Managing Risk in Research

By: Jamie Terrence, Director, Risk Management, Accountable Executive for Research, California Hospital Medical Center

In 2002, a woman was participating in a clinical research trial that dealt with a common blood condition during pregnancy which may result in a low platelet count for the mother and fetus. The study focused on how prenatal treatment during pregnancy might affect the condition of her unborn child. As part of the study, a fetal blood sample was to be taken from the umbilical vein of the fetus and analyzed to determine the effectiveness of the treatment.

During the woman’s procedure, after the administration of anesthesia, her blood pressure and that of the fetus dropped to a critical level. Despite this, both the obstetrician and the anesthesiologist continued the procedure without monitoring the status of the fetus. It was not until 20 minutes after the start of the procedure that the physicians noted a fetal heart rate in the 60’s which is less than half of what the normal rate should be. A decision was made to perform an emergency C-section.

Prescription for Reducing Risk Associated with Pharmaceutical Compounding

By: Vanessa M. Morales, Esq. and Patrick J. Murphy, Esq.

In the fall of 2012 there was a multi-state fungal meningitis outbreak which resulted in more than 50 fatalities and rendered hundreds of Americans ill. The contamination source was traced back to 17,000 vials of steroid injectables manufactured in bulk at New England Compounding Center ("N.E.C.C.") in Framingham, Massachusetts and distributed to 23 states. N.E.C.C. issued a product-wide recall in October 2012, and later filed for bankruptcy. The outbreak made national news and highlighted concerns regarding regulation of pharmaceutical compounders at both the state and Federal level. On May 22, 2013, in response to the N.E.C.C. incident, the United States Senate Committee on Health, Education, Labor and Pensions ("H.E.L.P.") passed S. 959, the Pharmaceutical Compounding Quality and Accountability Act, which proposes to amend portions of the Federal Food, Drug and Cosmetic Act ("F.F.D.C.A.") (21 U.S.C. 301 et seq.) and streamline regulation of compounders.

This article seeks to offer insight and recommendations prompted by the events in

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Communications Committee Report

Jamie Terrence, Chair, Communications Committee

Summer’s over and most of you are back from your vacations and digging in to your tasks at hand. Well, so is our communications committee. We have another exciting eNews this quarter which is packed full of information to enhance your knowledge and expertise in Risk Management and its many facets. As always, we encourage all of you to submit articles for future publications. Is there an RCA that you participated in that would interest our readers? Perhaps yours could be used in the RCA contest? There is a writer in all of us and that includes you! The eNews is a great way start getting published. We know exciting things are happening in your world. Why not share it with your peers?

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Massachusetts by exploring the nature of compounding, the reasons compounding is necessary for specialized patient care, and the potential exposure medical facilities and healthcare professionals face when contracting with offsite compounders.

**Compounding: What is it and Why is it Useful?**

Most people have at some point in their life taken medication that was prescribed by a doctor. It may have been an intravenous medication administered in a hospital setting, an injectable medication at a pain management clinic, or a pill taken orally from a prescription filled at the local pharmacy. What the general public is likely not entirely familiar with is how that medication is made and gets to the hospital, pain management clinic and local pharmacy. Certainly most people have a basic familiarity with some of the more well known pharmaceutical companies (e.g. Pfizer and Merck) that manufacture medications we see advertised on television every day. What you likely are not familiar with is the difference between those well known pharmaceutical manufacturers, and the lesser known facilities such as N.E.C.C. that are “compounding pharmacies.”

Traditional pharmacy compounding is defined by the Food and Drug Administration (“F.D.A.”) as “…combining, mixing, or altering of ingredients by a pharmacist in response to a physician’s prescription to create a medication tailored to the specialized medical needs of an individual patient.” Compounding in essence dates back to the formulation of medications with the mortar and pestle—an iconic symbol adopted by the pharmaceutical industry. The purpose of traditional compounding is to create patient-specific medications, pursuant to a prescription, by doing such things as adding flavoring to a pediatric medication, removing fillers and dyes that some patients are allergic to, or by converting a medication into liquid form for hospice patients unable to swallow pills.

Just as medication creation has evolved from beyond the corner druggist to include large scale machinery manufacturing, so has compounding production. Certain facilities have expanded the scope of their compounding to a much larger process of non-prescription manufacturing with multi-state distribution. Such facilities are known in the industry as “non-traditional” compounding facilities for medication preparations due to shortages of commercial products that can only be replicated by a compounding facility or because the hospitals do not have the equipment or facilities needed for preparation of high risk medications. Non-traditional compounders fill a large gap in the marketplace for specially formulated medications, yet they operate and exist in a gray area between drug manufacturers and the local or hospital-based pharmacy. As discussed below, this gray area has led to difficulties in ensuring uniformity and sterility, thus opening the door to public safety threats like the N.E.C.C. outbreak.

**Reaction to the N.E.C.C. Outbreak**

As is often the case following large scale incidents, the recurring question asked in response to the N.E.C.C. outbreak is: How did this happen? On a broad level, the explanation is a lack of formal regulation of compounders at both the state and Federal level.

In the wake of the N.E.C.C. outbreak, Congressman Edward J. Markey, Representative for Massachusetts’ Fifth Congressional District (“Rep. Markey”) launched an initial investigation into the respective regulatory roles played by the F.D.A. and the state Boards of Pharmacy by analyzing media accounts and all publicly available safety-related compounding pharmacy enforcement actions taken by the F.D.A. and 50 states.

Rep. Markey’s investigation revealed dozens of instances of injuries and death from contaminated compounded products across the county since 2001. The report outlines the current difficulties experienced by the F.D.A. and state Boards of Pharmacy in regulating non-traditional compounding facilities. These difficulties have arisen not just from questions about which agency has the authority to regulate compounding practices, but the expanding nature of the industry itself.

**REFERENCES**

3. www.help.senate.gov/newsroom/press/release/?id=bf2960e8-c506-4e01-9ac2-c0af34b6c7f&groups=Chair.
5. Testimony of Kasey Thompson, Vice President of Policy, Planning and Communications for the American Society of Health System Pharmacists (A.S.H.P.), November 15, 2012 before The United States Senate H.E.L.P. Committee. www.help.senate.gov/hearings.
Committee Reports

We would also like you to make suggestions on how we can improve the eNews and the SCAHRM website. Send us your suggestions. Email us at: info@scahrm.org or jamie.terrence@dignityhealth.org

Bylaws Committee

Submitted by Danielle Gleason Tarricone, RN, JD, CPHRM

The Bylaws Committee is currently reviewing the various board/committee responsibilities as outlined in the Bylaws to ensure that it is consistent with current practice. It has also drafted a Conflict of Interest Policy and Disclosure Statement for board consideration. The Bylaws Committee is always available to serve as a resource to the SCAHRM Membership on questions relating to the Bylaws, so please feel free to contact me with any questions or concerns.
dtarricone@memorialcare.org

Education Committee

Submitted by Lisa Ramthun, Chair Education Committee

It’s hard to believe we are already well in to Fall and October is over. SCAHRM was dark in October as many of our members attended the ASHRM conference. I enjoyed seeing many of you in Texas.

Education sessions are scheduled on the 3rd Tuesday of the month. If you have a suggested topic or speaker, or would like to volunteer yourself or someone else, please let me know by email or bringing your thoughts to the Education Committee meeting. The SCAHRM May 2014 conference theme is Enterprise Risk Management: Putting the Pieces Together. The Education Committee is looking for speaker submissions for the conference in the following ERM domains:

- Operational Risk
- Financial Risk
- Human Capital Risk
- Technology Risk
- Hazard Risk
- Strategic Risk
- Legal, Regulatory Risk

Please let me, or an education committee member, know if you have a great topic/speaker!

Space is filling up fast for our November 19, 2013 live luncheon meeting at the Montage Laguna Beach, so sign up now in order to make sure you have a seat. Steve Meister and Raymond McMahon will be presenting: You vs. The Two-headed Monster: How to Fight Simultaneous Medical Board and Criminal investigations. To learn more about this exciting and timely program click here or check the SCAHRM website. In addition to our networking and education session on November 19, 2013, the Education Committee will be meeting face to face from 1:00pm-2:00pm. lisa.ramthun@stjoe.org

Membership Committee

Submitted by Julie Hernandez, Chair, Membership Committee

The Membership Committee would like to extend a warm welcome to our newest SCAHRM members.

Scott Ducey
PIH Health
Deanne Munroe
PIH Health
Sarah Foss
UCLA Health System Risk Management
Curtis Holmes
Brobeck West Borges Rosa Douville, LLP
Matthew Yarvis
Brobeck West Borges Rosa Douville, LLP
Jack Raber
Clinipharm Services
Anup Patel
PIH Health
Brenda Benson
Baker Keener & Nahra
John Nahra
Baker Keener & Nahra
Mandeep Rupal
Law Office of Mandeep Rupal

We hope to see you all at our next in-person educational session on November 19th! julie.hernandez@stjoe.org

Nominating Committee

Submitted by Richard Bernard, Chair, Nominating Committee and SCAHRM Past Immediate President

In David F. D’Alessandro’s best seller, “Career Warfare,” the former CEO of John Hancock advises: “Ask for the big opportunities and promotions. It will remind your bosses that you are someone to keep in mind for big jobs.” The strength of any organization is determined by the quality of its leadership and commitment of its members. To that end, SCAHRM’s nominating committee has started work on two critically important initiatives.

1. A succession plan to formalize the process by which SCAHRM identifies, develops and retains future leadership.
2. Development of a Past Presidents’ Advisory Council to provide for a structure to access the wealth of experience and knowledge that resides with SCAHRM’s Past Presidents.

Becoming a leader in SCAHRM is an opportunity to demonstrate that you can handle the big jobs. If you are looking to enhance your professional brand, please reach out and let us know you are ready to become an integral part of building SCAHRM’s future.

We are only as strong as the community of practice that supports us. Please consider becoming one of its pillars by attending the meetings, joining a committee and running for office.

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The child was cared for in the neonatal intensive care unit but was eventually able to be discharged. Subsequently, at the age of 9 months, the infant was diagnosed with Cerebral Palsy due to anoxia from respiratory distress issues associated with prematurity.

The parents brought suit against the hospital, the obstetrician and the anesthesiologist on behalf of their child. The assertion was that the doctors failed to monitor both the mother and the fetus during the procedure and failed to immediately stop the procedure when the condition of the mother and fetus began to deteriorate.

A jury awarded a total of 15 million dollars to the family and held the medical center and the Obstetrician jointly liable for the damages. The Anesthesiologist was not found to be at fault. The study sponsor was not named in the lawsuit. This may have been a missed opportunity by the plaintiff’s attorney to bring in another very deep pocket.

While healthcare treatment in the United States is considered to be state-of-the-art, we rely on research to continue to find new ways to improve our lives and our health. Medical errors do not just occur during the routine treatment of an illness. They can and sometimes do occur during the course of research. Medical professionals and hospitals need to consider how clinical trials are managed in their organizations. All research studies, including clinical trials must be overseen by Institutional Review Boards (IRBs). IRBs approve research studies according to Federal Guidelines in order to protect the rights of human subjects, especially those in high risk categories such as pregnant women. The IRB will review the study protocol to assure that it meets the definition of research and shows a benefit to society that outweighs potential risks to the human subjects. The IRB also reviews the consent process for each study to assure that all of the potential risks are elaborated upon in language that the subject can understand.

Investigators are often paid for their research efforts by study sponsors. The IRB will request information to assure that no conflict of interest exists between the physician as Principal Investigator and that sponsor. Extra caution must be taken when money is awarded during research. No one wants to think that greed enters into the research arena but it does. A question that should have been considered in the above suit whether or not the obstetrician continued the procedure because he was incentivized by the study sponsor to meet the numbers required to validate the study.

In this particular study protocol, there should have been detailed information on how the fetus would be monitored during the procedure. Without that information, it is doubtful that the study would have passed IRB review. If there was deviation from the protocol and the fetus was not monitored as required, the Principal Investigator and the study sponsor would hold various degrees of liability, depending on their contractual agreement. In addition, an Adverse Event report would have to be promptly filed with the FDA.

Each organization that conducts its own research or allows investigators to use their facilities has an Accountable Executive for Research. The Accountable Executive will work closely with Risk Management to review prospective studies in order to ascertain the level of risk involved for the study subject as well as the hospital. If you are a Risk Manager, seek out your Accountable Executive and ask what research is being conducted at your hospital. You may be surprised to find out that studies are being conducted by physicians and other professionals without your knowledge. Ask your Department Directors if there are physicians or others collecting data on their units. This may be considered research. If your Accountable Executive is not aware of this activity than it is likely that your hospital’s or community’s IRB is also not aware. If this is the case, your organization may be at risk of additional liability including Federal penalties and, most importantly, the human subjects recruited for these studies from your patient base are not protected.
A special thanks to the nominating committee members: Maureen Archambault, Peggy Beauchamp, Heather Gocke and Karine Mkrtchyan. Their commitment and hard work is appreciated. bernardr@tmrrg.com

PR/Marketing Committee Report

Submitted by Diane Doherty, Chair, PR/Marketing Committee

It’s that time of year again and we are excited to start the planning of our Sponsorship Campaign for the 2014 Annual Conference. Please e-mail me if you are interested in being a part of the PR/Marketing Committee and/or you/your company is interested in being a Sponsor. On behalf of myself, the SCAHRM Board and all SCAHRM members, we would like to extend a big “Thank You” to all our generous sponsors over the years. Your loyalty and continued support is amazing and what makes SCAHRM so great!

diane.doherty@acegroup.com

Treasurer’s Report

Submitted by Josh Hyatt, SCAHRM Treasurer

Summary of Funds: 10/18/13
Checking Bank Balance: $26,163.95
Investment: $49,016.38
Income/Expense Amounts: Pending Monthly Reconciliation from Bookkeeper

Board Meeting Report

The SCAHRM Board met at the Langham Hotel in Pasadena on August 20, 2013.

Discussions involved: Topics of note that were discussed included the plans for the 2014 conference already entitled “Enterprise Risk Management-Putting the Pieces Together” Lisa Ramthun, the Chair of the Education Committee, will take the lead on conference planning. Also on the agenda were plans for the monthly webinars and on-site educational conferences. Our treasurer reported that SCAHRM is in a good position to fund the 2014 activities but will also be soliciting for new sponsorships.
What IS ASHRM?
Established in 1980, the American Society for Healthcare Risk Management is a personal membership group of the American Hospital Association. With more than 5,600 members, ASHRM represents healthcare risk management professionals, patient safety experts, attorneys, registered nurses, and quality & claims managers. ASHRM promotes effective and innovative risk management strategies and professional leadership through education, recognition, advocacy, publications, networking, and interactions with leading healthcare organizations and government agencies.

News and Events
ASHRM Launches Social Media!
Stay connected to ASHRM through the social media sites Facebook, Twitter and LinkedIn.
www.ashrm.org/ashrm/connections/Social_Media/index.shtml

Just Launched! NEW ASHRM Pearls for Enterprise Risk Management: The Foundation!
These Pearls are designed to help you understand ERM, how it can benefit your organization and help improve patient safety. ERM: The Foundation begins with an overview of ERM, and progresses to implementation of an ERM program and its benefits.
www.ashrm.org/ashrm/online_store/index.shtml

NEW! Risk Management Pearls for Obstetrics:
Part I and Part II
These Pearls provide the tools for healthcare risk managers, patient safety professionals, providers and administrators to help decrease risk and improve the safety in the delivery of care to pregnant women and their babies.
www.ashrm.org/ashrm/online_store/index.shtml

Q4 Forum Issue Now Available
Check out the last issue of ASHRM’s Forum newsletter.

Q4 Journal Issue is Now Available Online!
ASHRM’s Journal of Healthcare Risk Management, published quarterly, focuses on insightful, peer-reviewed content that relates to patient safety, enterprise risk management, insurance, legal and other timely healthcare risk management issues.
www.ashrm.org/ashrm/education/development/journal/index.shtml

Disclosure of Unanticipated Events in 2013
It is a unique world that Healthcare Risk Managers live in; regarded as leaders which can result in periodic public belittlement. As reflected in the ASHRM vision, we see our role as advocates for safe and trusted healthcare. We recognize that by bestowing the best care to our patients we are also able to provide financial savings to the organizations we serve.
www.ashrm.org/ashrm/education/development/monographs/index.shtml

Enterprise Risk Management Handbook for Healthcare Entities addresses the need for and implementation of a comprehensive risk management process and plan that encompasses the entire enterprise and crosses departmental barriers.

ASHRM Awards 2013 Research Grant
ASHRM has awarded a 2013 Research Grant to George Mason University, Fairfax, Va., for its project entitled “Designing Highly Reliable Adverse Event Detection Systems.”
www.ashrm.org/ashrm/education/development/research/2013-research-grant-announcement.shtml

Visit the ASHRM Patient Safety Portal
Throughout ASHRM’s Patient Safety Portal, you will find strategies, tips, resources and more that all healthcare providers will find useful. With these efforts, we hope to promote a comprehensive, organization-wide framework that includes all healthcare employees from operations, to clinical, to financial and beyond—to assist you when making valuable risk management decisions.

eNews
ASHRM’s weekly e-mail newsletter carries the latest risk management news and information.

Special Focus Newsletters
Targeted newsletters that deliver timely content for risk managers.
What's the VERDICT?

By Engle Carobini, Covner & Coats LLP

**FACTS:** The plaintiff's decedent, an elderly man, had suffered a series of falls and was sent to the defendant hospital by his primary care physician. He was seen by a neurosurgeon, and diagnosed with acute and chronic subdural bleeding. He underwent a craniotomy at the defendant hospital. The patient was moved to the ICU post surgery. On the day after his surgery, the surgeon authorized the patient to get out of bed and into a chair. Early in the morning, a nurse put the patient into a cardiac chair and left the room to get supplies. While the nurse was out of room the patient tried to get out of the chair and fell.

The fall necessitated a repeat craniotomy two days later. As a result of the fall and subsequent surgery, the patient required a longer hospitalization and was then released to a long term rehabilitation facility where he fell again requiring a third craniotomy. The patient subsequently passed away for unrelated reasons.

At trial, the plaintiff presented a nursing expert who testified that it was outside the standard of care to leave a patient in the decedent's condition unattended. The plaintiff also presented testimony from the neurosurgeon who testified that he did not believe that the patient would be left alone.

The hospital called as witnesses the nurses and the physician's assistant on duty in the ICU at the time of the decedent's fall. The witnesses testified that the patient was improved and had been previously out of bed into the chair with no problems. Further, the witnesses stated that the patient gave no sign that he would do anything except follow the nurses' instructions. The witnesses stated that the patient had been compliant and had not tried to get out of bed or out of the chair prior to his fall. According to the witnesses, before the fall the patient had followed instructions as given.

**PLAINTIFF’S CONTENTIONS:** The plaintiff asserted that leaving the patient unattended in a chair amounted to negligence by the defendant hospital and its employees. As a result of the hospital’s negligence, the patient underwent two additional craniotomy surgeries which would not have otherwise been necessary.

**DEFENDANT’S CONTENTIONS:** The hospital maintained that there was no negligence on the part of the defendant or its employees. The hospital contended that there was an order to allow the decedent to be out of bed and therefore, there was no negligence on its part. Furthermore, the neurosurgeon did not put any order in the chart to indicate that the patient was not to be left alone, which he could have ordered if he felt it necessary. Additionally, the hospital noted that the decedent was in a unit with a nurse to patient ratio of two to one and as such, he was adequately supervised. The hospital contended that the nurse was authorized to leave the room to attend to other patients or to get supplies if necessary.

**VERDICT:** The jury found no breach of the standard of care and returned a verdict in favor of the defendant.

**LESSON LEARNED:** All accidents are preventable, but not all accidents are caused by someone’s negligence. Still, it is important to strictly follow all safety policies and procedures (as well as physician’s orders) and periodically review those policies and procedures for compliance and performance issues. Even the best practices can and should be improved over time.
BETA Healthcare Group (BETA) is comprised of two insurance entities, BETA Risk Management Authority (BETARMA) and Health Providers Insurance Reciprocal, RRG (HealthPro). With over $500 million in assets, almost $250 million in surplus and an A- (Excellent) rating from A.M. Best, BETA has grown and expanded since it was formed as a California joint powers authority in 1979 to pool the liability claims and losses of district hospitals. Today, BETARMA is the largest writer of hospital professional liability coverage in the state, serving more than 100 county, district and nonprofit hospitals and healthcare facilities and covering over 5,000 physicians. BETA also insures over 30 medical groups and six for-profit facilities through its risk retention group, HealthPro. The cost-effective structure and dedicated management of these risk financing vehicles have earned BETA a reputation for financial strength, rate stability, quality service and breadth of coverage that is unparalleled in the industry.

Critical Alarm Safety
A 43 year old male with a history of alcoholism and well known to the hospital comes to the Emergency Department. His initial complaint is fever and nausea. A work-up shows he has bilateral infiltrates consistent with pneumonia and a high WBC count. Antibiotics are started. His troponin was elevated to 0.36 (<=.26) so he is probably positive for an M.I. He currently does not have any symptoms recent alcohol use. He is hyponatremic. He has a normal sized liver. He does have a history of Hepatitis C. While in the ED he has a seizure and is treated with Ativan and Librium orally. He is admitted to a monitored step-down unit. The admitting MD documents rule out alcohol (ETOH) withdrawal. He is awake and alert.

He is given IV boluses of NS. The admitting nurse notes his elevated troponin and he is on a Venti mask at 8L. When off the O2, his O2 Sat was only 88-90%. The RN increases the O2 to 10L. Respiratory therapy has not been ordered. The next morning, the day shift nurse gets a report that the patient is admitted for ETOH withdrawal. He is off the monitor when he coded.

What is the Root Cause?
1. Patient was off of the monitor when he coded
2. The patient should have been restrained
3. Patient’s hyponatremia was not corrected
4. Admitting MD documented r/o ETOH withdrawal
5. Low heart rate was not reported to the RN
6. His elevated troponin was not addressed
7. He was on 10 L of O2 with no Respiratory treatments

Click here to enter the contest.

Root Cause Analyses (RCA) from interesting or unusual cases will be presented in each edition. Get the Root Cause correct and be entered into a drawing for free registration and a 2 night stay at the SCAHRM Annual Conference in 2013! To enter the contest go to www.scahrm.org/index.php?page=RCA-Contest.
Welcome to the SCAHRM Quarterly: What’s Happening Now, a member benefit established by the SCAHRM Board of Directors. As long as we have your current email address, you will automatically receive this publication approximately once per quarter. Please email info@scahrm.org, if you do not wish to receive this publication, or if you change or delete your email address. In addition, if you have any items you feel would be ideal to include in this eNews in the future, please email Jamie Terrence, Chair of the SCAHRM Communications Committee at jamie.terrence@dignityhealth.org.

**OUR MISSION:** The mission of SCAHRM is to provide its members with continuing education, networking opportunities and professional enhancements within the health care community.

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**Medical Error with Harm Enalapril**
Patient was getting Enalapril 10mg for hypertension. As the patient’s blood pressure stabilized, the Cardiologist decided to reduce the dose to 2.5 mg. However, the physician wrote 25 mg PO BID in error. Maximum safe dose of Enalapril is 40 mg per day. Usual dose for hypertensive patient is 5 to 20 mg per day. The order was faxed to the pharmacy the dose was printed on the medication record. Four doses were given to the patient over 2 days. Nurses were withdrawing five 5mg tablets from the automated dispensing cabinet for each dose. The patient developed early signs of renal failure. The attending physician noticed the dose of Enalapril and called the Cardiologist who said he had ordered 2.5 mg not 25. The Cardiologist went to the chart and put a decimal point between the 2 and the 5 on the original order. The patient continued to receive 25 mg the following day. During a routine chart-check, a nurse noted the new decimal point and added a decimal point to the medication administration record. The patient began getting 2.5 mg and recovered from early renal failure.

**What is the Root Cause? Answer: #4**
4. Pharmacist did not question the cardiologist about the high dose.
Physicians often make prescribing errors. Most hospitals have systems set up to catch those errors before they get to the patient. It is up to Pharmacy to question the dosing. In the event that they miss it, the second tier would be for nursing to catch it. While it complicates things when the physician goes back and tries to cover up the error, it is not the root cause.

**Winner:** Unfortunately there was no winner this month. Next month we will award 2 prizes for the correct answer.

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**Upcoming Events**

**MemorialCare Medical & Nursing Liability Symposium**
*Date:* Saturday, November 9, 2013
*Time:* 7 am to 2:15 pm
*Location:* Long Beach Memorial Medical Center

**SCAHRM In-Person Program: Luncheon**
*Date:* Tuesday, November 19, 2013
*Time:* Lunch & Networking: 11:30 am
Educational Program: 12-1 pm
*Location:* Montage Laguna Beach
Montage Laguna Beach
30801 South Coast Highway
Laguna Beach, CA 92651

For more details on all SCAHRM events please visit [www.scahrm.org/index.php?page=events](http://www.scahrm.org/index.php?page=events)

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**Current members:** click on the “forgot password” link on the member login screen to set up your account (your username is your e-mail address). For questions about the website, contact our website administrator, Kim Erwin at info@scahrm.org.

**Twitter & LinkedIn:** Please sign up and follow your fellow members on Twitter [https://twitter.com/SCAHRM](https://twitter.com/SCAHRM) and LinkedIn [http://www.linkedin.com/companies/scahrm](http://www.linkedin.com/companies/scahrm).


We at SCAHRM realize that it is important to protect your inbox from SPAM. Unfortunately, it often means the e-mails you want to receive don’t quite make it. To ensure delivery of SCAHRM’s e-mails, please forward this document to your IT department so our e-mail service provider can be “white-listed.”

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