the-job injuries and work-related illnesses. In this regard, it is important that risk management professionals maintain a working knowledge of relevant state workers' compensation laws and regulations promulgated by the federal Occupational Safety and Health Administration (OSHA). Such understanding allows them to work effectively with human resource departments, employee health nurses, and designated safety officers to establish successful employee injury and management programs.

Posing particularly serious problems for today's health care organization are allegations of discrimination in recruitment, hiring, and promotion based on age, race, sex, national origin, or disability; wrongful termination; and other claims filed with the Equal Employment Opportunity Commission (**EEOC**). Claims involving alleged sexual harassment are also increasingly common.[14] The risk management professional must work closely with the facility's human resource director to help minimize such claims exposures, manage the claims that do occur, and finance the costs associated with such losses.

Property-Related Risks

Many complex health care entities have significant property assets, including large hospital and clinic structures, medical office buildings, and valuable medical and data processing equipment. It is incumbent on the risk management professional to protect these assets from risk of loss due to fires, acts of God, floods, natural disasters, and other perils that might damage or destroy such property. In addition, health care institutions typically maintain a large volume of paper and electronic records that are essential to the ongoing operations of the entity, and they must be protected from damage or destruction. Obviously, the costs associated with repairing and replacing damaged assets can be significant, and the revenues lost during the period of business interruption can have disastrous effects on the organization.

Many health care employees routinely handle cash, checks, and credit cards in the course of their job duties. Hospitals and nursing homes are often requested to safeguard cash and other valuables belonging to patients and residents. Home health workers, who function independently and without direct supervision in a client's home, are particularly vulnerable to allegations of theft. Thus it is important for the risk management professional to evaluate hiring and screening protocols for such workers, to review policies and procedures for handling cash and safeguarding valuables, and to consider various bonding and insurance alternatives to adequately protect the facility from such losses.

Financial Risks

Although the ordinary business risks associated with new ventures or services and the continued financial viability of the organization's existing operations are traditionally considered to be outside the sphere of risk management concerns, there are at least two areas of financial risk with which the risk management professional must be concerned.

First, the directors and officers of health care organizations, like those of other corporate entities, may face liability imposed by suits from shareholders or others alleging inappropriate conduct in the fulfillment of the directors' and officers' duties. Corporate charters and bylaws frequently require the entity to defend and indemnify its directors and officers against such claims. Likewise, the entity itself may be

named in such actions. It is therefore important for the risk management professional to understand the corporate structure of the organization; any requirements imposed by the charter, bylaws, or other documents; and the opportunities to transfer such risks through policies of insurance, to adequately protect the organization's assets.

Second, risk management professionals who represent the interests of health care providers who contract with managed care organizations (**MCO**s) on an "at-risk" basis (typically through capitated payment arrangements) need to consider available options for limiting the financial risks inherent in such agreements. These risks may be characterized as either specific, in which case the costs associated with providing care to an individual plan subscriber greatly exceed expectations, or aggregate, in which case the total costs of providing required health care services under the plan agreement are higher than anticipated. Various options exist for contractual transfer of risks above a certain level back to the MCO or for the purchase of "stop-loss" insurance coverage.

Other Risks

There are, of course, other areas of potential concern for the health care risk management professional. Among these are property and liability losses related to the operation of automobiles, trucks, vans, and ambulances owned or leased by the organization. Many facilities also own or operate helicopters or fixed-wing air transport services or maintain heliports or helipads that pose additional liability and property risks.

Since September 11, 2001, U.S. health care institutions have become increasingly aware of their vulnerability to terrorist and bioterrorist attack. Organizations have sought to augment existing disaster and emergency preparedness plans to address scenarios in which the facility itself is the target of such an attack and those in which the institution plays a key role in triage and treatment response to an attack occurring elsewhere. Planning for such contingencies requires an analysis of patient care, employee-related and property-related risks of potentially staggering proportions, and the coordination of resources on a local, statewide, and national level.[15] (For more information on emergency management, see Chapter Sixteen.) Although typically representing a lesser proportion of the total cost of risk, hospitals and most other health care entities are accessible by the public and vulnerable to a wide variety of general liability claims stemming from visitor injuries caused by slips, falls, and other mishaps. The risk management professional must therefore be concerned with the overall maintenance of buildings, parking lots, and sidewalks and with visitor access and supervision.

Hazardous materials management is yet another area of concern for health care risk management. Ensuring that appropriate protocols are in place for the safe storage, use, and disposal of the myriad toxic chemicals and radioactive materials routinely used by health care organizations is a highly regulated and important risk management activity.[16] The implications for patients, employees, and the community at large should

such materials find their way into the environment are chief considerations in managing hazardous materials programs. Proper disposal of infectious biological waste generated by hospitals and other health care entities continues to be a significant public health and environmental concern.

Special issues involving auxiliary personnel and other volunteers who may provide services at hospitals and students involved in clinical training experiences who sustain injuries in the course of their duties or may inflict harm on others also merit the risk management professional's attention. Such individuals may not be routinely covered under the organization's workers' compensation and liability insurance programs, and the risks pertaining to both groups must be specially considered by the risk management professional from both a **risk financing** and **loss prevention** perspective. Requirements for training and supervision of volunteers and students and clearly delineated duties appropriate for such nonemployees must be adequately defined.

For senior-level health care risk management professionals rising within their organizations to the level of chief risk officer (CRO), an even larger universe of potential risks merits attention. The CRO concept was developed initially in the banking and financial services industries to describe the role of a broadly experienced executive charged with responsibility for identifying and analyzing risks to an organization, whether or not insurable, developing strategies for handling such risks, and advising the governing board and senior management team. While still rare in health care settings, CROs often address issues ranging from the risk of increased market competition to the risk of regulatory sanctions if a certain course of corporate conduct is pursued and typically work closely with an organization's internal audit, legal, and finance departments to formulate risk identification, loss prevention, and risk financing strategies.

THE RISK MANAGEMENT PROCESS

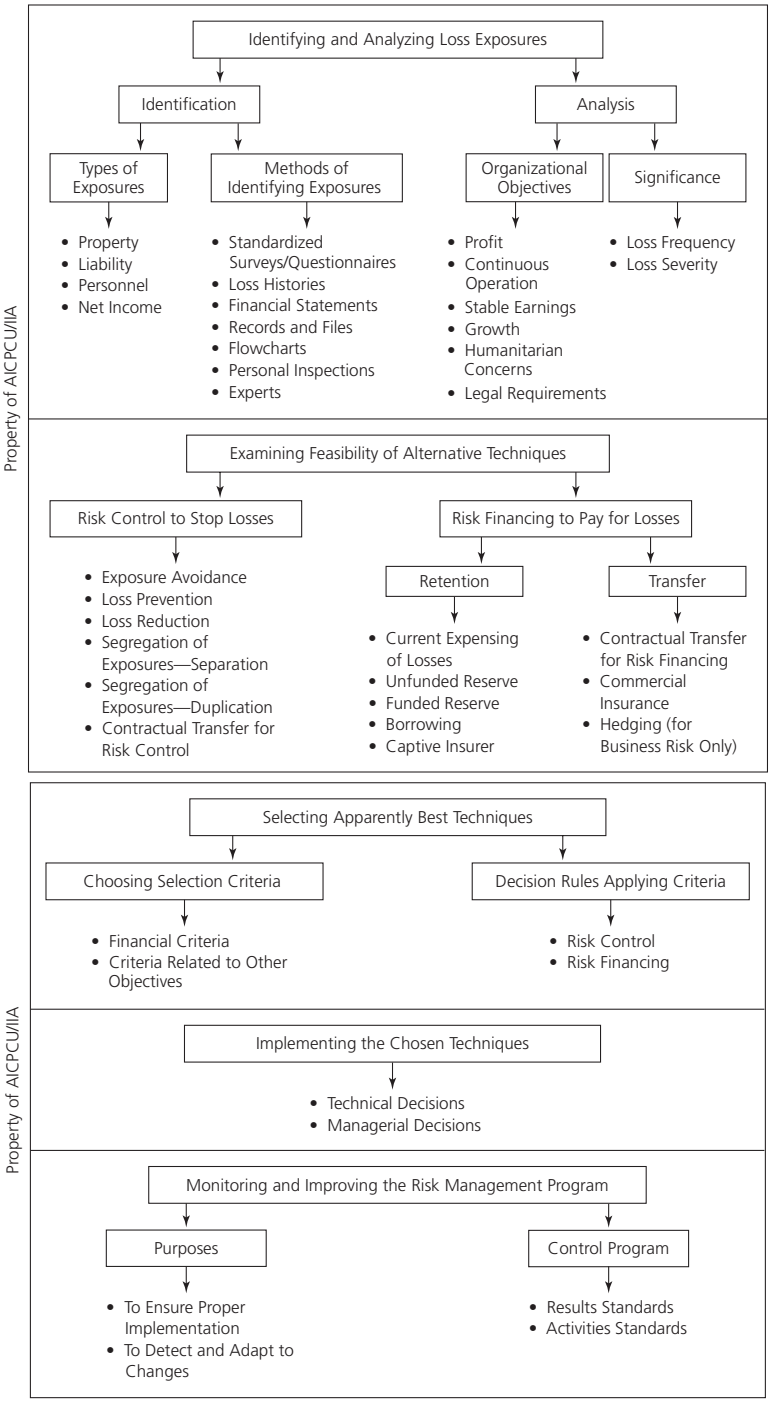
Viewing risk management as a process helps the risk management professional set priorities and assists in ensuring a comprehensive risk management effort. The risk management process consists of five steps (see Figure 1.1):

1. Identify and analyze loss exposures.
2. Consider alternative risk techniques.
3. Select what appears to be the best risk management technique or combination of techniques.
4. Implement the selected techniques.
5. Monitor and improve the risk management program.[17]

The sections that follow describe how each step of the risk management process should be considered in developing a comprehensive risk management program.

FIGURE 1.1. Steps in Risk Management Decision Making

Source: George L. Head and Stephen Horn II, *Essentials of Risk Management*, 3rd ed., vol. 1 (Malvern, PA: Insurance Institute of America, 1997), p. 15. Reprinted with permission.



Step 1: Identify and Analyze Loss Exposures

Risk identification is the process whereby the risk management professional becomes aware of risks in the health care environment that constitute potential loss exposures for the institution. Such exposures can include loss of financial assets through liability judgments and out-of-court settlements or casualty losses to physical plant and property, human losses through death or injury of employees, and intangible losses to public image and reputation.

The risk management professional uses many information sources to identify potential risks. **Incident reporting**, in which employees report accidents and occurrences not consistent with normal operating routines or expected outcomes, is the cornerstone of most risk identification systems. Incident reporting systems range from sophisticated point-of-service electronic reporting and analysis packages to simple paper forms. Regardless of the format, incident reporting systems allow caregivers to provide the risk management department with basic early warning information about occurrences that are inconsistent with normal, expected patient care processes and that result (or have the potential to result) in injury to patients, visitors, staff, or property. Other common risk identification processes include the following:

- *Generic occurrence screening.* Generic occurrence screening is a risk management process often performed as part of a health care organization's performance improvement program. In a generic occurrence screening process, patient records are reviewed retrospectively to determine whether the care provided meets specific predetermined criteria. Generic screening criteria of interest to the risk management professional might include "Did the patient sustain a fall during this admission?" or "Were all medications administered as ordered?" Although generic occurrence screening often provides information that duplicates that reported through incident reports, the systematic nature of the process may capture incidents that should have been reported but were not. The major disadvantages of generic occurrence screening from a risk management perspective are the time lag inherent in reviewing records retrospectively and the fact that only incidents meeting preselected criteria will be identified though the process.
- *Patient complaints and satisfaction survey results.* Survey data tallied by patient representatives (or community relations or marketing departments) is another source of risk management information. Such survey results may provide insight into individual patient issues and may offer aggregate trend data regarding patient experiences with the health care organization.
- *Prior medical professional liability, property and casualty, and workers' compensation claims data.* The analysis of such claims is a frequently used and valuable risk identification tool. By studying the specific services, procedures, and activities that have resulted in claims against the organization in the past, the risk management professional is in a better position to anticipate future areas of concern and take appropriate action to mitigate subsequent losses.
- *Surveys by The Joint Commission, the National Committee on Quality Assurance (NCQA),*[18] *liability or other insurers, and risk management consultants.*

Such survey processes help the risk management professional identify sources of potential risk that might have previously been overlooked by the organization. Outside experts and consultants draw on their experience to provide insight into the risk identification process for the organization and compare the organization's performance with national standards, pointing out areas meriting the risk management professional's additional attention.

- *State licensure surveys.* These surveys play an important role in risk identification. Although sometimes less important in hospitals and acute care settings, state surveys are an important part of risk management programs in long-term care facilities and outpatient settings. Findings from such surveys frequently identify areas of concern for risk management and performance improvement and guide loss prevention efforts.
- *Contracts, leases, and other agreements.* A review of salient contract provisions entered into by the organization frequently reveals risk exposures that must be addressed through modification of the contract or agreement, insurance, or enhanced loss prevention activities.
- *Information generated through the facility's infection control and performance improvement functions.* The data generated through such related functions should be routinely reviewed by the risk management professional to the extent permitted by law. (Concerns have been expressed in some jurisdictions that free access to medical staff peer review information by a risk management professional, who might use it in part to prepare for the defense of medical professional liability claims, may waive statutory protections provided under state peer review protection statutes. Seek the counsel of an attorney with expertise in this area when developing a mechanism for reviewing such information.)
- *Informal discussions with managers and staff.* Line managers and other staff members are excellent sources of information about potential risks with which the risk management professional may previously have been unfamiliar.

Risk analysis is the process of determining the potential severity of the loss associated with an identified risk and the probability that such a loss will occur. Together, those factors establish the seriousness of a risk and guide the risk management professional's selection of an appropriate risk treatment strategy. Risk management professionals need to give priority to the areas of greatest potential risk of financial loss, such as an anesthesia or obstetrical mishap, even though claims in these areas may occur infrequently. Ordinarily, less emphasis is given to small claims that occur frequently, unless the total costs associated with a certain type of incident are especially significant. Although risk analysis is in part an art—a judgment call based on the training, experience, and instincts of the risk management professional—it is also a science in that certain data and objective sources of information are taken into consideration in evaluating a given risk. In particular, closed claims data, which reveal the frequency and severity of prior losses, should be reviewed to gain insight into the analysis of current risks. The organization's legal counsel, insurance brokers, and insurance carriers

may be consulted for additional information (for more information on risk identification and analysis, see Chapter Six).

Step 2: Consider Alternative Risk Techniques

Risk management techniques or treatments refer to the range of choices available to risk management professionals for handling a given risk. Risk treatment strategies include two general categories: risk control and risk financing. Risk control involves preventing losses or mitigating the magnitude of losses, while risk financing involves paying for those losses that do occur.

Risk Control Risk control includes the following treatments or techniques:

- Exposure avoidance
- Loss prevention
- Loss reduction
- Segregation of loss exposures (separation or duplication)
- Non-insurance transfer l

Exposure Avoidance

Exposure avoidance reduces the possibility of a loss to zero. Whereas other risk control techniques will reduce the frequency or severity of a loss, avoidance is the only risk control technique to eliminate any possibility for the loss to occur. When a given risk poses a particularly serious threat that cannot be effectively reduced or transferred, think about eliminating it. For example, a hospital might elect not to provide obstetrical services, thereby avoiding the risk of a birth trauma claim. Although the strategy might be very effective in terms of controlling risk exposure, it could come at the high cost of a loss of hospital mission effectiveness, market share, revenues, patient satisfaction, and medical staff relations, which could outweigh the risk management benefit of the avoidance technique.

Loss Prevention

Loss prevention as a risk control technique reduces the likelihood of an untoward event occurring and focuses on reducing the frequency of loss. Loss prevention efforts are at the core of most health care risk management programs, are proactive, and include staff education, policy, and procedure review and revision. These interventions aim to control the number of adverse occurrences without unduly eliminating potentially risky activities.

Loss Reduction

Loss reduction or minimization involves various loss control strategies aimed at limiting the potential consequences of a given risk without totally accepting or avoiding them, thus focusing on reducing the severity of losses. Loss reduction or minimization

efforts may also include risk management techniques, such as establishing and maintaining a rapport with injured patients and their families, thus limiting the severity of a loss that has already occurred. Other loss reduction treatments include prompt incident investigation, disaster and business continuity drills, written plans to support emergency management, fire drills, and building structures equipped with sprinkler and alarm systems. Also, a facility offering obstetrical services may develop a protocol to save placentas from births meeting certain criteria for pathological review. Such an examination may encourage an early settlement if the examination is unfavorable and does not support quality care. If the review does support the care rendered, the pathological findings become a defense tool in any subsequent claim against the facility or the practitioner. Although such a process does not prevent poor obstetrical outcome, it tends to reduce the potential financial consequences of such occurrences to the organization.

Accreditation agencies such as The Joint Commission have instituted formal requirements for clinical loss prevention efforts, such as prescribed root cause analysis (RCA) and failure mode and effects analysis (FMEA) processes. These analytical methodologies have long been intuitively applied by risk management professionals and are considered key patient safety and risk control activities. RCA represents a systematic approach to identifying the underlying causes of adverse occurrences so that effective steps can be taken to modify processes and prevent future losses. Through the use of FMEA, organizations analyze processes associated with high-risk procedures and clinical services so as to identify weaknesses in systems before a problem actually occurs. The processes examined need not be complex but are typically those that can have serious consequences if a systems failure occurs. The Universal Protocol, a methodology adopted by health care organizations to reduce the occurrence of wrong-site surgeries, was the result of an FMEA process.[19]

Segregation of Loss Exposures

The fourth risk control technique is segregation of loss exposures. This technique involves arranging an organization's activities and resources so that if a loss occurs, it will not affect the entire organization. Segregation of loss exposures consists of two categories: separation and duplication.

Separation Separation, when properly applied, results in the distribution of a particular activity or asset over several locations, thereby confining the extent of the loss to only a portion of the organization should a loss occur at a single location. For example, a medical supply company might distribute its inventory among multiple warehouses or purchase supplies from different vendors to reduce the potential losses associated with a warehouse or manufacturing plant fire. In a medical office, separation may be evidenced by obtaining medications from multiple suppliers and the practitioner's maintaining staff privileges at several hospitals.

Duplication Duplication results in a reserve, or substitute for a product or service, being available for use even if the primary source or activity is affected by a loss.

Keeping copies of electronic records and computer files is a form of duplication. Although duplication of records is generally a convenient method to mitigate loss, duplicate records and files should be stored off-site to prevent accidental loss.

Non-Insurance Transfer Non-insurance transfer reduces the transferor's loss exposure by contractually shifting legal responsibility for a loss through leases, contracts and agreements.

Courts often refuse to enforce non-insurance transfers which:

- Unreasonably interfere with the rights of others (against public policy); or
- Were not fairly bargained between the parties (unconscionable because they are so drastically unfair to the transferee)

Risk Financing **Risk financing** strategies include many ways to generate funds to pay for losses that risk control techniques do not entirely eliminate. These treatment techniques include both risk retention and risk transfer.

Risk Retention One strategy for managing an identified risk is risk retention. This treatment strategy involves assuming the potential losses associated with a given risk and making plans to cover the financial consequences of such losses. The retention options open to health care organizations include the current expensing of losses, using an unfunded loss reserve (an accounting entry denoting a potential liability to pay for a loss), using a funded loss reserve (a reserve backed by set-aside funds within the organization), borrowing funds to pay for losses, and providing insurance through an affiliated captive insurer.[20] Another (less thought of) form of risk retention occurs when the risk of exposure to loss is unknown and has not been identified by the organization or risk management professional, and therefore the opportunity to evaluate appropriate risk financing strategies is lost. Failure to identify a risk will result in unwitting risk retention unless insurance coverage is available under an existing policy. Risk retention is most appropriate for managing (1) risks that cannot be otherwise reduced, transferred, or avoided; (2) risks for which the probability of loss is not great and for which the potential consequences are within the institution's ability to self-fund; (3) losses that are quantifiable and predictable; and (4) small risks (such as missing dentures and eyeglasses) for which the purchase of cost-effective insurance coverage might not be feasible.

For purposes of illustration, assume that a risk management professional has identified a risk of injuries related to misdiagnosis of patients seen in the facility's emergency department. Because the hospital's governing board and administration might have identified the provision of emergency services as central to both its mission and its market-positioning strategy, the hospital is unwilling to forgo providing such services as a means of eliminating the risk. The hospital may then choose to self-insure for losses associated with injuries (retention) or perhaps purchase an insurance policy to cover such losses (a risk transfer strategy). The purchase of insurance combined with a deductible, or a program of primary self-insurance, may be a viable option to

help reduce cost. Likewise, a physician's office practice in California may elect (absent any loan covenants, mortgage restrictions, or regulatory requirements to the contrary) not to purchase earthquake insurance coverage on its office building. The risk management professional may determine that the chances of the building's being seriously damaged or destroyed in an earthquake are sufficiently remote and the costs of securing such coverage are sufficiently high to merit "going bare" for the exposure. If such a risk retention strategy is selected, it may be appropriate for the risk management professional to increase loss prevention and loss reduction efforts, such as the installation of sway bracing near sprinkler heads to reduce potential water damage in the event of an earthquake. Thus risk retention, like other available risk treatment strategies, should not be viewed in isolation but rather should be regarded as part of an overall strategy for managing an identified risk.

Risk Transfer Contractual transfer techniques for risk financing involve shifting the financial obligation for a loss, but not the ultimate legal responsibilities for losses, to an outside entity through the purchase of insurance from a third-party, unaffiliated insurer or noninsurance transfer through a contract provision, commonly described as a hold-harmless agreement. Through **risk transfer**, an institution can continue to engage in a risk-producing activity while transferring the financial risk of loss to another party. For example, a hospital may purchase a medical professional liability policy to pay for any losses associated with medical malpractice, thereby transferring the financial obligation for the loss to an insurance company while remaining legally liable for patient injuries caused by the **negligence** of its staff.

Step 3: Select the Best Risk Management Techniques

Selecting the best risk management technique or treatment for a specific situation is a two-part activity. The first part requires forecasting the effects that the available risk management options are likely to have on the organization's ability to fulfill its goals. The second is defining and applying criteria that measure how well each alternative risk management technique contributes to the organization's objectives in a cost-effective way.[21] For most identified risks, the health care facility will employ a combination of risk treatment and risk financing techniques to manage a given risk. At a minimum, one risk control technique and one risk financing technique should be combined to address each significant exposure. The risk management professional may elect to employ any available combination of risk control and risk financing techniques to obtain the desired results. Typically, health care organizations accept a certain amount of patient care liability risk through an insurance deductible or self-insured retention; attempt to limit potential risk by not offering some inherently high-risk services; seek to reduce the severity of loss for incidents that have already occurred through prompt incident investigation and claim resolution; prevent future losses through in-service education, appropriate staffing, and credentialing; and transfer the remaining financial risk by purchasing insurance.

Step 4: Implement the Selected Techniques

The implementation process involves both the technical risk management decisions that must be made by risk management professionals and the related decisions that are made by other managers within the organization to implement the chosen risk management techniques. Technical expertise exercised by risk management professionals may include selecting an appropriate insurer and choosing appropriate policy limits and deductibles. In working with managers and other personnel, risk management professionals advise and influence others in implementing selected techniques that are not within their direct areas of responsibility.

Step 5: Monitor and Improve the Risk Management Program

The final step in the risk management process is to evaluate and monitor the effectiveness of the risk management program by assessing the adequacy and appropriateness of the techniques employed to identify, analyze, and treat risks. Risk management evaluation involves not only the risk management professional but also senior management, medical staff and governing board, insurers, claims managers, and legal counsel. A multidisciplinary approach to evaluating the risk management program ensures that the impact of risk management activities on various constituencies is measured accurately and that additional opportunities to improve the risk management function are fully explored. To facilitate the risk management evaluation process, the risk management professional needs to prepare a comprehensive annual report of risk management efforts, highlighting significant claims activity, new program developments, changes in insurance coverage, and contractual modifications having risk management significance. These results should be compared against clearly defined benchmarks that have been identified in advance of the review. Such benchmarks can be internal or external to the organization and may be as simple as comparing the current program results against those from the previous year. The risk management professional can also use data from independent but similar organizations against which to benchmark. Benchmarks frequently include a comparison of claims data. Claims data provide frequency and severity information for losses incurred, including the number of events reported and dollars spent to defend and settle them. (For more on benchmarking and program evaluation, see Chapter Fifteen.)

EVOLUTION OF THE RISK MANAGEMENT PROGRAM

As the delivery of health care continues to change, so must the structure of risk management programs. The existing and emerging principles that apply to risk management will need to adapt to ensure safe, cost-effective, and clinically effective care. The health care organization as it is known today will be different in the future, with multiple levels and both horizontal and vertical integration. Interdependency on organizational strategic and financial goals must be integrated into risk management program development and must meet the needs of the changing customer base and payer mix. It is possible that within one organization there will be a need to create different risk

management program structures and take different steps in assessing risk management needs in the health organization's different areas.

SELECTING AN APPROPRIATE RISK MANAGEMENT PROGRAM STRUCTURE

A variety of risk management program structures can be considered, based on organizational size, scope of services and activities, available resources, and locations. Generally, acute care hospitals have preexisting systems that introduce and enhance risk management program components, whereas integrated delivery systems, long-term care settings, physician's office practices, home health care, and ambulatory care centers are less likely to have formalized risk management efforts.

The overall level of risk management responsibility can vary greatly. It can be any one of the following (or a combination, depending on organizational structure and expectations):

- *All related risk management functions.* In a traditional model, this structure requires an experienced risk management professional and a vast array of resources that can address each type of service provided within the organization. Knowledge of and experience in clinical care delivery, plant engineering, safety, claims, and finance are particularly helpful in large, multi-institutional organizations. The newest enterprise risk management model encompasses strategic planning, marketing, and even branding components. In many situations, on-site risk management coordinators integrate activities with the corporate or home office. In many smaller organizations, all related risk management activities may be managed by one department or by one person. A physician's office practice is an example where one employee may be responsible for risk management, quality improvement, safety, medical records, disaster planning, infection control, and other functions.
- *Responsibility for a set of defined risk management activities and services.* This structure continues to be the model of choice at community hospitals and hospitals in a system. Responsibility in this structure is spread among multiple departments. The coordination and facilitation of activities that affect risk management activities should still be managed and controlled out of a single office, preferably the risk management department. In this model, there are generally separate departments for safety, security, quality improvement, corporate compliance, education and in-service, risk financing, contract review and negotiating, claims administration, and so on. For example, the CFO may be responsible for the risk financing program, in-house legal administration may be responsible for the claims administration and contract review, or the director of the emergency department may be responsible for disaster planning. The hospital or other health care setting that is part of an organized health system also has a limit to the breadth and depth of risk management responsibility at the local level. In many cases, the corporate office mandates the risk financing program and

may also manage all claims. Risk management positions at the local site generally revolve around loss control activities and are far more common than control of all risk management functions. The intent of systemwide programs is to create a general operational structure that encourages consistency and cost control while allowing for flexibility, timeliness, and accountability at the lowest possible levels.

- *Role referred to external consultants or an outsourced professional.* At times, an organization may choose to supplement its risk management functions. Consistent with the consulting and outsourcing structure model is a process to internally manage the flow of information and facilitate communication. Consultative and outsourcing structures are commonly used during times of merger, acquisition, and divestiture, when the organization faces severe financial constraints, has a loss of key risk management personnel, or is undergoing reengineering efforts or management change. It is not unusual that in this structure the need still exists for a risk management professional. This individual then becomes the contact point between the outsourced organization or consultant and senior management, and the outsourced organization becomes the risk management "back room."

Regardless of the health care organization's choice of formal structure, its risk management program should incorporate the basic elements, components, and functions described throughout this chapter. All risk management activities require alignment with the organization's mission and strategic plan.

ASSESSING AREAS OF THE ORGANIZATION THAT NEED RISK MANAGEMENT

Assessment methodology may vary, but consistency in its application should be maintained. Assessment findings, and any improvement strategies, should be presented uniformly so that the organization and individuals maintain a clear understanding of the findings and resulting recommendations.

Any assessment can be approached in various ways, but most risk management professionals find that having written guidelines helps avoid overlooking key points. There are many tools from which to choose, one of which is the *Risk Management Self-Assessment Manual*.[22] Other sources can be found through literature searches and in outside organizations such as insurance companies, regulatory agencies, and consulting firms.

Identify the Various Areas for Assessment

Because assessments can take time, after evaluating basic organizational structures, the focus should usually start with high-risk, high-volume, and high-visibility areas. In multi-institutional organizations, assessments should be tailored so that organization-wide processes and institutional specific programs are assessed. This will allow for more comprehensive findings that reflect the organizational status.

In general, profiling the organization's current services and business relationships is important in identifying the various areas for assessment. The assessment process should include the organization on an enterprisewide basis, assessing it from an operational, clinical, and business perspective. This process could be viewed as taking inventory of activities that might have potential risk and as finding a starting point for developing or renewing the risk management program's focus. This inventory includes a systematic review of the organization's functions, data, budget, and workforce and a survey of perceptions about the effectiveness of systems and processes already in place. The assessment may reveal findings and needs that differ according to the organization's various areas. An example could be if an organization decides to institute a research department but lacks a defined and operational institutional review board, which could result in regulatory noncompliance and direct patient risk.

Analyzing Current Systems

The second phase of the assessment is to analyze systems that are already in place for minimizing risk and then determine current effectiveness. Profiles should include identification of key contacts and responsibilities, level and types of risk financing, contractual relationships, and risk management activities (including policies, orientation, job and credentialing requirements, integration into current organizational structure, and safety and quality program integration). Areas or topics to be inventoried may include these:

- Educational relationships—levels and types of agreements, formal or informal
- Staff relationships—employed, contracted, independent, network (where staff float from one entity of a large organization to another), or consulting (may involve the assessment of staff issues)
- Scope of services—not only types but also where and to what degree; might also include reporting relationships
- Subsidiaries owned, partnered, or otherwise associated with the organization
- Accreditations, licenses, certifications, or other designations in which any or all parts of the organization participate
- Human resource issues, with focus on preemployment screening, ongoing competency evaluation, and staffing
- Information management methodologies, computerized information and access, and other information issues such as retention and release
- Clinical technology issues—selection, maintenance, user training, and product and equipment problem-tracking systems—and level of support technology, such as bar coding and order entry software
- Level of consistent application of systems throughout the organization

- Assessment of the organizational core values, including philosophy and practice with regard to disclosure and nonpunitive environment
- Loss assessment data, **loss runs**, and results of inspection by regulatory agencies
- Credentialing and orientation processes for nonemployee staff, both initially and at reappointment
- Contract management protocols
- Safety and quality management program structure and its integration and effectiveness
- Emergency preparedness protocols and emergency management relationships external to the organization

Assessing Compliance

Risk management programs must meet not only organizational needs but also the requirements of outside entities that by choice or mandate make demands on the health care organization's operation. The managed care market may require not just a slate of activities and reporting provisions but also that certain accreditations be maintained. Rules set forth by regulatory agencies must also be factored into the activities and processes as the risk management program develops and expands. One should first review and analyze the most recent findings of all external reviews, inspections, and surveys and any reports from consultants. These reports and the status of the action taken in response, along with appropriate standards issued by various bodies, can be used to compile assessment tools that can assist in evaluating the risk management program and in planning for improvement. During this review of external demands, attention to the organization's ability to identify, track, and integrate external mandates should also be assessed.

Reviewing the Assessments

Assessments are often performed to identify risk management program strengths and opportunities for improvement. Analysis should include categorizing findings according to severity, frequency, effect on the organization's strategic plan, areas identified for improvement, and best practices identified. Good practice without supporting documentation should be assessed as both a practice strength and an information weakness. For example, even if it is identified that the patient care process might need no immediate attention, the recording or tracking of patient care information might require integration into a better-defined information process to substantiate practice patterns.

Setting Priorities for Program Implementation

Established risk management programs should undergo continuous reassessment, particularly as new areas are added or for those previously identified as weak. Regulations and other external mandates, along with areas of severe loss, should command the

most immediate attention. Organizational emphasis (what the strategic plan and the mission support) will also need to be factored into the list of areas to be addressed first. One useful tool is to map out a strategy to take advantage of the many activities that are interdependent. Some risk management activities that might seem less important may need to be initiated to lay the groundwork for success in high-impact areas. An example might be the development of user-friendly reporting or early identification tools that are adapted for the organization's various departments and services. Such a project could be multidisciplinary and supported by various areas within the organization, which can lead to an enhanced quality-improvement database. In setting priorities for program implementation, risk management professionals should clearly define the desired **outcome**. Having done an analysis, the risk management professional should be aware of the organization's strengths and weaknesses and of improvements or expansions that need to be accomplished. Preliminary work may consist of collecting data and drafting early versions of future measurement tools. Another key item is to identify levels of understanding, not only during the assessment but also once an analysis has been formulated. The result of action or inaction must be clearly defined in relation to the direct effect on the organization.

KEY COMPONENTS FOR GETTING STARTED

For any risk management program to achieve its goals, several key components must be in place. Organizational commitment—that is, acceptance of roles and support for program aspects by the various levels of leadership, starting with the board—is a necessity. Commitment is often demonstrated through assignments of responsibility, adoption of accountability systems, approval of the program, and participation in aspects requiring support and action. The ultimate goal is to integrate risk management components, systems, and strategies into the overall organizational culture of safety.

Access to all levels of the organization, with defined accountabilities and identification of resources, is also part of the initial structure formation. No risk management program can function in isolation; its integration with other initiatives, particularly safety, is crucial to its success. By relying on already established relationships, risk management professionals can enhance programs with limited resources by strengthening operational linkages and avoiding duplication of effort. Negative perceptions about the risk management program might damage its credibility before it even gets under way. Physicians often perceive that risk management's involvement after an event has occurred only makes matters worse or that the only motivation is to minimize costs. Frequently, risk management programs are viewed as reactive to crisis rather than proactive in creating a safe culture.

Risk management activities should focus on support and service, using facilitative techniques in guiding the clinicians' understanding of the nonnegotiable forces (regulatory fines, accreditations, citations, and agency requirements) and the alternatives available. Clinical staff should have input into both the risk management process and the analysis, redesign, and monitoring stages. Most program elements that affect clinical functions

require that clinical staff members become committed to risk management concepts and understand the desired outcomes. Ensuring that duplication of effort is minimized can be a key selling point to staff members in accepting their roles in the risk management effort. Simplification of any process is always welcome. A method for seeking continual staff feedback should also be developed to ensure ownership of the program by all staff.

WRITING A RISK MANAGEMENT PROGRAM PLAN

The written risk management program plan includes an overview of the purpose, structure, and process of risk management activities within the organization. Within this framework, organizational performance objectives can be developed in addition to policies and guidelines to support the identified processes that maximize achievement of the program's objectives. It is critical to maintain an integrated approach at this point of development to achieve consistency of purpose within the organization and to avoid duplication of effort. Rather than create new systems for the risk management process, the risk management professional should evaluate how best to enhance existing systems.

As with all programs that have a data collection and monitoring function, reports, memos, and minutes will be generated as communication tools. To be most effective, these tools must meet the needs of those responsible for the implementation and change of risk management and safety practices. Therefore, it is important that those served by such information have input into its ultimate design and format as a means of maximizing its usefulness. (See Appendix A for an example of a risk management program plan.)

ACHIEVING PROGRAM ACCEPTANCE

Often the quickest way to gain support for a program is to provide visibility and education on its related topics. A well-designed risk management program will not be successful unless staff members at all levels understand its purpose and methods. In some cases, the risk management professional may even provide unrelated services simply as a means to gain the acceptance and trust vital to the program's success. Often the support of an interested medical staff member serving as an advocate familiarizes others with the merits of the risk management program. The risk management program achieves visibility through participation in employee orientation and continuing education activities. A focus on the prevention aspects of risk management creates a less threatening atmosphere and aligns efforts with the increasing focus on safety. Maintaining a subject file on risk management topics such as consent, information release, falls, medication process, human factors that contribute to error-prone behavior, and credentialing allows the risk management professional to have supplemental resources when participating in education and quality and performance improvement projects. Another strategy is to become involved in the organization's efforts in responding to external initiatives or mandates such as The Joint Commission's National Patient Safety Goals, insurance carrier criteria, state licensing requirements, and conditions of participation from the Centers for Medicare and Medicaid Services.

SUMMARY

Establishing a risk management program is no simple task, particularly in today's complex health care environment. Assessment of the health care organization's internal and external relationships and forces will provide an excellent basis for the issues the risk management program must address. Establishing risk management's role in the overall safety initiatives and safety culture development must also be included in the risk management program. Obtaining commitment to the program from all levels of the organization, top to bottom, can be a slow process but must be achieved for full integration to occur. Translating a written plan into functional risk management processes requires collaboration and facilitation skills now more than ever. No matter how detailed the risk management plan may be, the program will always be evolving as it adapts to the changes in health care.

KEY TERMS

Accidental loss
Adverse occurrence
Adverse medication event
Adverse outcome
Ambulatory care
Chief risk officer
Error
Event
Exposure
Hospital-acquired infection
Incident
Incident reporting
The Joint Commission
Loss
Loss control
Loss prevention
Loss reduction
Loss run
Malpractice
Neglect
Negligence
Outcome
Patient safety
Risk analysis
Risk avoidance
Risk control techniques
Risk financing
Risk identification
Risk management
Risk reduction
Risk transfer
Sentinel event

ACRONYMS

ASHRM
CEO
CFO
CMS
CRO
DED
EEOC
FME
HIPAA
IDS
MCO
NCQA
OSHA
RCA

NOTES

1. Kuhn, A. M. "Introduction to Risk Management." In B. J. Youngberg (ed.), *The Risk Manager's Desk Reference*. Gaithersburg, Md.: Aspen, 1988.
2. Ibid., p. 1.
3. Ibid.
4. Taravella, S. "The Rise of Risk Management." *Modern Healthcare,* Oct. 8, 1990.
5. Ibid.
6. Kohn, L. T., Corrigan, J. M., and Donaldson, M. S. (eds). *To Err Is Human: Building a Safer Health System.* Washington, D.C.: National Academy Press, 1999.
7. Joint Commission on Accreditation of Healthcare Organizations. *2005 Comprehensive Accreditation Manual for Hospitals.* Oakbrook Terrace, Ill.: Joint Commission, 2004.
8. Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191); 45 CFR, Parts 160 and 164 (Aug. 14, 2002); Sarbanes-Oxley Reform Act (P.L. 107-204); 116 Stat. 746, USC, Title 15, §§7201 et seq.
9. *Medical Malpractice: Verdicts, Settlements and Statistical Analysis.* Horsham, Pa.: LRP Publications, 2002.
10. "What's Ahead on the Medical Liability Front in 2002?" *Medical Liability Monitor,* Jan. 21, 2002.
11. Ibid.
12. Ibid.
13. 42 USC 1320.
14. *Laughinhouse* v. *Risser,* 786 F.Supp. 920 (Kan. 1992); *Trotta* v. *Mobil Oil Corp.,* 798 F.Supp. 1336 (D.C. N.Y. 1992); *Jewell* v. *Palmer Broadcasting Ltd.,* Iowa Dist. Ct. No. CL94-56040, Dec. 30, 1993.
15. Gamble, R. H. "The Insurance Renewal Marathon," http://businessfinancemag.com /article/insurance-renewal-marathon-0201, Feb. 1, 2002.
16. *Hazard Communication Standard: Final Rule.* Occupational Safety and Health Administration, 29 CFR 1910-1200.
17. Head, G. L., and Kwok-Sze, R. W. *Risk Management for Public Entities*. Malvern, Pa.: Center for the Advancement of Risk Management Education, 1999, pp. 4–5.
18. JCAHO, *2005 Comprehensive Accreditation Manual;* National Committee on Quality Assurance. *NCQA Standards for Accreditation* (CR 8.0, CR 13.0). Washington, D.C.: National Committee on Quality Assurance, 1995.

19. Joint Commission on Accreditation of Healthcare Organizations. *Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery.* Oakbrook Terrace, Ill.: Joint Commission, 2004.

20. Head and Kwok-Sze, *Risk Management for Public Entities,* pp. 4–5.

21. Ibid.

22. American Hospital Association, *Risk Management Self-Assessment Manual.* Chicago: American Hospital Association, 2000.

SUGGESTED READING

Brown, B. L. *Risk Management for Hospitals: A Practical Approach*. Rockville, Md.: Aspen, 1979.

Healthcare Risk Control, published monthly by the Emergency Care Research Institute (ECRI), 5200 Butler Pike, Plymouth Meeting, PA 19462.

Hospital Peer Review, published monthly by American Health Consultants, Inc., 3525 Piedmont Road NE, Building 6, Suite 400, Atlanta, GA 30305.

Hospital Risk Management, published monthly by American Health Consultants, Inc., 3525 Piedmont Road NE, Building 6, Suite 400, Atlanta, GA 30305.

Jessee, W. F. *Quality of Care Issues for the Hospital Trustee: A Practical Guide to Fulfilling Trustee Responsibilities*. Chicago: Hospital Research and Educational Trust, 1984.

Joint Commission on Accreditation of Healthcare Organizations. *Hospital Patient Safety Standards: Examples of Compliance*. Chicago: Joint Commission Resources, 2002.

Journal of Healthcare Risk Management, published quarterly by the American Society for Healthcare Risk Management of the American Hospital Association, One North Franklin, Chicago, IL 60606.

Kraus, G. P. *Health Care Risk Management: Organization and Claims Administration*. Owings Mills, Md.: National Health Publishing, 1986.

Risk Management Pearls series, published by the American Society for Healthcare Risk Management of the American Hospital Association, One North Franklin, Chicago, IL 60606.

Rowland, H., and Rowland, B. *Hospital Risk Management: Forms, Checklists, and Guidelines*. Gaithersburg, Md.: Aspen, 1993.