Healthcare Risk Assessment and Management

Everyone is a Risk Manager!

Objectives

- Discuss the history and background of Risk Management

- Describe the process involved in identifying risks

- Explain how to apply risk management concepts to quality and safety goals in a healthcare organization

- Discuss CMS Conditions of Participation (CoP)

- Review methods to reduce risk

What is Risk Management?

Risk

- Uncertainty arising from the possible occurrence of a given event

Exposure

- A state of being subject to loss because of some hazard or condition

Risk Management

- Process to Identify, assess and control threats to an organization's capital and earnings. The goal of risk management is to control threats by making decisions that will assist in the prevention of adverse consequences or minimize the effects of loss upon an organization.

What is Healthcare Risk Management?

An organized effort to:

❖ Identify
❖ Evaluate
❖ Reduce *RISK*

- Patients
- Visitors
- Employees
- Business Operations

Goal: Protect assets of the hospital

Improve Patient Safety

Historical Overview

- 3rd Century – Chinese Merchant Ships distributed goods/products among many boats to share the risk of loss if one or more boats sank on the way to market
  - Merchants evaluated the impact of losing their goods and made plans to lower the cost of loss

- Insurance (Shipping Insurance) developed late 1600s near London docks –Lloyds Coffee House – 1st "underwriters" or investors selling cargo insurance

Healthcare Risk Management History

Darling V. Charleston Community Memorial Hospital Supreme Court of Illinois (1965)

- ❖ 18 y/o fractured leg playing football
- ❖ Treated in Emergency Department by on-call orthopedic physician, leg cast
- ❖ Hours later, extreme pain, toes blue
- ❖ Next day, "notched cast"
- ❖ Later, cut sides of cast (subsequently cut leg)
- ❖ Two weeks later (patient still an inpatient) transferred to large hospital for treatment
- ❖ Leg required amputation related to infection

Healthcare Risk Management History

Darling V. Charleston Community Memorial Hospital Supreme Court of Illinois (1965)

- ❖ Hospital's duty extended to ensuring proper treatment

- ❖ Hospital held liable – "knew / should have known"

- ❖ Failure to report suspected deviation from accepted practice

- ❖ Hospital obligated to protect the patient
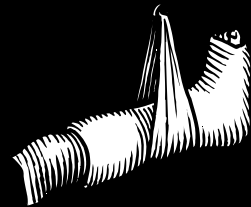
Historical Overview

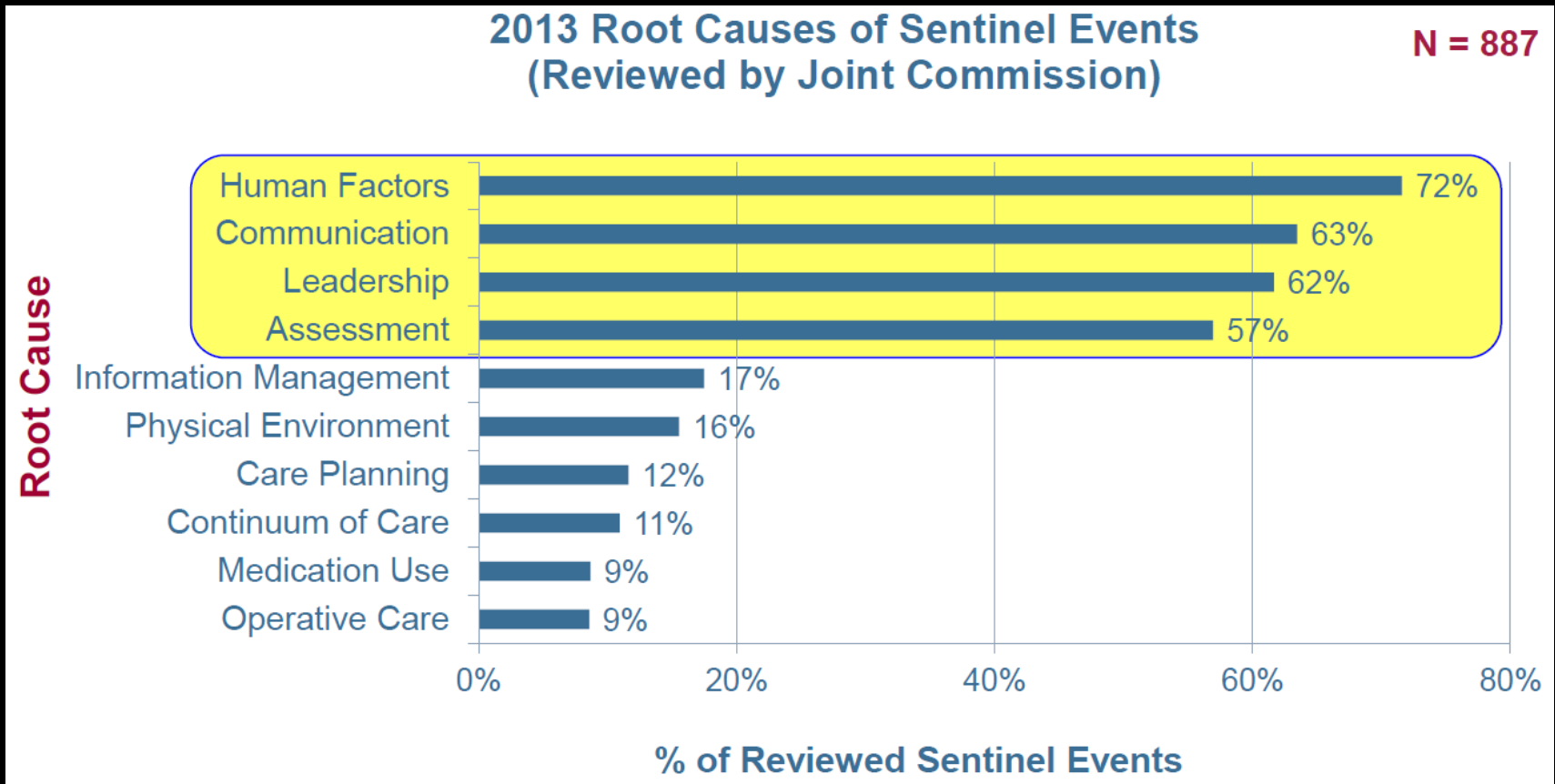| 50 Years of Risk Management History |
| --- |
| **1970s** |
| Statute of Limitations, Formal Risk Programs, Injury Compensation Reform-Capped non-economic damages and attorney fees |
| **1980s** |
| National Practitioner Data Bank, Peer Review Protection, EMTALA, –Patient Anti-Dumping law, Pre-suit notification Malpractice cases, False Claims Act |
| **1990s** |
| American Disabilities (ADA), Safe Medical Device Act, Patient Self-Determination Act, Health Insurance Portability and Accountability Act (HIPAA) |
| **2000s** |
| Amendment-7 (Patient's Right to Know), Patient Safety and Quality Improvement Act (PSQIA) – Patient Safety Organizations, CMS Mandatory Reporting Act, CMS Inpatient Prospective Payment System – no payment for "Never Events" |
| **Present** |
| Affordable Care Act |

Historical Overview

Did you know?

❖ **1999 - The Institute of Medicine** (IOM) estimates that over 98,000 patients die annually from *preventable* events that occurred in hospitals

❖ January 2012 OIG Report - 86% of patient harm events are **not reported** in internal events systems

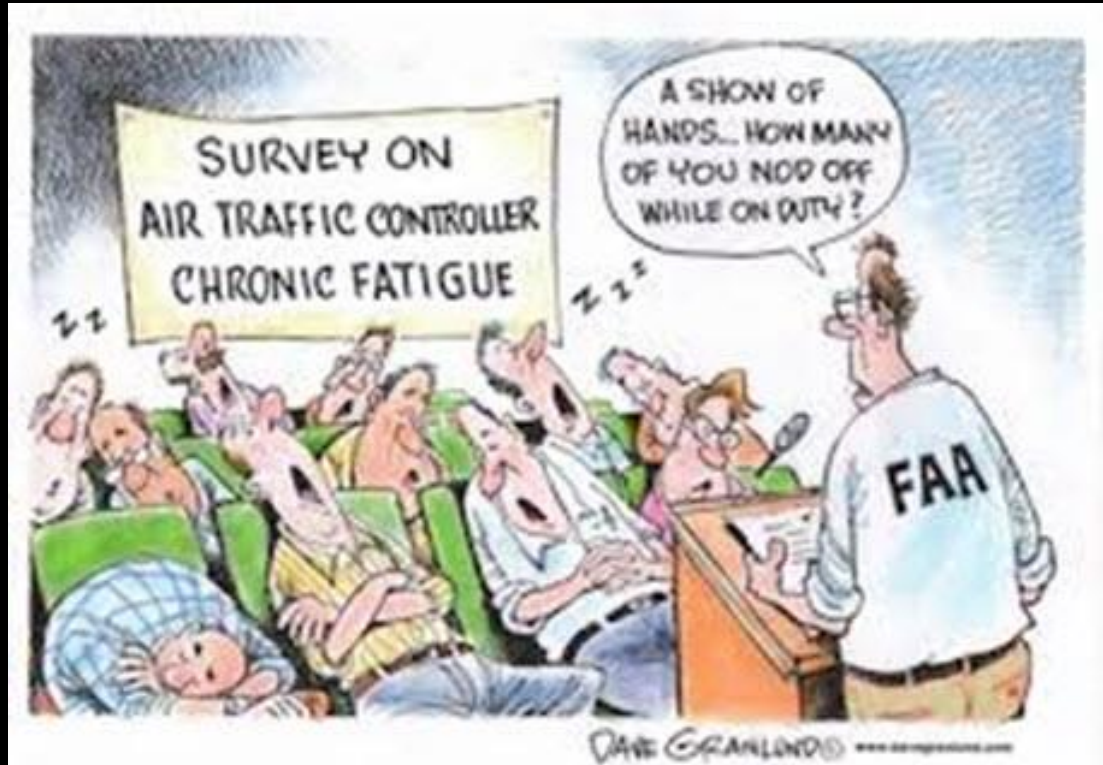Common allegations against healthcare professionals:
- Failure to recognize signs and symptoms
- Failure to monitor and/or report
- Failure to timely diagnose and treat <u>or</u> improper treatment
- Medication errors and/or reactions
- Failure to prevent falls
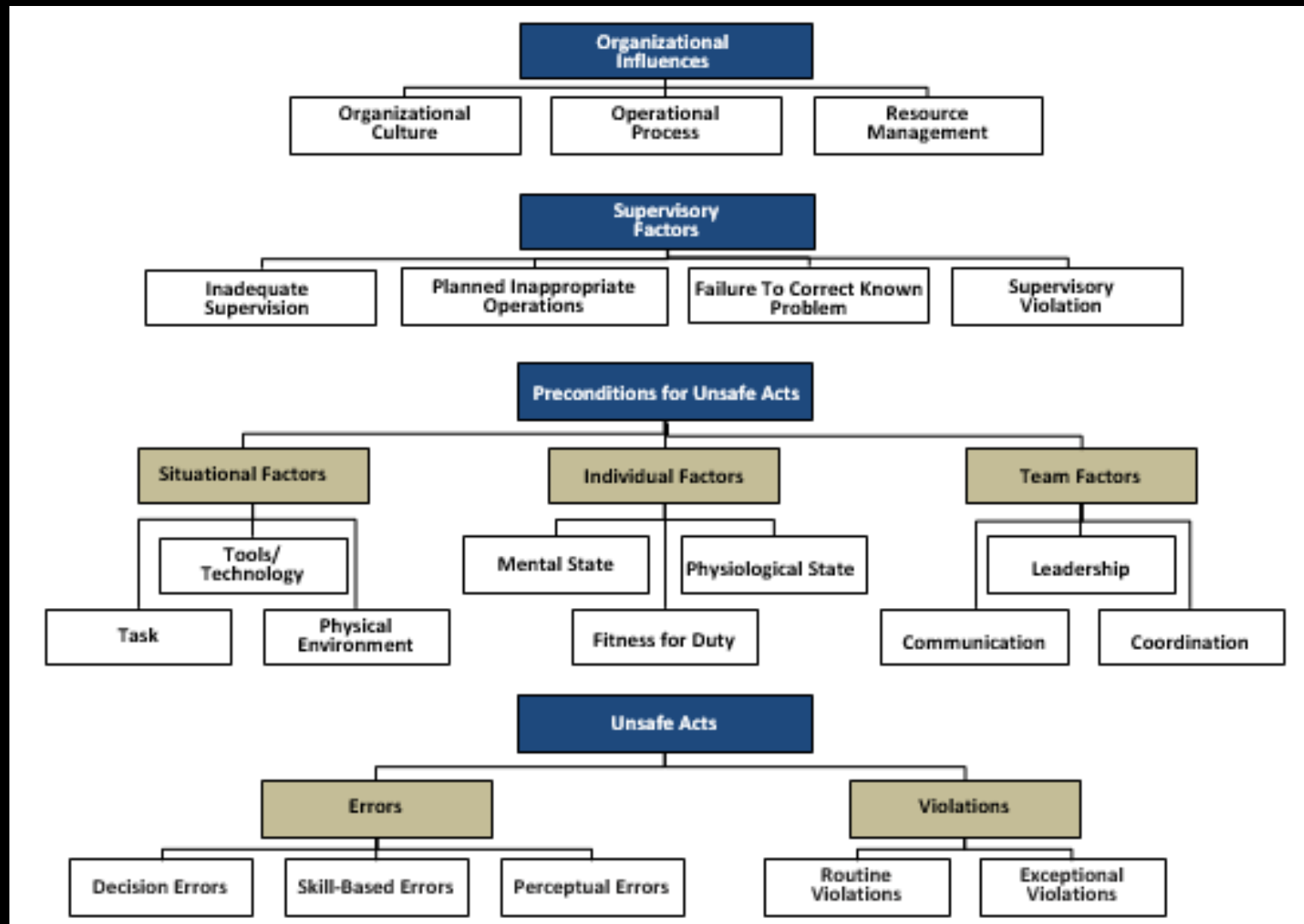- Failure to follow policy and/or procedure

Did you know?

2013 Root Causes of Sentinel Events (Reviewed by Joint Commission)

N = 887

Root Cause	% of Reviewed Sentinel Events
Human Factors	72%
Communication	63%
Leadership	62%
Assessment	57%
Information Management	17%
Physical Environment	16%
Care Planning	12%
Continuum of Care	11%
Medication Use	9%
Operative Care	9%

The Joint Commission, Office of Quality Monitoring, Sentinel Event Data Root Causes by Event Type 20014-2013

Human Factors

Human Factors

Communication

Communication

TeamSTEPPS
Strategies & Tools to Enhance Performance and Patient Safety

Culture

Culture

1. A. Edmondson
2. Thomas-Kilman
3. J. Reason, D. Marx

Transparency:

1. Continuous Learning is visible through Learning Boards and other messaging.

2. Leaders participate in making learning visible.

Accountability:[3]

1. You can't be malicious.
2. Your sensorium must be intact.
3. If you break a rule, we will apply Reason's substitution test.
4. You can't have a history of unsafe acts.

Leaders:

1. Guardians of Learning.
2. Create an environment of Psychological Safety.
3. Nurture an environment of Respect.

Psychological Safety:[1]

1. Comfortable asking questions.
2. Comfortable asking for and receiving feedback.
3. Comfortable being appropriately critical.
4. Comfortable being innovative.

Reliability:

1. The ability of a system to perform its required function under stated conditions for a specified period of time.
2. Reliable process developed with patients, customizable

Improvement and Measurement:

1. Aims identify where you want to go and identify 'how much by when'.
2. Strategy Tactic maps explain your theory and what ACTIONS you need to take to achieve the Aim.
3. Systematic testing cycles (PDSA's) are the small episodes of learning that help you refine your ACTIONS.
4. Measures reflect the magnitude of improvement; reflect the adequacy of the processes; the related outcomes; this includes some measures ("balancing measures") that allow us to know if there are any unintended consequences.
5. Data is measured over time using run charts or statistical process control charts .

Continuous Learning:

1. Continuous Learning is Defect Identification and Idea Generation, and occurs through Debriefing (reflecting on performed activity).
2. Defects are acted upon in a timely fashion.
3. Feedback occurs regularly to those who identify defects and generate ideas.

Teamwork & Communication:

1. Plan Forward - Briefing/Pause/Checklist/Huddle
2. Reflect Back - Debrief
3. Communicate Clearly - SBAR, Repeat Back
4. Resolve Conflict - Critical Language

Negotiation:[2]

1. Five types of negotiation: avoid, accommodate, compromise, compete, collaborate.
2. Look for the Interests that underlie Positions.

Learning — Reliable Process — Improvement and Measurement — Transparency — Continuous Learning

Culture — Accountability — Teamwork & Communication — Leadership & Psychological Safety — Negotiation

Framework for Operational Excellence

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Just Culture

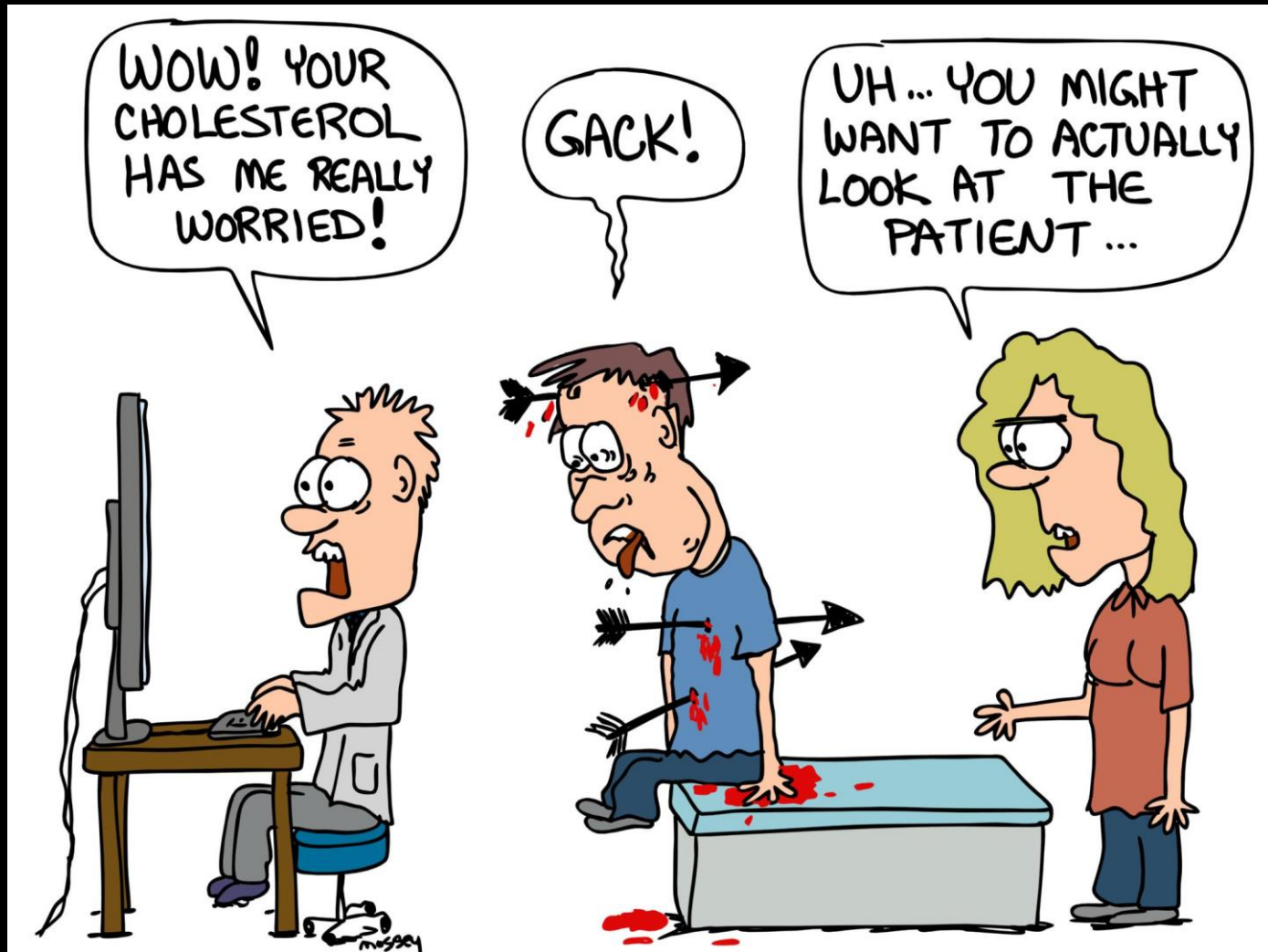**Supports system learning through error reporting without fear of retribution for mistakes**

A clear line must be drawn between acceptable and unacceptable behavior

System SAFETY

Personal ACCOUNTABILITY

Assessment

Present Day Risk Management

Assessment of Risk

- Retrospectively
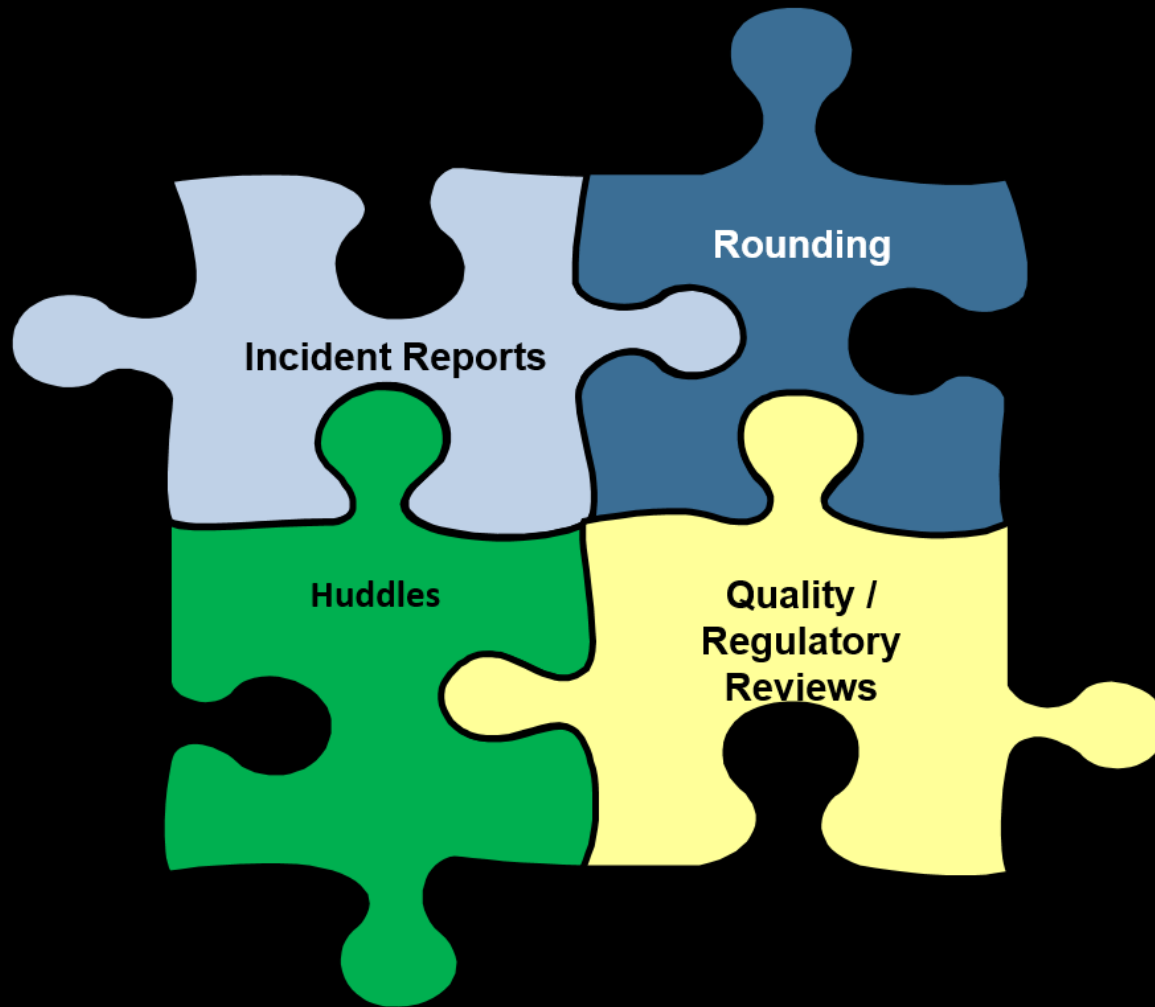- Prospectively
- Concurrently
- Pre-intervention basis

Assessment of Risk

❖ What makes a Healthcare Setting High Risk?

- Complex setting
- Technology
- Small margin for error
- Potential for injury is high
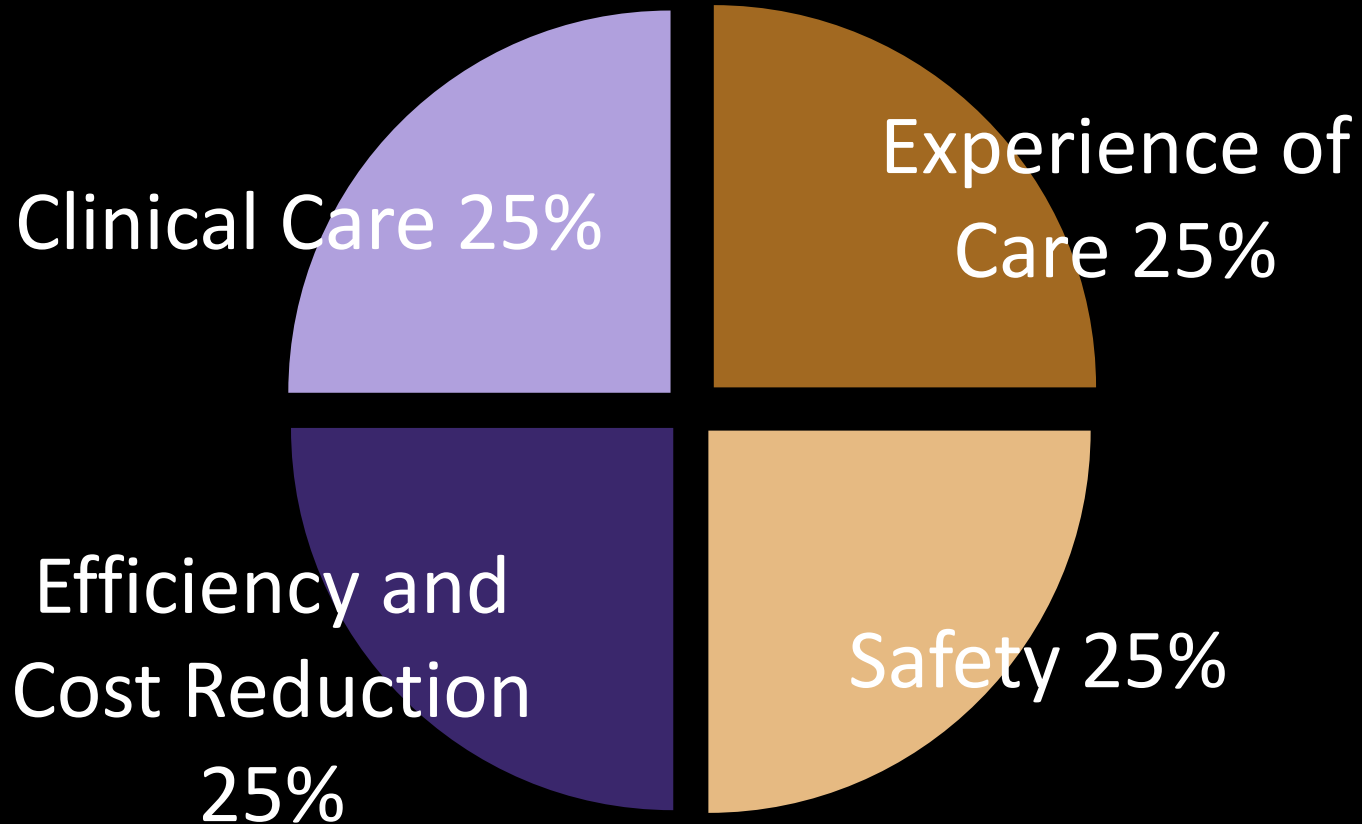- Multiple hand-offs
- High level of stress – Patients and Providers

Assessment of Risk

Assessment of Risk - ERM

Value-Based Care

Clinical Care 25%

Experience of Care 25%

Efficiency and Cost Reduction 25%

Safety 25%

Risk Management vs. Quality Management

- Two Departments: Same Goal ➡ Patient Safety

- CMS is the highest payor source for hospitals

- Previously - DRG

- Now – Affordable Care Act ● pay or penalty

  o Experience of Care
  o Clinical Care
  o Safety
  o Efficiency and Cost Reduction

"Instead of payment that asks, *How much did you do?*, the Affordable Care Act clearly moves us toward payment that asks, *How well did you do?*, and more importantly, How well did the patient do?"

Don Berwick

Risk Management vs. Quality Management

- Data Drives Pro-Active Mitigation Strategies

    o Evidenced Based Practice
    o Claims History
    o Reputation

- Regulatory and Accreditation Standards

    o Complaint / Grievance
    o Serious Safety Events

"It takes twenty years to build a reputation and five minutes to ruin it."

"Building a genuine culture of *'doing the right thing'* can help off-set risks"

Warren Buffett

Government Regulations

Conditions of Participation (CoP):

As a condition of participation in CMS programs hospitals are required to develop and maintain a Quality Assurance Performance Improvement program (QAPI)

- Hospitals must track medical errors and adverse patient events

- Hospitals must measure, analyze and track quality indicators and their causes

- Hospitals must implement preventive actions and mechanisms that include feedback and learning throughout the hospital

Risk Management Stories

Risk Management Stories

Clostridium difficile is shed in feces. Any surface, device, or material (e.g., toilets, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the *Clostridium difficile* spores. *Clostridium difficile* spores are transferred to patients mainly via the hands of healthcare personnel who have touched a contaminated surface or item. *Clostridium difficile* can live for long periods on surfaces.

C-Diff

500,000
Number of C. diff infections in the U.S. in 2011

30,000
Number of people who died of C. diff within 30 days of infection

$35,000
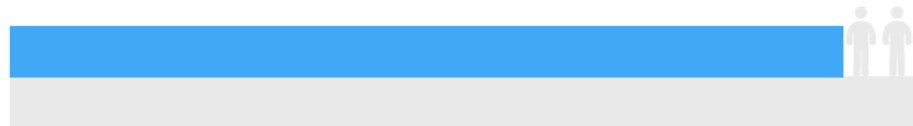Average total cost for a single patient with C. diff

$3 billion
Average annual cost of C. diff

94%
Percentage of C. diff infections connected to getting medical care
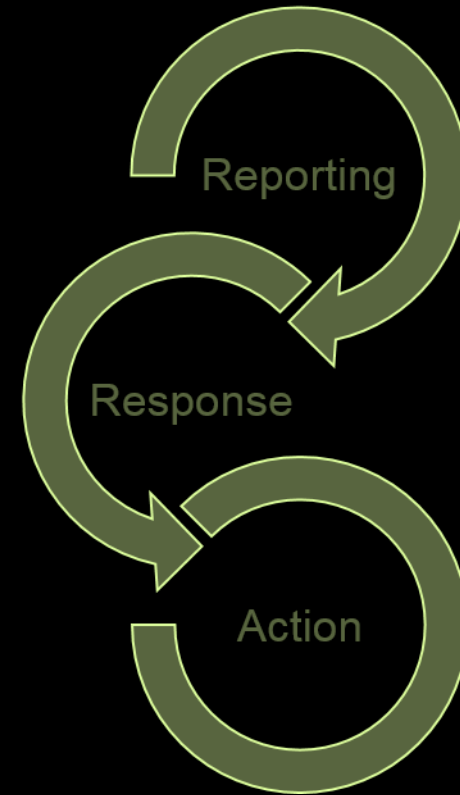
Betty's Story

Root Cause Analysis
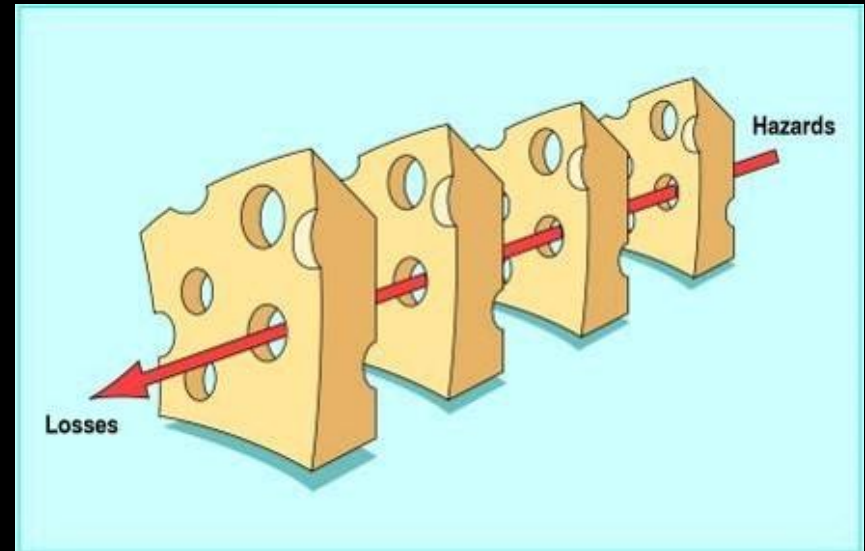
Root Cause Analysis

- Process
- Immediate Action
- Classification
- Investigation
- Resolve

Root Cause Analysis

Corrective Action Plans

- Human factors –
    - Unsafe Acts
    - Preconditions for Unsafe Acts
    - Supervisory Factors
    - Organizational Influences
- Sharp and blunt end
- Latent and active failures

RCA2 – Human Factors

- RCA^2 focuses on identifying system vulnerabilities

- RCA^2 is not used to focus on or address individual performance

- Benefit for patient safety occurs when system based vulnerabilities are addressed

Risk Management Summary

- Healthcare risk management is charged with the protection and preservation of organizational assets

- The best way to accomplish this task is to deliver quality patient care in an environment that is safe, equitable, and efficient

- Pro-active Risk Mitigation can and will meet the challenges of the changing environment we experience in healthcare

Thank you

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QUESTIONS