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Embracing change: From volume-based to value-based healthcare

By Robin Maley, RN, MPH, MS, CPHRM, CPHQ
SVP, Healthcare Risk Management and Patient Safety

Providers today are transitioning to a value-based world. Financial rewards are no longer reaped based upon the volume of services provided, sometimes regardless of necessity or outcome, but instead upon positive patient outcomes and pleased consumers. Accountability for patients' total experience is being vigorously enforced and has risen to the forefront of providers' responsibilities. Healthcare models are changing to focus more on the health and well-being of populations, rather than on the "break-fix" model of treating individuals primarily when they experience acute episodes of illness. Emphasis is on patients' clinical, financial and emotional status, as well as their expectations, which are assessed on an ongoing basis. The needs of specific populations and cultures must be carefully considered.

The healthcare organization-provider relationship has also changed. Institutions, once focused on pleasing providers as a strategy for maintaining and growing market share, have shifted gears to become patient-centered instead of provider-centered.

For many providers, this transition is challenging. They must actively participate in cross-disciplinary teams, often as leaders, to implement measures designed to continually improve upon the value, cost and quality of patient care.

New attitudes and new models of care

Value-based reimbursement for services has gradually gained ground, but now is moving ahead full steam. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) forged the way for value-based payments, laying out specific payment plans for healthcare providers. Plans emphasize clearly that cost control and quality care are necessary

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in order for payments to be approved. As a result of the sea change focused on value versus volume, providers must change their methods and, most importantly, adopt a new mindset. They must actively partner with healthcare institutions to establish, promote, and practice within a culture of safety. These transformations in business models and ways of thinking require new skills and education. Many providers, anxious to understand the complexities of the new healthcare environment are going back to school, both literally and figuratively.

New roles, new job skills, new insights

The role of "physician executive" is fast becoming one of the most important roles in the healthcare paradigm. Innovative educational programs are preparing physician leaders and other providers to focus upon the importance of quality over quantity, patient safety and process improvement. These programs are often designed to take the provider out of his or her comfort zone by exposing them to the experiences of other industries, such as manufacturing, engineering, finance and even the airline industry.

A very strong focus has been placed on the impact of systems versus individual actions. Healthcare organizations now realize that poor outcomes can be improved when process improvements are identified and acted upon swiftly instead of blaming an individual for a patient harm event. This is not news to risk management, quality and patient safety professionals. However, concepts that promote the reduction of patient harm are not necessarily well-known to others practicing within the healthcare profession. Many clinicians may have seen risk management, patient safety and process improvement as administrative functions secondary to their provision of clinical treatments.

The role of risk managers, patient safety and quality professionals has changed, too, with increased emphasis on demonstrating value and quality. A major responsibility for these professionals is to teach all levels of healthcare workers how to implement safe, standardized and evidence-based processes that enable health interventions to reach those who need them on a timely basis. Proactive, innovative means to accomplish safety goals are imperative. Data collection is important, but the actions taken following the observance of trends and/or system breakdowns make the difference in ultimate outcomes. Herein lie the greatest challenges. Actions risk management, safety and quality professionals must take to help others embrace the value paradigm include the following:

- **Educate** – Share knowledge regarding the science of patient safety, the principles of risk management and methods of process improvement. Multidisciplinary forums, including those used after serious safety events such as root cause analyses, present an ideal opportunity to share knowledge and problem-solve as a team.
- **Engage** – Let team players know "what's in it for them." Value-added services are designed to eliminate waste and streamline activities. A more efficient and joyful workplace can equate to happier employees, better communications and better patient outcomes.
- **Strategize** – Help members of healthcare teams and departments set goals through the establishment of benchmarks that support positive patient outcomes. For example, establishing objectives to reduce infection rates can support both patient safety goals as well as financial targets through reduced readmission rates.
- **Promote** – Secure leadership support and make it well-known that providing value to patients is part of the overall mission and vision of the organization. Use social media, newsletters, broadcast emails, job fairs, posters and other means to keep the focus on providing value to patients.
- **Evaluate** – Implement realistic success monitors and use technology to ease the workload as much as possible. Modify measures as changes occur so they remain meaningful and applicable to patient care and workflow.
- **Innovate** – Support new technologies. Innovation is a clinical and cost imperative. Examples of innovations include artificial intelligence, virtual reality, telehealth and biosensors and trackers, to name a few. Innovations that target, track, prevent, monitor, and treat illnesses demonstrate value. Risk management and patient safety professionals can assist in the determination of return on investment when decisions are made regarding the purchase of new technologies by factoring in the likelihood for reduction in patient harm, improved patient outcomes and patient satisfaction.
- **Celebrate** – Create reward systems to recognize providers, staff, teams and departments that are promoting value and achieving established goals and positive outcomes for patients.
- **Sustain** – Build in systems that check for "slippage" in improvements.

The bonus

Risk management, patient safety and performance improvement efforts are bolstered by new mandates to demonstrate value. Now, goals are better aligned, and with the dedicated efforts of healthcare staff working in teams, costs can be controlled, the patient experience will be ultimately positive and outcomes improved – the overarching aim of value-based healthcare.

My view: Perinatal safety and risk reduction

By Victor R. Klein, MD, MBA, CPHRM, FACOG, FACMG, FASHRM, Vice Chairman, Quality & Patient Safety Obstetrics & Gynecology Service Line-Northwell Health

Practicing obstetrics is an exciting field of medicine because it involves bringing life into the world. However, it is a high-risk specialty associated with frequent and high-cost liability claims. For over 30 years, I have been both a perinatologist specializing in high-risk pregnancies as well a risk manager promoting patient safety and working to decrease adverse outcomes. In this commentary, I will identify current perinatal safety issues, outline methods to reduce liability exposures and review techniques that decrease perinatal risk.

Quality, patient safety and risk management are all interrelated. As quality care and patient safety strategies decrease adverse outcomes, the likelihood of liability claims also decrease. Common areas of obstetrical liability include birth injury, perinatal asphyxia and maternal death. There are a number of things that can be done to improve patient safety and reduce these risks.

The old paradigm of the hospital being the "bricks and mortar" with the private physician responsible for the patient no longer holds. Today, the hospital has an independent responsibility and duty to the patient to ensure that the care rendered is within the standard of care. Hospitals, perceived to be the deep pockets in liability claims, are often held responsible for multimillion-dollar payouts in settlements and verdicts.

Managing risks throughout the perinatal period

Every pregnancy can be divided into four stages: prenatal care, intrapartum care, postpartum care and neonatal care.

In the prenatal period, it is important to do the appropriate laboratory testing, and carry out antepartum surveillance of the fetus. This includes testing for diabetes, performing screening for genetic diseases, and conducting a pregnancy risk assessment to determine if a patient is at high risk for adverse outcomes. An emerging area of risk is failure to offer genetic screening and testing. Noninvasive tests are available to screen for chromosomal abnormalities, for example; a risk assessment is also available for maternal adverse outcomes and carrier testing is available for hundreds of genetic diseases. Standards of care now include screening tests for cystic fibrosis, fragile X and spinal muscular atrophy, and for genetic diseases found in certain ethnic groups. Failure to offer appropriate testing can result in wrongful life allegations following the birth of a neonate affected with such diseases.

In the intrapartum period, it is the management of the patient in labor that often leads to allegations of deviations in the standard of care. The proper interpretation of fetal heart monitor tracings and accurate fetal assessment during labor are important aspects of prenatal care. Accurate documentation of patient assessment during the course of labor, and a clear treatment plan are key. Obtaining informed consent for the management of the patient is recommended when interventions such as labor induction or operative vaginal delivery are considered.

Assessment of the newborn includes Apgar scores at one and five minutes. The 1-minute score determines how well the baby tolerated the birth process. The 5-minute score tells how well the baby is doing after birth, with lower scores indicating possible distress.

In my experience, performing umbilical cord blood gas analysis to assess the fetus has been critical to mitigating obstetrical liability claims. The process involves testing the arterial and venous cord blood gases for pH and base excess, objective tests to assess the neonate at birth. Claims of perinatal asphyxia are often argued based on fetal heart rate monitor tracings. However, the gold standard to assess the neonatal status is the pH and base excess. Umbilical artery cord gas reflects fetal acid-base status at birth. Low pH and an elevated base excess can indicate acidosis. The absence of metabolic acidosis precludes acidosis as a causative factor in cerebral palsy. A normal pH and normal base excess can be used to defend neonatal liability cases when it is alleged that labor is the etiology of perinatal asphyxia and subsequent cerebral palsy. I believe cord gases should be obtained after all deliveries rather than in selective cases to have objective evidence that birth asphyxia was not caused by the birth process. The majority of causes of cerebral palsy are not due to an intrapartum event.

The examination of the placenta by pathology should be performed either routinely or on selective cases. Deliveries involving fetal growth restriction, meconium stained fluid, hypertension, diabetes, elevated temperature in labor, multiple births as well as low Apgar scores are some of the

indications for examination of the placenta by a pathologist. For example, chorioamnionitis, inflammation and/or infection in the placenta, can explain the cause of preterm labor and delivery as well as increased risk of the development of cerebral palsy. The timing of the passage of meconium (neonatal fecal material) as well as abnormalities of the placenta can also be helpful in explaining the neonatal condition and are helpful to the defense of a claim of substandard care.

Shoulder dystocia, a condition of arrested labor where the infant's shoulders fail to deliver shortly after the head, is another hot spot in obstetrical liability cases. There are two tracks taken by the plaintiffs when alleging substandard care. First, that a Cesarean section should have been done and therefore shoulder dystocia would have been avoided; and second, once shoulder dystocia was encountered, that either the treatment maneuvers were not done or not performed correctly. It is important to anticipate shoulder dystocia in patients who have risk factors. It is critical to document the shoulder dystocia event and the maneuvers used to intervene clearly and accurately.

Co-management of care is an area of increasing exposure and lawsuits. This is when an obstetrician co-manages a pregnant woman with high-risk obstetrical issues such as diabetes, twins or chronic hypertension along with a generalist who relies on a perinatologist (specialist in maternal-fetal medicine) to make decisions. I have seen numerous times when there is lack of care coordination and miscommunications leading to adverse patient outcomes. It is important to clearly outline roles and responsibilities when co-management occurs to avoid communication breakdowns that can negatively impact patient care.

In the postpartum period, adequate deep vein thrombosis prophylaxis and proper assessment of maternal medical complications are critical for safe care. This includes attention to blood pressure, signs of infection and possible maternal bleeding for a safe transition to post-delivery care. Deep vein thrombosis and pulmonary embolisms in the mother are sources of adverse outcomes that can result in liability claims. It is important to do a risk assessment on every obstetrical patient during the prenatal period, including on admission to labor and delivery as well as in the postpartum period. Every patient who is admitted to should be assessed to see if she is at increased risk and implement interventions such as early ambulation, use of compression stockings or prophylactic administration of heparin as indicated to decrease the risk.

Documentation for care and safety

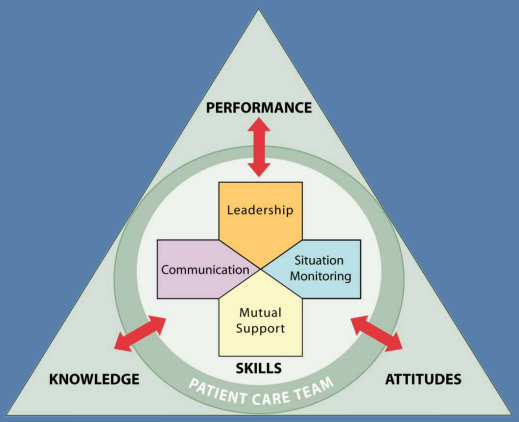
The purpose of the medical record is for ongoing patient care, but also to memorialize care that is rendered so that, at a later time, one can understand both the thought process for medical decision-making and the plan for care. It is important to take frequent notes during labor and, in particular, document discussions of medical interventions such as vacuum or forceps use, and record actions for induction of labor.

Informed consent and informed denial are also important to document. For example, when patients decline genetic testing or refuse clinical recommendations, that must be documented in the medical record. Failure to accept a flu or TDAP vaccine should be documented because the standard of care is to offer these vaccines during pregnancy when appropriate.

A formal risk and safety program needed

A perinatal patient safety and risk management program should include a robust performance improvement process that is multidisciplinary with obstetricians and other physicians, nurses, neonatologists and others, such as anesthesiologists, participating to review adverse outcomes and perform case reviews. This type of process helps to determine lessons learned and apply best practices for avoiding similar events in the future.

Creating a culture of safety is also paramount for a safe and effective labor and delivery unit. All members of the obstetrical care team should be able to escalate concerns and respectfully question the plan of care. Teamwork training and standard communication tools such as those applied in TeamSTEPPS® can reduce unsafe environments, allowing patients to be cared for by a high-functioning team with each member supporting the best possible outcome for both mother and baby.



TeamSTEPPS: Team Strategies and Tools to Enhance Performance and Patient Safety (learn more at http://teamstepps.ahrq.gov)

Medication errors: Causes and prevention

By Deborah N. Gold, RN, BSN, M.Ed., Nurse Consultant, Sr-PL

Medications can be life-saving when prescribed, prepared, dispensed, and administered to patients safely and appropriately. Yet, healthcare providers are human and, as such, imperfect. In spite of their expertise and commitment to patient care, errors and adverse events with medications occur.

Errors – such as administering the wrong drug, strength or dose; mistaking a look-alike or sound-alike drug name for another; prescribing or transcribing the wrong medication; or choosing the wrong patient from a list on the computer screen – can and do happen every day, despite best efforts. The large number of new drugs and technologies introduced each year further complicates medication use, as does a growing elderly population with chronic and acute conditions that require complex treatment strategies. Each error can be tragic and costly in both human and economic terms. According to Makary and Daniel in The BMJ, 2016, if medical error was a disease, it would rank as the third leading cause of death in the U.S., only preceded by heart disease (#1) and cancer (#2).1

Additional causes of medication errors

Lack of information about the patient
Prescribing clinicians need appropriate information about the patient for accurate drug selection and dosing. Key elements include current allergies, patient weight and for some drugs, body surface area and current laboratory values for patients with hepatic or renal impairment. Often, there is incomplete information about a patient's home medications as they might not remember all the medications/doses they are taking, thereby increasing the risk of errors in prescribing medications upon admission.

Inadequate communication
Communication between healthcare providers is critical to the safe delivery of medication. Failure to question ambiguous or unclear orders or to pursue safety concerns may happen if staff feels rushed or intimidated by the prescriber. Abbreviations can be misunderstood and spoken orders can be misheard.

Unclear drug names, labels and packages
Associated concerns with drug names, labeling and packaging include confusing or ambiguous labels on medications, unlabeled medications or syringes, mislabeled medications, poorly positioned labels that obscure vital information, and doses dispensed in bulk without patient-specific labels.

Errors in drug standardization, storage and distribution
Medication errors can happen in the interaction between and among the physician, the nurse and the pharmacist. Failure to properly dilute concentrated medications and electrolytes before giving them; storage of hazardous chemicals, fixatives and developers with medications, leading to mix-ups; missing medications due to problems with pharmacy distribution; nonstandard medication times – all these can contribute to medication errors.

Improper use of medication delivery devices
It is imperative that the healthcare provider administering medication be familiar with the particular delivery device used. Otherwise, mistakes can include pump programming errors, failure to notice an incorrect default setting on the pump that can lead to dosing errors, rapid free-flow of solution when tubing is removed from the pump, and line mix-ups.

Challenging environmental factors and staffing patterns
Distractions and noise can lead to misinterpretation of the spoken or telephone order and interruptions during medication administration or preparation can be particularly problematic. Staff member fatigue can also be a cause for concern, as inadequate breaks can lead to impaired judgment, mental overload and error potential.

Missed opportunities for staff competency and education
Ongoing in-services must not be neglected; they are an invaluable resource to help staff become familiar with preparation, dose, route, action and/or effects to anticipate with new medications. In-services allow time to discuss problems (especially near misses) and review the causes of errors or potential errors and their prevention.

Gaps in patient education
Whenever possible, the patient should be part of the care process. This includes attention to their preferences and values, their own knowledge of their condition and the kinds of treatments and medications they are receiving. Patients often feel uncomfortable reminding staff to verify their identity and feel reluctant to ask questions about the medications they are receiving. Because of medical jargon or language barriers, patients might not understand all information given to them. Additionally, low health literacy or poor reading skills might

prevent patients from understanding printed information or directions for using medications. And, patients often lack resources for finding answers to questions about drug therapy after discharge.

Quality process and risk management

The importance of patient safety and medical error reduction is a unifying theme in risk management and quality management. Disincentives that continue to surface are the culture of secrecy and blame that prevents disclosure of errors to patients and families, and shame, blame, fear of disciplinary action and documentation of errors in personnel files that prohibit the transparency of such errors. Often, ineffective error prevention strategies are focused on individual performance improvement rather than system improvements.

All medical errors need to be accurately categorized and tracked. Finding the root cause of medication errors is almost impossible without an effective error-reporting and evaluation system.

In the quest for understanding causes and finding ways to prevent medication errors, risk managers and safety professionals should lead the way. To make a difference, we must influence effective reporting, tracking and cultural change within healthcare organizations.

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Resources

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10 STRATEGIES FOR SUCCESSFULLY RESOLVING A MEDICAL MALPRACTICE CLAIM

By Jayme T. Vaccaro, J.D., Vice President, Specialty Claims Operations

From never being afraid to try a case, any case, to knowing what ultimately motivates the plaintiffs, thinking outside the box and utilizing creativity can be a mantra for successfully resolving medical malpractice claims. In a series of ten articles, Jayme T. Vaccaro shares time-tested strategies for resolving a medical malpractice claim.

Ten strategies:

1. **Never be afraid to try a case – any case**
2. **Always be aware of the plaintiff's attorney vulnerabilities – leverage**
3. **Always know where your codefendants lie and wait – friend or foe**
4. **Use your tools – from high/lows to bifurcation**
5. **The courtroom is sometimes not the place – alternative forums**
6. **Know when to hold – and know when to fold**
7. **Know what the plaintiff wants out of the case – the sweet spot, and it may not be money**
8. **Back to basics – know your case inside and out, legal, medical and the like**
9. **Anyone can help you mediate – from the judge to the structured settlement representative**
10. **Understand risk appetites – client/insured/defendant**

Read strategies 1-3 in our recent *Risk Resource* newsletters, archived at: http://www.sedgwick.com/news/Pages/newsletters.aspx. In this issue, we will explore Strategy 4.

Strategy 4: Use your tools – from high/lows to bifurcation

There is a veritable plethora of tools we can use to achieve a better outcome when resolving a medical malpractice claim. Sometimes the hardest part is actually using them. Consider indemnity agreements. Indemnity agreements are found in most healthcare contracts between hospitals and physicians. Depending upon your venue, they are rarely enforced or they do not have clear, concise language that benefits the parties. Having a strong equitable indemnity and contractual indemnity claim can mean double trouble or pressure for an opponent.

Consider the option of negotiating a high/low agreement. Unless restricted by your venue, these arrangements can drastically lower the risk of a runaway verdict. Even if the parties agree to disagree on settlement value, they can try a case but avoid uncertainty. A high/low is an agreement between the plaintiff and defense on the maximum and minimum they will pay on a case even if the jury comes back with a different amount. The low amount, say $1 million, will be paid even if the defense wins at trial, and a high, say $5 million, will be paid even if the defense loses and the jury

comes back with a $20 million verdict. In a high-stakes injury case, your CFO and excess carriers will sleep easier if they know you have arranged a high. While it may be painful to pay the agreed low if the defense "wins," this type of agreement limits the parties' risks.

Consider another tool: objecting to a "good faith settlement" of your codefendant. While many will argue for the majority of the motions, judges grant good faith findings and it's not worth the effort or angering the plaintiff or codefendant. There are exceptions and you need to know them.

Numerous other alternatives remain in your tool box: waiving a jury, enforcing binding arbitration, bifurcation of issues and alternative mediation forums. While many of these tools have pros and cons, a key factor is knowing when using such tools poses a risk. While use of an indemnity agreement may prove too hostile to a business relationship in one case, it may be perfect for another. If a high/low is not a good alternative in one case, keep your mind open for another.

Example #1: Everybody gets high, everybody gets low

A 38-year-old woman was seen by physicians for blurred vision and a headache. Examined and discharged, she suffered a stroke the next day. The patient was left in a vegetative state. The woman and her husband are plaintiffs and the case is tried. The plaintiff boards over $11 million in damages.

The jury is out three days and, from the questions asked, appears to be hung (unable to reach a verdict). Both the defense and plaintiff are motivated to not try the case again. A high/low is negotiated even in the event of a hung jury. The jury is, in fact, hung and the high/low is enforced. The parties had agreed to pay the low if the defendant won the trial; if the jury was hung, the defense would pay the low.

Unbeknownst to the defense, the plaintiff did not want to retry or prolong the case because the husband, also a plaintiff, wanted to divorce his wife after the trial. The plaintiff did not know the defense was concerned that, while the second physician to see the patient on her return visit was never named in the case, his partnership was named. If it was discovered that the second physician actually had the true exposure, it could be a case of huge liability for the partnership.

Where the parties prior to trial could not reach a settlement amount, the high/low resolved the case for all involved.

Example #2: Objecting to a good faith settlement: Creating bad blood?

There are three codefendants in a medical malpractice lawsuit. Two of the defendants have large, self-insured retentions with layers of excess insurance available. The third defendant has a $1 million policy which he shares with his group. The group is a large, intentionally underinsured, asset-rich entity. The injury to the patient is catastrophic and large damages are sought. The physician and group tender the $1 million policy and the plaintiff accepts it. The remaining codefendants have minimal liability but high exposure due to joint and several liability and available limits. Evaluation of the case shows the lead actor was the physician and the remaining codefendants remain in the case due to an ostensible agency theory.

One codefendant objects to the settlement, arguing the physician and his group would have paid proportionately more than the $1 million but for the shared and limited insurance available. Moreover, the physician and group intentionally carry minimal limits, gambling the plaintiff will take it and higher-limit codefendants will pay the remainder of the settlement. The codefendant shows proof of the group's size and wealth and explains the plaintiff's attorney's incentive to take the million: the remaining codefendants with larger limits are an easier target with deeper pockets.

The judge finds the settlement in good faith but states in this case the group was not named and had it been named, different considerations would have been explored. While you lost the motion, the judge gave a hint at what might have been with a different fact scenario.

While some might deem these arguments treacherous, if not made, the larger limit codefendant is basically serving as excess coverage for the underinsured physician/group. It is true these motions are often denied; however, when the difference between a single or small physician group and a mega group carrying such limits is competently explained, judges may be more apt to grant your motion. You will never know how a judge may rule on this type of fact scenario unless you make your motions. In the example given, yes, the judge did as many will argue, not overturn the good faith settlement finding. He did, however, give a hint as to how he might rule had the group been named.

Example #3: Admitting liability: Taboo voodoo?

An x-ray reveals a large mass in the patient's right lung. The patient is not told and two years later is diagnosed with terminal stage IV lung cancer. The patient sues for malpractice. While the defense admits the standard of care was not met and the delay in diagnosis caused the patient harm, the plaintiff and defense cannot agree on settlement value. The patient was a high-wage earner; however, the defense has legitimate issues with the plaintiff's case value.

The defense needs to make a difficult decision: pay full jury verdict value and then some or try the case on damages. If the case is tried on damages only, little or no evidence on the standard of care and causation is submitted to the jury. This takes away the impact, sympathy and potential emotional aspect of the case. The hope is the jury will focus on real damages. The main issues presented are work history, life expectancy and earning capacity. This is very limited compared to a full-blown medical malpractice trial.

This case is tried and the jury finds against the defense. The amount, however, is closer to the defendant's damage assessment, not the plaintiff's unreasonable demand.

It is unfortunate when such a case must be tried and the parties cannot reach a settlement without the jury's help. Admitting negligence is a tool in your tool box. Do the math on such a case: pay $15 million or take a chance with a jury and pay $5 million.

When the numbers don't make sense, it is time to reach into your tool box and focus on how to achieve a better outcome.

Conclusion

Certain tools may accomplish better outcomes for medical malpractice claims. Knowing when a case or fact scenario fits the right alternative helps you choose the proper tool. Taking a chance and using available tools requires teamwork and thinking outside the box. Sometimes you need to try a few times before you get the desired result. Not trying may leave you with an unsatisfactory result and overpayment of your claim.

If you have such tools but rarely use them, is it time to rethink the unthinkable? Always keep your tools in mind and know when they may be the key strategy.

Next time, strategy 5: The courtroom is sometimes not the place – alternative forums.

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Upcoming events

Sedgwick supports Healthcare Risk Management Week June 19-23

Sedgwick's healthcare risk management team works alongside healthcare risk managers to reduce risks and improve safety by delivering cost-effective claims, productivity, managed care, patient safety, risk consulting and other services. Taking care of people is at the heart of everything we do. **Caring counts.**[SM]

Connect with Sedgwick's professional liability and healthcare risk management team at these upcoming conferences:

- **Florida Society for Healthcare Risk Management & Patient Safety, August 10-11, Orlando, FL** | *visit the Sedgwick booth*
- **OR Manager Conference, October 2-4, Orlando, FL** | *visit Sedgwick at booth #734*
- **American Society for Healthcare Risk Management (ASHRM) 2017, October 15-18, Seattle, WA** | *visit Sedgwick at booth #511*

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HealthcareRM@sedgwick.com | 866-225-9951

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