HIROC

THE HIROC CONNECTION

…keeping subscribers connected

Issue # 28
SUMMER 2011

FEATURE

HIROC Gives Back to Subscribers

Healthcare Insurance Reciprocal of Canada experienced excellent financial results in 2010, due to favourable underwriting and investment results. The subscribers' surplus grew from $172 million to $222 million and our Minimum Capital Test ratio increased to 186 percent, exceeding the target of 175 percent. As a result, **the Board of Directors voted to make a surplus distribution of $3.8 million to eligible subscribers**—those subscribers whose surplus balances exceed their individual surplus target of 1.75 times their annual net premium.

Bryan Leier, Chair, HIROC Board of Directors

This is the first time since 2004 that HIROC has been able to exceed its surplus target to such an extent, making a distribution possible. Since being founded in 1987, HIROC has returned over $76 million to Canadian healthcare organizations. While not every subscriber will receive a distribution, this is good news for all subscribers, as it demonstrates HIROC's financial strength and ongoing commitment to responsible underwriting, effective claims management, prudent investment policies and sound surplus management.

These results show that HIROC will continue to fulfill its vision of *partnering to create the safest healthcare system*.

All subscribers will receive surplus statements in the mail shortly and eligible subscribers will also receive a cheque representing their share of the surplus distribution.

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FEATURE

Highlights from HIROC's 24th AGM

By Victoria Musgrave
Manager, Communications and Marketing
HIROC

Hiroc's 24th Annual General Meeting was held on May 2, 2011 at the Metro Toronto Convention Centre. The event was attended by approximately 250 subscribers, stakeholders and HIROC staff.

Bryan Leier, Chair of the Board of Directors, presented the financial results for the fiscal year 2010. HIROC generated a net comprehensive income of $48 million, comprising an underwriting loss of $6 million and total investment income of $54 million ($32 million of realized gains and $22 of unrealized gains).

During the year, HIROC welcomed 27 new subscriber organizations, bringing the number of subscribers to 527, representing over 600 facilities across Canada. The majority of new subscribers are family health teams, midwifery practice groups, rural hospitals and regulatory colleges. As well, several rural hospitals joined HIROC when one of our competitors decided to reduce its obstetrics exposure. No subscribers left HIROC.

Peter Flattery, CEO, also reported that the results for the first quarter of 2011 were very positive, with a comprehensive income of $7.9 million.

Highlighting Board activities of the past year, Bryan Leier noted that individual assessments were conducted by an independent consultant to gauge how well each Board member performed their duties in areas such as member accountability, fiduciary stewardship, asset and risk management and strategic leadership. These assessments reflect best practices in board governance. All Board members scored extremely high on the assessments, indicating that HIROC has a highly effective board.

One new Director was welcomed to the Board. Arlene Wilgosh is the President and Chief Executive Officer of the Winnipeg Regional Health Authority in Winnipeg, Manitoba.

The Year in Review

In 2010, the Healthcare Risk Management Department embarked on a service review and, based on feedback

Peter Flattery, CEO of HIROC

received from our subscribers and our partners, began refocusing risk management services to target the highest priority risks based on our claims experience and the needs of subscriber organizations. Throughout 2011 and 2012, subscribers will be introduced to new risk reference sheets, resource guides, improved reports and a streamlined RMSAM™ aimed at identifying the highest risk factors and suggesting mitigation strategies.

HIROC continued its efforts to meet with key representatives from the public sector to increase awareness of issues that are important to subscribers, as well as taking the opportunity to advance our vision of partnering to create the safest healthcare system. During the year, HIROC met with representatives from provincial ministries of health including Alberta, Manitoba, Newfoundland and Labrador, Nova Scotia and Ontario.

We also completed and published a position paper on physician credentialing that included input from the

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Abigail Carter-Langford, Privacy Officer, University Health Network (middle) and Bonnie Freedman, Counsel, Health Law Group, Borden Ladner Gervais LLP presented on Social Media/Electronic Communications at the 9th Annual Risk Management Conference.

Ontario Hospital Association and the Canadian Medical Protective Association. This paper, along with our other position papers and white papers, is available on our website.

Our commitment to our vision—partnering to create the safest healthcare system—remains strong. We value the partnerships we have with organizations dedicated to improving patient safety and look forward to continuing to strengthen those relationships in the years to come.

The 2010 Annual Review is available to subscribers on our website at www.hiroc.com, in the Subscribers Only section.

FEATURE

HIROC's 9th Annual Risk Management Conference

By Arlene Kraft
Manager, Healthcare Risk Management
HIROC

HIROC's 9th Annual Risk Management Conference provided an opportunity for attendees to network with peers and to advance their risk management knowledge in the areas of:

- Lessons learned from the Cameron Inquiry in Newfoundland and Labrador, and the status of national standards for pathology and laboratory medicine;
- Class action lawsuits;
- Visitor and patient falls;
- Social media / electronic communication; and
- Fraud.

Most topics included a panel of presenters composed of legal counsel, subscriber representatives and HIROC staff, providing a variety of perspectives on the subject matter.

Audience feedback was overwhelmingly positive with over 94 percent of respondents indicating an overall rating of 5 or 6 out of 6 (with 1 being very unsatisfied and 6 being very satisfied).

For those unable to attend the conference, a webcast can be viewed on the HIROC website, or materials can be obtained by emailing riskmanagement@hiroc.com. We look forward to seeing you next year for the 10th Anniversary of the Conference.

SUBSCRIBER EXCLUSIVE

Introducing Guide to Integrated Risk Management

By Polly Stevens
Vice President, Healthcare Risk Management
HIROC

In response to requests from subscribers, HIROC has prepared a guide to help healthcare organizations implement Integrated Risk Management (IRM) (also called enterprise risk management or ERM). The guide includes helpful advice from the literature and input from a number of HIROC subscribers in various stages of IRM implementation—specifically what has worked, what hasn't, and if they were to start over, what would they do differently?

IRM provides a common framework for understanding and prioritizing very different types of organizational risks, and for creating a concise list of the most significant risks facing the organization. A number of internal and external factors have provided impetus for implementation of IRM in healthcare.

There are considerable challenges and costs associated with IRM implementation and unfortunately the value of IRM has not always been realized. It has been suggested that one of the biggest barriers to successful implementation of IRM is overly complicated structures and processes. The HIROC IRM guide reviews the basic elements of IRM and, without prescribing an exact format or critiquing any particular approach, offers sensible, efficient and effective techniques and tips for IRM implementation, with the objective of reducing the effort and frustration that may be experienced by organizations starting down this road.

The guide includes a review of internal and external drivers, outlines elements of IRM implementation including determination of a framework, oversight and coordination and organizational context. The processes of risk assessment, reporting and management are also described. Appendices include: a list of sample risks; common sources of risk information; top ranked risks from HIROC claims data (for acute care); sample risk assessment matrix; and, an outline for a simple risk register.


IRM for Healthcare Organizations 1

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The guide will be updated as new information and insights arise and we are interested in receiving questions, suggestions and feedback regarding this work.

SUBSCRIBER EXCLUSIVE

Introducing Risk Reference Sheets

Two new risk reference sheets were launched at HIROC's 9th Annual Risk Management Conference. Additional reference sheets on a variety of topics will become available to subscribers throughout 2011 and 2012.

Employee Fraud

A fiduciary duty is a legal duty that arises in the context of certain relationships. Employee fraud represents one type of fiduciary risk and is defined as using one's occupation for personal gain by intentionally misusing the employer's assets or resources. Employee fraud causes both significant financial and reputational harm to organizations. Fiduciary claims encompass approximately two percent of HIROC's claims costs, and of that, the majority consist of employee fraud claims. The average cost of a fraud claim is $125,000 and the largest claim paid was over $2.5 million.

A key element of fraud deterrence is the implementation of strong internal controls to reduce the opportunity for committing fraud. The reference sheet provides mitigation strategies organizations should implement, ranging from the importance of segregating duties to conducting frequent surprise audits. The reference sheet was developed to help identify common fraud schemes, provide lessons learned from claims and to offer fraud deterrence strategies for our subscribers.

Visitor Falls

Injuries sustained by visitor slips, trips and falls are prevalent in healthcare and result in significant harm and costs. Claims of this nature are also difficult to defend as they are generally avoidable with proper risk management and preventive maintenance practices. When the entire HIROC claims database was analyzed, falls accounted for seven percent of all claims costs and among long-term care/chronic care/rehab peer groups, they are the second highest ranked risk. A more in-depth analysis revealed 60 percent of visitor falls occur inside buildings while 40 percent occur outside. Our largest claim was settled for over $2 million.

The reference sheet was developed to help mitigate the losses from visitor falls and focuses on snow and ice hazards, contract management, facility inspection, housekeeping and maintenance including video surveillance. Spill response and loss control are also addressed and sample forms for documenting risk management practices are included.

The Integrated Risk Management Resource Guide and the Employee Fraud and Visitor Falls Risk Reference Sheets are available to subscribers by emailing riskmanagement@hiroc.com.

FEATURE

HIROC Revitalizes Relationship with Accreditation Canada

ACCREDITATION CANADA
AGRÉMENT CANADA

Driving Quality Health Services
Force motrice de la qualité des services de santé

HIROC and Accreditation Canada recently agreed to strengthen the relationship between the two organizations and are moving forward on plans to increase collaboration and knowledge sharing to the benefit of healthcare organizations.

Accreditation Canada and HIROC share a common goal of assisting healthcare organizations to manage risk, prevent adverse events, and ultimately improve patient safety and the quality of the care and services delivered.

"Through Qmentum, our rigorous and comprehensive accreditation program, Accreditation Canada provides organizations with the opportunity to assess their programs and services against national standards based on evidence and research, and to use the results to foster quality improvement. As such, accreditation is a risk mitigation strategy. This partnership with HIROC, allows us to foster a culture of learning, and enable positive change in the system," said Wendy Nicklin, President and Chief Executive Officer of Accreditation Canada.

Accreditation Canada and HIROC are looking forward to working collaboratively on a number of initiatives that will benefit HIROC subscribers who participate in accreditation. This will include writing joint articles and offering presentations on key areas regarding patient safety, such as obstetrics.

In 2008, Accreditation Canada recognized HIROC's innovative Risk Management Self-Appraisal Modules (RMSAM™) in its Qmentum Standards. In the Governance Standards (Sustainable Governance), RMSAM™ is referenced in the section related to the governing body's role in working with senior management to identify risks to the organization. In the Leadership Standards (Effective Organization) a similar guideline appears related to an organization's requirement to define and coordinate a performance management system and to use an integrated risk management approach to identify, report, measure and manage risks.

HIROC recently embarked on a re-visioning of RMSAM™ to increase its impact on patient safety and claims by ensuring the program is focused on the high cost/high frequency risks and the most impactful evidence-based risk mitigation strategies.

"We are excited about the opportunity to streamline RMSAM™ and minimize any overlap with Qmentum," said Polly Stevens, Vice President, Healthcare Risk Management at HIROC.

COLUMN

Ask a Lawyer

By Gordon Slemko
General Counsel
HIROC

Q: I have just received a subpoena which states that I have to attend court next week in connection with a patient I treated sometime ago. I was not consulted about this date and I am leaving on vacation tomorrow. Can I ignore the subpoena? If I attend will I be reimbursed if I have to cancel my travel plans?

The short answer to your question is that you cannot ignore a subpoena. Serious penalties exist for individuals who do not comply with a subpoena.

By way of background, a subpoena or summons to witness, is a document that requires an individual to attend at a court proceeding and give evidence. The subpoena will set out the time, date and place of the required attendance. The subpoena will also require the individual to attend with all documents and materials relevant to the matter. In the case of health professionals, this requirement typically requires that the individual bring a copy of a patient's health record with them.

It is unclear from your question whether you have advised your employer of the subpoena. If you have not, you should do so. Your employer can provide you with support (chances are they have dealt with subpoenas before) and arrange for the involvement of legal counsel if necessary.

Although you cannot ignore the subpoena, there is often a great deal of flexibility regarding the time and date specified in the subpoena. I recommend you contact the lawyer who served the subpoena to discuss the scheduling of your attendance. It may be the case that you have received the subpoena as a precautionary measure or the matter may settle and your attendance will not be required at all. Even if your attendance is required, you may be able to arrange a mutually convenient time for you to attend.

When speaking with the lawyer, you should be careful not to reveal any medical information. A subpoena does not entitle you to breach patient confidentiality. A subpoena is simply a command to attend. As is always the case, you may only provide records or discuss patient care with a third party if you have the patient's authorization to do so or if you are required to do so by law (such as when you attend at court and are directed by the judge to answer questions asked of you).

If you are required to attend at court you should bring the original paper record with you. If the original record no longer exists, a photocopy will suffice. If the record is electronic, you should bring a printout and be prepared to answer questions regarding the integrity of the record (the court will want to know that there have not been any changes to the record since it was created). If you have any questions as to what to bring to court you can discuss this with the lawyer who served the subpoena, but again you should not discuss the contents of the medical record.

Finally, an individual who is required to appear as a witness generally receives "conduct" or attendance money. The rules of court contain tariffs which set out how such amounts are to be calculated. Although the tariffs provide for witness fees and travel allowances such amounts are minimal and will not come close to reimbursing someone who has lost income or cancelled travel plans as a result of having to take time off to testify.

This column is intended to convey brief and general information and does not constitute legal advice. Readers are encouraged to speak to legal counsel to understand how the general issues discussed in this column may apply to their particular circumstances.

Subscribers are invited to submit questions **of a general legal nature** to our General Counsel Gordon Slemko at **gslemko@hiroc.com**, who will review the queries submitted and write a response relevant to many HIROC subscribers.

FEATURE

FIPPA: Application to Hospitals and Implementation by Hospitals

By Bonnie Freedman
Counsel
Borden Ladner Gervais LLP

This article is based on a webinar presented by HIROC on May 12, 2011 and addresses questions submitted following the webinar by participants.

Overview

The Freedom of Information and Protection of Privacy Act (FIPPA) applies to organizations which it defines as "institutions" and is administered by the Office of the Information and Privacy Commissioner/Ontario (the IPC). FIPPA provides access to information controlled by public sector organizations in the interests of transparency, accountability and the exercise of democracy and protects the privacy of the individuals to whom that information relates.

Access to Information: Part II of FIPPA establishes a right of access, by anyone who pays the application fee and puts his or her request in writing, to recorded information in the possession or under the control of an institution. The test for determining whether **recorded information is in the possession or under the control of an institution** has been established by the IPC (see for example Order P-120). The right to access is qualified by a number of **exemptions and exclusions**. Where an exemption is mandatory, the institution must refuse access and where it is discretionary, the institution may refuse or provide access. There is an obligation to sever information that is subject to an exemption and disclose the other parts of a record [s. 10(2)].

Exemptions: The IPC has established criteria that must be met for certain exemptions to apply. Although there are about 15 "heads" of exemption, only a limited number are likely to apply to hospital records, including those for:

1. advice or recommendations of a consultant or employee [s. 13];
2. trade secrets, technical, commercial or financial information that was provided to the hospital by a third party in confidence, where the disclosure of the information could reasonably be expected to result in prejudice to the third party [s. 17];
3. proposed plans, policies or projects where their disclosure could reasonably be expected to result in undue financial benefit or loss to a person [s. 18];
4. information provided in confidence to, or records prepared with the expectation of confidentiality by, a hospital committee to assess or evaluate the quality of healthcare and directly related programs and services provided by a hospital, if the assessment or evaluation is for the purpose of improving that care and the programs and services [s. 18(1)(j)];
5. information that is subject to solicitor-client privilege [s. 19];
6. information, the disclosure of which may reasonably present a serious threat to safety or health of an individual [s. 20];
7. information, the disclosure of which would constitute an unjustified invasion of privacy [s. 21];
8. information that has been or is soon to be published [s. 22].

Some of the exemptions may be overridden where "a compelling public interest in the disclosure of the record clearly outweighs the purpose of the exemption" [s. 23].

Exclusions: Certain classes of records are excluded from the application of FIPPA, including:

1. information that came into the custody or control of the hospital before January 1, 2007 [s.69(2)];

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2. certain employment and labour relations records and records related to meetings and discussions about labour relations matters in which the hospital has an interest [s. 65(6)];
3. records related to meetings and discussions about applications for hospital appointments and privileges and appointments and privileges and the personnel file of professional staff members [s. 65(6.5)];
4. records about research including clinical trials conducted by an employee or person associated with a hospital [s. 65(8.1)(a)];
5. records relating to the operations of a hospital foundation and charitable donations made to a hospital [s. 65(5.4) and 65(5.6)];
6. ecclesiastical records of a religious organization affiliated with a hospital [s. 65(5.3)];
7. records of abortion services [s. 65(5.7)];
8. records of reviews conducted under the Quality of Care Information Protection Act, 2004 ("QCIPA") [s. 1.1 of QCIPA]; and,
9. with limited exceptions, information that constitutes personal health information under the Personal Health Information Protection Act, 2004 [s. 8 of PHIPA].

Privacy: Part III of FIPPA contains provisions designed to protect individual privacy and to this end, establishes requirements for the collection, use and disclosure of personal information for example, about applicants, employees and members of a hospital's professional staff. In general, personal information must be collected directly from the individual to whom it relates and the collection must be authorized by a statute and necessary to the proper administration of an authorized activity. Hospitals and organizations collecting personal information on behalf of hospitals, are required to give notice of:

1. the legal authority under which personal information is being collected (for hospitals, s. 274 of the Corporations Act and ss. 1, 7 and 32.1(2) of the Public Hospitals Act)
2. the principal purpose(s) for which the information will be used; and,
3. contact information for the FIPPA "Co-ordinator".

Notice may be given on application forms, on an intranet or in a policy designed to address employee and staff privacy.

FIPPA also creates rights of access and correction for individuals to their personal information in the custody or under the control of an institution [s.47].

Access Process and Appeals

Sections 24 through 28 of FIPPA establish the process for accessing records. Access requests must be made in writing to the "head" of the hospital (the Chair of the Board), and accompanied by the prescribed fee ($5.00 at time of writing). Continued or "rolling" access may be requested for the same information as it becomes available over a period of up to 2 years. Notice to third parties, such as service providers, is required in some circumstances where their confidential or personal information is responsive to a request. Affected third parties must be given 20 days in which to provide submissions about the disclosure of their information. Access requests must be processed in 30 days, although in defined circumstances, an extension is permitted on written notice to the requestor. Requestors should be advised where hospitals anticipate, for any reason, that they will not be in a position to respond to an access request within 30 days. There is no prohibition on contacting the requestor to ask for clarification, although the identity of the requestor, except in limited circumstances, is considered confidential information and as such, is not to be disclosed to affected third parties.

The fees which institutions may charge for processing an access request are set out in the regulations made under FIPPA. Institutions are required to provide requestors with an estimate of the fees [s.57(3)] and may be required to justify their fees, which means that hospitals will have to track the time involved in processing a request. No fees are permitted for certain activities whether the requestor is seeking his or her own personal information and there are conditions under which institutions are required to waive fees [57(4)]. Fees have been appealed so that there is guidance on what the IPC considers appropriate.

A refusal to grant access to information, to correct personal information on the request of the individual to whom it relates and to process an access request within the mandated time lines, as well as the fees for processing an access request, may be appealed to the IPC in writing and on payment of the prescribed fee [s. 50] within 30 days of notice of the decision being appealed.

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Top Three Implementation Issues/Suggestions

The volume of requests for access or to investigate a suspected breach of FIPPA is hard to estimate as it varies from institution to institution and may be influenced by external events such as elections. Many of the procedures hospitals have in place for processing requests for access and correction and complaints under PHIPA may be adapted for FIPPA. However, the time lines for responding to an access request are short if the request is broad or complex and any requests which are not processed within the mandated time lines is deemed to be a refusal of access. Further, hospitals will not always be able to recover the cost of processing an access request.

Information subject to an exemption or exclusion may be disclosed inadvertently, for example where through clerical error, it is not redacted.

The retroactive application of FIPPA may present challenges where hospitals have not tracked the date on which a record was created or received or receives old records after January 1, 2007, for example in connection with a restructuring of services. Risks arising out of historical events or decisions may have to be managed without the benefit of staff with relevant information.

Identify a FIPPA "Co-ordinator" and team: The head is entitled to delegate his or her responsibilities under FIPPA. For more information on this point, see BLG FOI-ables, Issue 3 at: http://www.blg.com/en/home/publications/Documents/publication_1871.pdf.

Inventory Records: To facilitate the processing of access requests, hospitals should inventory their records by type and department or service and consider centralizing records. Hospitals should also verify that record retention and destruction policies are being followed.

Develop/Choose Procedures and Forms: Procedures are important to ensure that access requests and complaints are delivered to the appropriate person and processed within the mandatory time lines, that a reasonable search or investigation is carried out and that permitted fees are collected, among other reasons. The Ontario Hospital Association is creating a number of forms that hospitals may prefer to creating their own.

Questions from Webinar Participants

1. Why would a hospital want to maintain both QCIPA and non-QCIPA quality review committees if non-QCIPA committees are subject to an exception?
2. Does the recent exception suggest that more critical/catastrophic patient harm events will be reviewed in non-QCIPA quality review forums?
3. With respect to the Morbidity and Mortality (MM) rounds, it was noted that unless these were linked to a Quality Care Committee and utilized for quality improvement, they may not be exempted. Should I be recommending that the MAC have its own Quality Committee and have the MM rounds linked to that committee and ensure that they are following the same framework as our Quality Reviews?
4. What should we be doing with respect to all of the MM information that was produced since 2007?

Hospitals will have to take into account all of the factors involved in deciding whether to create a quality of care committee under QCIPA, not simply those affected by the application of FIPPA, in deciding how to structure their quality of care activities. It may merit emphasizing that there is an exemption for non-QCIPA quality of care information, whereas quality of care information created under QCIPA is excluded from the application of FIPPA. As pointed out in Issue 1 of BLG FOI-ables (https://www.blg.com/en/home/publications/Documents/publication_1851.pdf):

> The exemption is discretionary ("the head may refuse to disclose") and is subject to section 23 of FIPPA, under which all exemptions may be overridden "where a compelling public interest in the disclosure of the record clearly outweighs the purpose of the exemption".
>
> Therefore, the exclusion under QCIPA provides a better or stronger protection from access under FIPPA than the exemption for non-QCIPA quality records.

FIPPA works on the principle that "necessary exemptions from the right of access should be limited and specific". The exemption covers information "prepared with the expectation of confidentiality by a hospital committee to

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assess or evaluate the quality of health care… provided by a hospital and improve that care". A committee must be legitimately engaged in the activities described in the exemption for the exemption to apply.

MM information, like all hospital records, should be managed in accordance with applicable hospital policies and law, including a hospital's records retention and destruction policies.

5. Does this recent exception prohibit/restrict the hospital from sharing some/all findings from non-QCIPA quality reviews with families/ patients?

The exemption for non-QCIPA quality of care information is discretionary, however hospitals should consider whether information that is disclosed to families and/ or patients meets the criterion of being "provided in confidence to" or "prepared with the expectation of confidentiality by a hospital committee".

6. Is there a current list of or examples of the type of requests hospitals could get under FIPPA?

The orders and reports of the IPC and of commissioners in jurisdictions in which access to information legislation currently applies to hospitals, including British Columbia, provide insight into the types of requests that hospitals are likely to receive: requests for minutes of meetings, proposals submitted in response to RFPs, contracts, information surrounding decisions affecting staff, programs and services, information about severance packages and information about the cost of programs, projects and services.

7. What are the criteria for deciding that a request is frivolous or vexatious?

Section 5.1 of Regulation 460 made under FIPPA establishes the following criteria:

> A head of an institution that receives a request for access to a record or personal information shall conclude that the request is frivolous or vexatious if,
>
> A. the head is of the opinion on reasonable grounds that the request is part of a pattern of conduct that amounts to an abuse of the right of access or would interfere with the operations of the institution; or
>
> B. the head is of the opinion on reasonable grounds that the request is made in bad faith or for a purpose other than to obtain access.

The criteria have been applied in a number of IPC Orders, including P-1431 in which relevant factors were said to include: the volume of requests; the nature and scope of the requests; whether the requests were intended to harass or accomplish an objective outside of the objectives of FIPPA; and whether the requests revisit an issue previously addressed by the institution. The IPC has noted that the right of access granted under FIPPA should not be interfered with lightly. On this basis and given that the institution bears the burden of demonstrating that the criteria in the regulations have been met, the conclusion that a request is frivolous or vexatious must be the product of a rigorous analysis of the facts.

8. Regarding employee records, your presentation talked about professional staff and protecting those, but what about non-professional staff?

The presentation referred to the exclusion applicable to records about appointments and privileges of professional staff members and their personnel file. There are other exclusions and exemptions which may apply to records about employees such as the exclusion for records relating to communications about labour relations or employment-related matters in which the hospital has an interest and the exemption for personal privacy. Section 21(4) of FIPPA provides that the disclosure of information, including salary ranges, benefits and employment responsibilities, does not constitute an unjustified invasion of personal privacy, however the IPC has upheld refusals to provide access to parts of employment contracts in Orders including PO-2050.

FIPPA Resources

1. Office of the Information and Privacy Commissioner/ Ontario (IPC) at http://www.ipc.on.ca/english/Home-Page/

2. OHA at http://www.oha.com/SERVICES/FOI/Pages/ Default.aspx

3. *BLG FOI-ables Bulletins* at http://www.blg.com/ en/home/practice-areas-industries/Pages/health-sector-services.aspx

FEATURE

How and When to Report a Claim

By Ed Corcoran
Team Lead, Claims
HIROC

With the growth of HIROC and the number of recent changes experienced by healthcare subscribers, we realize that personnel often change and that some procedures may not have been passed on to incoming staff at subscriber organizations. As such, on occasion, our subscribers have encountered some confusion when reporting a new claim. This article is intended to clarify the reporting procedures to ensure all actual and potential claims are reported and responded to at the earliest opportunity.

We will focus our discussion on two distinct claims categories. Medical malpractice and liability claims, and property claims.


HIROC

Claim Reporting Form

Contact Person for this Claim

Incident/Occurrence Details

Medical Malpractice and Liability Claims

These claims represent the most serious exposure to HIROC and its subscribers. A liability claim is an occurrence that takes place when the healthcare subscriber and/or its staff are responsible or alleged to be responsible for injuries sustained to a person or for damage sustained to another party's property. The typical injury claim involves a slip and fall that occurs on grounds that the subscriber is legally responsible for either in or outside the insured premises. A property damage liability claim is a distinct and separate event from a first party property damage loss which will be discussed later in this article. A typical example of a property damage liability claim would be where a tree on the subscriber's property falls onto a car in the parking lot. Damage has been sustained and a claim is made against the hospital. An investigation is then carried out to determine if indeed the subscriber is responsible for the tree falling and the resulting damages.

Medical malpractice is also a liability injury claim, involving much more serious consequences. An obstetrical incident would be a typical example.

Subscribers often face questions as to when and why an incident should be reported. The following should serve as a guide as to when an incident involving an injury should be reported to HIROC.

1. An incident has occurred, and there is legitimate suspicion that the involved caregiver(s) did not meet the applicable standard of care.
2. An event has occurred resulting in serious medical consequences, such as permanent neurological damage, amputation, blindness or death.
3. A notice of action and/or a statement of claim has been served upon the subscriber or a HIROC insured employee.
4. Correspondence has been received from a lawyer, law firm or patient requesting a copy of the patient's chart and you feel it is likely in regards to impending litigation.
5. A letter has been received from a patient, next of kin of a patient, or a representative of a patient/former patient requesting compensation for alleged sub-standard treatment or care (a letter of demand).

With respect to how a claim should be reported to HIROC, claims are to be submitted in accordance with the claims reporting criteria within the HIROC website at www.hiroc.

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com. To access the website, the subscriber will need a login and a password. If your institution cannot locate its login and password or have found that they have expired, please contact our Insurance Operations Department at the earliest opportunity, or email inquiries@hiroc.com. They can immediately supply you with a new password that will let you proceed forward through the claims reporting process, which is explained in detail in the claims section of the website. You will note that all that is required to review the reporting criteria is to mouse click on the province in which your facility is located.

However, with consideration of the above, if you have encountered a very complex event with likely serious consequences and you need to speak to someone immediately, do not hesitate to telephone the HIROC Claims Department to consult with a staff member. The claim report can then be submitted in accordance with the website criteria immediately after the call with the claims examiner is completed.

Property Claims

A property claim involves direct first party physical damage sustained to a subscriber's owned property or property they are legally responsible for such as a building, tenanted premises, equipment or supplies. Typical examples are losses sustained as a result of water from broken pipes, fires or burglaries. Note that property claims do not involve damages to non-subscriber property such as buildings, equipment or automobiles. If property owned by others is affected, these occurrences are considered property damage LIABILITY claims and should be reported in the manner set out above.

A property loss is also reported to HIROC in accordance with the criteria set out on the website www.hiroc.com and the process is almost identical. The only distinction is with respect to who the report is directed to and the instructions for this are clearly set out. Again, as mentioned above, if the healthcare subscriber sustains an event with very serious consequences, i.e. a significant fire, a call to the HIROC property Claims Department can be made immediately and the notice of loss submitted after the call to the claims examiner is concluded.

Unfortunately, severe property losses can often occur after business is concluded for the day or the week. If this is the case and you require an adjuster to attend on the scene immediately, please contact the following after hours claims specialists who have complete knowledge of HIROC's claims procedures:

Manitoba: QA Adjusters: QA Adjusting Company (Senior Adjuster: Russ Malkoske): 204-981-1134 or 204-795-7397

All other provinces and territories:

Cunningham Lindsey Adjusters Canada (HIROC Team Leader: Jeff Shurtleff): 1-800-235-8784.

Upcoming Conferences

HIROC supports and exhibits at a number of healthcare-related conferences each year. We have several events coming up this Fall.

September 22-23 – OHA Patient Safety and Mental Health Conference, Toronto, ON. HIROC is the exclusive Silver Sponsor for this conference and Joanna Noble, Supervisor Healthcare Risk Management is presenting as part of a panel. To learn more or register visit. www.oha.com.

September 29-30 – OHA Regional Education Conference, Region 5, Stratford, ON. HIROC will be exhibiting at this event. www.oha.com

October 25-28 – Canadian Homecare Association Summit, Niagara Falls, ON. HIROC will be exhibiting at this event. www.cdnhomecare.ca

November 7-9 – OHA HealthAchieve 2011, Toronto, ON. HIROC will be sponsoring the Patient Safety Session, as well as exhibiting at this annual event. www.healthachieve.com.

November 9-12 – North American Midwifery Conference, Niagara Falls, ON. HIROC will be sponsoring and exhibiting at this event for midwives. www.canadianmidwives.org.

FEATURE

Professional Liability Insurance –'Going Bare'

By Joanna Noble
Supervisor, Healthcare Risk Management
HIROC

Professional liability insurance—'going bare'. It can't happen in Canada. Or can it? A twenty-five year old American exchange student presents to your emergency department with a recent onset of headaches. After consultation with a neurologist, the patient is discharged with a diagnosis of cluster headaches secondary to recent dental extractions. Eight months later your hospital and treating physicians are named in a legal action alleging that the patient collapsed three hours after discharge due to a failure to diagnosis and treat an unruptured aneurysm resulting in a vasospasm and long term brain damage. The suit is launched in the State of Florida (the patient's home state), demanding compensation for $25 million dollars. A Governing Law and Jurisdiction Agreement form was not completed, as hospital policy only requires the use of the form in elective care or treatment situations. Based on the facts of this case, is the organization entitled to full coverage under the HIROC policy?

Based on recent concerning claims, HIROC is encouraging all subscribers to revisit their policies and practices regarding the provision of care and services to non-residents of Canada, in particular the use of the joint HIROC-CMPA Governing Law and Jurisdiction Agreement (GLJA) forms.

Effective January 1, 2005, the Territorial Limitation clause was added to HIROC's Master Policy to mitigate potential exposure from U.S. liability claims. This amendment reflected HIROC's and our subscribers' collective concerns regarding some of the astonishingly large and common place judgments occurring south of the border. As per the Beals v. Saldanha Supreme Court Decision (http://en.wikipedia.org/wiki/Beals_v._Saldanha), U.S. judgments can be enforced in Canada.

While HIROC's policy continues to provide coverage for losses and accidents occurring anywhere in the world, the determination of liability and assessment of damages must be tried and decided in a Canadian court of competent jurisdiction. **Effectively, this means that a legal action must be launched in Canada, recognizing Canadian laws and jurisdiction, before the HIROC policy will step in to assist the subscriber (assuming the risks are covered under the policy). However, coverage will be extended to subscribers in the following scenarios—the provision of healthcare services in Canada:**

- **To a patient/client on an emergency basis, by an Insured; and,**
- **For humanitarian purpose, by an Insured.**

HIROC defines emergency care as "a life-threatening medical condition requiring immediate medical attention." This definition also includes "non-life threatening illness or injury of a nature that failure to provide immediate medical attention could result in serious threat to quality of life, to an organ or a body part."

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"Humanitarian treatment" is defined by HIROC as "treatment provided by an Insured to a patient who comes from a country where the treatment is not available." Evidence of this unavailability is expected to be confirmed in writing by the referring physician.

Subscribers are expected to have effective mechanisms in place to ensure reasonable efforts are undertaken to ensure a GLJA form is completed for all cases involving a non-resident. While not defined in HIROC's policy, non-residents may include (but are not limited to) students, diplomats, employees on work contracts/exchange and military personnel posted in Canada. Refugees and asylum seekers are generally considered residents of Canada. Where there is any doubt as to a patient/client's country of residency, HIROC recommends the use of the GLJA form.

GLJA forms are preventative measures to help ensure that in the event of a claim, the patient/client will pursue legal action in Canada where the care was provided. While the form itself may not prevent or prohibit a non-resident from launching legal action in her/his country of origin, it may be enough to persuade a foreign court's decision regarding jurisdiction. The GLJA form should be secured in and retained as a permanent part of the patient/client's health record. Should legal action be commenced, access to this form will become of vital importance.

A recent Canadian Medical Protective Association (CMPA) article (www.cmpa-acpm.ca/cmpapd04/docs/resource_files/ml_guides/consent_guide/com_cg_treatments-e.cfm), suggests that "(t)here is a greater likelihood the foreign court will permit the legal action to proceed in the patient's home jurisdiction:

- the more it appears that a foreign resident was encouraged or invited to attend in Canada for medical care or attention;
- the more it appears that arrangements for such care were initiated while the patient was in the foreign jurisdiction;
- the more elective the care or treatment provided was; or,
- the more it appears foreign funding was involved."

Subscribers are assuming undue risks if GLJA forms are not consistently used with non-residents of Canada. The key risk is lack of liability protection – i.e. going bare. If a subscriber (including its employees and volunteers) is named as a defendant in an action commenced in a foreign jurisdiction, and is without coverage, the subscriber is personally liable for legal defense costs and any damages awarded.

Take home message—HIROC strongly recommends the use of the GLJA forms for all cases involving non-residents. When in doubt, get the form completed.

Copies of the forms are available at http://www.hiroc.com/cmpajointstatements.asp. For coverage questions, please contact Heather Galli (hgalli@hiroc.com) or Wally Yerro (wyerro@hiroc.com) at 416-733-2773 or 1-800-465-7357.

FEATURE

The Excellent Care for All Act, 2010 – One Year Later

By Patrick J. Hawkins, LL.B., LL.M.
Partner, Health Law Group
Borden Ladner Gervais LLP

The Excellent Care for All Act, 2010 (ECFA) became law on June 8, 2010. At the one year anniversary of its passage, it is important for healthcare organizations to review their compliance with its requirements.

Overview

ECFA applies to "healthcare organizations" which are defined to include hospitals and any other healthcare organization provided for in the regulations[1]. Section 2 requires that healthcare organizations shall comply with every requirement in ECFA and ensure that their quality committee complies with its responsibilities under ECFA.

As set out in the preamble, the focus of ECFA is on a "high quality healthcare system" that is "accessible, appropriate, patient centred, population health focussed, and safe". Further, "patient experience and the support of patients and their caregivers to realize their best health is a critical element of ensuring the future of our healthcare system".

The key requirement of ECFA is that every healthcare organization shall establish a "quality committee" that reports to the "responsible body" (Board) of the organization. The quality committee is given specific responsibilities to monitor and report on the overall quality of services within the organization. Its membership is set out in the regulations (sections 3-4).

ECFA set out specific requirements for hospitals to conduct patient and staff surveys, and to have a patient relations process and patient declaration of values (sections 5-7). Under the oversight of the quality committee, each organization is required to develop an annual quality improvement plan (QIP) which is to be developed with regards to the results of the surveys and patient relations processes, as well as aggregate

critical incident data[2]. The QIP must contain, at a minimum, annual performance improvement targets and information on how executive compensation is linked to the achievement of those targets. A draft of the QIP is to be provided to the LHIN, if requested, and a copy of the final plan to the Ontario Health Quality Council (section 8).

Finally, ECFA continues and redefines the responsibilities of the Ontario Health Quality Council (section 10-13).

Implementation of ECFA

ECFA imposed new responsibilities on healthcare organizations. While many healthcare organizations likely already had some of the processes required by ECFA, all organizations needed to review/revise existing processes and/or establish new processes in compliance with ECFA's requirements.

[1] At the present time, there are no regulations that include other healthcare organizations in the definition.
[2] Amendments to the Public Hospitals Act regulation require analysis of critical incident and reporting to the administrator, medical advisory committee and quality committee.

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Most of the provisions of ECFA came into force on June 8, 2010, with the exception of the requirements for the quality committee which came into force on January 1, 2011. Many of the obligations are also recurring obligations linked to the fiscal year of the organization. For these obligations, organizations will now be into the second fiscal year since ECFA's coming into force.

At the one year anniversary of ECFA, healthcare organizations should ensure:

1. That the quality committee has been established, with defined membership and responsibilities in compliance with ECFA. This committee could continue or replace an existing board committee with new mandates, or be a newly established committee. The quality committee should be established and working now.

2. That there is a process for patient/caregiver and staff surveys as required by ECFA. Surveys of patients are required at least once every fiscal year and of staff at least once every two fiscal years. Patient surveys are therefore required at this stage, with staff surveys within the current fiscal year.

3. That the patient declaration of values is finalized within 12 months of an organization becoming subject to ECFA, which for hospitals means that the declarations needed to be finalized by June 8, 2011. The declaration is to be based on public consultation undertaken within six months of becoming subject to ECFA.[3]

4. That the organization has a patient relations process that reflects the patient declaration of values. The patient relations process should therefore be reviewed again, to ensure that it reflects the newly developed declaration of values.

5. That the QIP is being developed in accordance with the minimum requirements set out in ECFA. This must be developed in every fiscal year for the next fiscal year. The first QIP is therefore now required.

6. That the organization's other quality systems and communication processes provide the necessary flow of information, including reporting and analysis of critical incidents as required under the Public Hospitals Act (PHA), so that the quality committee is properly informed and the QIP developed in accordance with ECFA.

The flow of information may be the most important, and potentially the most difficult, part of ECFA compliance—working to ensure that all quality systems work together in an effective manner with the goal of overall quality improvement within the organization. ECFA and the PHA changes mandate certain communication/consideration of critical incidents, patient relations and survey data, but hospitals should also review all quality systems to ensure optimal performance on an on-going basis.

These are the main responsibilities under ECFA and the items that should be reviewed by healthcare organizations at the one year mark. If further detail is required, reference can be made to the specific requirements of ECFA and the regulations (available at www.e-laws.gov.on.ca) or to resources available from the MOHLTC and OHA.

[3] The requirement to develop a patient declaration of values following public consultation only applies to organizations that did not already have a patient declaration of values before ECFA came into force. Any subsequent changes to any declaration of values must include public consultation.

New Subscribers To HIROC

We are pleased to welcome the following new subscribers that have joined HIROC since the Winter 2011 issue of *The HIROC Connection*.

MANITOBA

The **Southeast Personal Care Home** provides care that is holistic, compassionate, culturally sensitive and respectful of residents and their families. Partnerships with healthcare providers are encouraged at this 80-bed facility owned and operated by the Winnipeg Regional Health Authority (WRHA). Mr. Sais Madansingh is Director of Operations for this home located in Winnipeg, Manitoba.

ONTARIO

Accreditation Canada Global specializes in the provision of health services accreditation, advisory and education services around the world. This team works collaboratively with clients to assist them in the promotion of quality healthcare. Located in Ottawa, Ontario, Mr. Patrick Girard is the Chief Financial Officer.

The **Champlain Hospice Palliative Care Program** delivers a comprehensive range of hospice palliative care in the community, institutional and residential settings. Individuals nearing the end of life and their families are ensured of the physical, emotional, spiritual and practical support they require. Ms. Jocelyne Contant is Executive Director for this program, located in Ottawa, Ontario.

The **Chapleau and District Family Health Team** is located in the Chapleau Township of Sudbury, Ontario. A dedicated team of physicians, nurse practitioners, social workers and dieticians offer healthcare services and programs to residents, including those with no access to a family physician. Ms. Allison Murphy is the Office Manager.

Inner City Health Associates works within the Department of Family Medicine at St. Michael's Hospital in Toronto, Ontario. It is the only program of its kind in Canada to provide primary care services, including psychiatry, to the homeless and marginally housed across the Greater Toronto Area. Ms. Alexandra Pinto is the Homeless Outreach Coordinator for the Associates.

The **Nipigon Family Health Team** uses a patient-centred approach to achieve excellence in rural healthcare and wellness. Medical professionals from various fields work as a team to provide quality care to residents close to their homes. The team is located in Nipigon, Ontario, a township in the Thunder Bay District of Northwestern Ontario. Mr. Carl White is the Executive Director.

The **North West Community Care Access Centre (CCAC)** assists people in obtaining healthcare and social services in their homes, communities and placements in long-term care facilities. Customized care plans that enhance quality of life are developed by knowledgeable medical staff based on individual needs. Ms. Alison Chony is Manager, Contracts and Relationships, and Mr. Chris Houle is Senior Manager, Finance for this CCAC, located in Thunder Bay, Ontario.

Since 1958, **St. Joseph's General Hospital Elliot Lake** has provided care and comfort to the residents of Elliot Lake, Ontario. This public hospital is committed to providing convenient access to healthcare services for patients and their families, reducing the need to travel to larger urban centres. A wide range of services are offered, including a long-term care facility and substance abuse treatment centre. Mr. Mike Hukezalie is the Chief Executive Officer and Ms. Heather Negrych is the Chief Financial Officer.

Sanguen Health Centre Foundation is Ontario's first community-based organization formed to meet the needs of people living with hepatitis B and C in Waterloo Region and Guelph. The clinic provides specialized assessment and treatment with access to affiliated health and other needed programs and services. Ms. Michelle Steingart is the Administrator and Clinic Program Coordinator.

The **Twin Bridges Nurse Practitioner Led-Clinic** will focus on improving access to family healthcare with services and programs tailored to the needs of communities in Sarnia. Twenty-five clinics are expected to be operational in 2012, improving access to primary care for more than 40,000 Ontarians. They will also support chronic disease management and prevention, including the Ontario Diabetes Strategy. Ms. Valerie Winberg is the Project Lead for this clinic.

SUBSCRIBER EXCLUSIVE

Upcoming Webinars

Once again this year, HIROC's Healthcare Risk Management Department has organized a series of webinars on topics of interest to our subscribers. The upcoming webinars are now offered **free to subscriber organizations** and will be conducted using online webinar software.

Contracts and Risk Management Issues
Thursday, September 22, 2011 12:00pm-1:00pm (EST)
Presenters: Heather Pessione, Associate, Borden Ladner Gervais LLP and Mitra Nadjmi, Senior Healthcare Risk Management Specialist, The HIROC Group

Insurance Coverage for Midwives (as well as a midwife specific topic)
Thursday, October 27, 2011 12:00-1:00p.m. (EST)
Presenters: AOM representative, Joanna Noble, Supervisor, Healthcare Risk Management, The HIROC Group and Wally Yerro, Supervisor, Insurance Operations, The HIROC Group

LEAN Initiative in the Emergency Department
Thursday, November 24, 2011 12:00-1:00p.m. (EST)
Presenters: Kim Dieleman, Director, Health Information Service & Quality and Maxine Bryan, Director, Programs and Patient Services - Emergency, both from Concordia Hospital, Manitoba

To register for any of these sessions, please go to www.hiroc.com and click on the Education & Conferences box on the homepage.

SAVE THE DATE

HIROC SERVICES ORIENTATION

Is your organization new to HIROC? Would you like to know more about the various programs and services offered by HIROC? If yes, then plan to attend the HIROC Services Orientation.

During the orientation, you'll have the opportunity to learn about the services provided by HIROC departments, including:

- Insurance Services
- Claims Management
- Healthcare Risk Management Services
- Finance and Administration

The next session will be held on Wednesday, September 14, 2011 in the afternoon at our Toronto office and streaming live via the Internet to our Western Region office in Winnipeg.

For your convenience, you can also attend the session via **webconference**.

This session is **FREE** for subscriber organizations.

Please check our website, www.hiroc.com, for more information and to register.

SUBMIT TO THE HIROC CONNECTION

We welcome submissions on a variety of topics including risk management, patient safety and legal issues. To discuss an article idea or to submit an article, please contact Victoria Musgrave, Manager, Communications and Marketing at 416-730-3085, 1-800-465-7357 ext. 3085 or by email to vmusgrave@hiroc.com.

Please visit our website at: **www.hiroc.com.**

HIROC subscribers can access back issues of *The HIROC Connection* by clicking on SUBSCRIBER LOGIN then THE HIROC CONNECTION. If you have misplaced your password, please e-mail **inquiries@hiroc.com** for assistance.

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