Risk Management in the ASC

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Conflict of Interest Disclosure

I DO NOT have an actual, potential or perceived conflict of interest to disclose for myself or my spouse/partner or the organization I represent.

Risk management

- Broad or narrow scope
- Opportunities for synergy
- Staff education and involvement
- Goal of patient safety and enterprise protection
- Manage and meet requirements and organizational goals
**Risk management**

- Risk Identification
  - Investigation
  - Loss control
  - Risk-financing program

**Quality management vs. Risk management**

- Quality Management
  - Quality indicators and quality assessment
  - Infection prevention and control
  - Utilization - medical necessity
  - Performance improvement

**Quality management vs. Risk management**

- Risk Management
  - Identifying risk factors
    - Monitor, profile, and trend
  - Prompting remedial action
  - Reducing occurrences
- Management
  - Compliance
QM and RM overlap

- Identification of suspected or actual problems leading to adverse events
- Intervention to reduce likelihood of occurrence or recurrence
- Monitoring systems
- Analysis
- Education
- Everybody’s responsibility

Risk management & QAPI

- What came first?
  - Managing risk to reduce losses?
- Patient Safety
  - System and process design and quality assessment so there were no losses to reduce
  - QAPI
  - Risk finding, assessment, reduction

Scope of Risk management

- Comply with Regulations and Standards
  - Medicare, CMS Appendix L
  - State licensing regulations
  - Accreditation standards
  - OSHA
  - HIPAA
  - CLIA
  - False Claims Act, Anti-kickback laws
  - Employment laws
  - More, more and more
Scope of Risk management

- Financial risk management: insurance coverage, loss control activities
- Coding and billing compliance
- Conferring with claims management
- Patient grievances, patient satisfaction
- Protecting information: HIPAA & Business
- Data collection and analysis, treatment, action
- Adherence to Medical Staff bylaws, rules, regulations

Scope of Risk management

- Adherence to policies, procedures, protocols
- Accreditation standards compliance
- Staff training and education
- Staffing, competency, skill level
- Credentialing and privileging
- Peer Review process, findings, actions, protected information
- Life Safety Codes
- Patient safety
- Performance improvement

Scope of Risk management

- Med Record management & documentation
- Medication safety: administration, procuring, protecting/security from theft
- Consent
- Infection prevention
- Never events
- Reporting requirements
- Process analysis
- Communication
### Define scope

- Risk management to meet State requirements
- Patient safety including operational processes
- Regulatory compliance such as CMS, OSHA
- QAPI
  - Assessment
  - Coordination and guidance
  - Action plans
  - Risk reduction
- Patient Safety

### Patient safety: what is it?

- Freedom from accidental injury. Establishing systems and processes to minimize likelihood of errors and maximizing the likelihood of intercepting them when they occur. (IOM)
- Preventing and avoiding errors, deviations, and accidents. Patient safety as a subset of quality. (NPSF)
- Reduce the probability of adverse events resulting from exposure to the health care system. (AHRQ)

### Commonality of QAPI and RM

- Emphasis on creating improvements in process and systems in order to create safe patient care services
- Identify potential for error
- Be proactive to have a process to reduce errors
- Develop and implement
- Review implementation and results
- Change, update, tweak as needed
Identification of potential issues

- Identify and recognize areas where there are potential problems.
  - Miscommunication or lack of communication
  - Lack of complete information
  - Lack of training and ongoing review of implementation
  - Breakdown in transmission of data and information
  - Failure to understand impact

Identification

- Errors
  - Lack of knowledge
  - Lack of sufficient orientation
  - Unclear policies and procedures or no guidance
  - Staff not educated on new or revised procedures
  - Staff not educated on new equipment and alerted to difference between odd and new equipment
  - Lack of up-to-date information
  - Expecting patients to know more than they do

Methods to identify exposures to poor outcome and potential loss

- Audits: Observation, Documentation Review
- Inspecting facilities, equipment, operations
- Reviewing policies, procedures
- Reviewing outside service contracts and fulfillment of obligations
- Regulatory compliance and Standards of Care
- Medication management practices
- MDFU
How to identify?
Incident reports, indicators, variances

- Mandated reports versus helpful alerts of potential issues:
  - Only what the state defines?
  - Any Variances?
  - Quality Indicators?
  - Unplanned events?
- Employee participation through education, training, supportive Q&A program

Methods to identify exposures, cont’d

- Patient Safety Goals
- Assessment of processes and practices
- Trends in incident reports, near misses or indicators
- Mini “tests,” taking a section of policies or regulations, testing your processes
- CDC guidelines
  - Available nationally recognized standards

Staff participation

- Learn from staff
- Get input and involvement:
  Manufacturer’s DFUs, LSC requirements, safety checklists, regulatory and accreditation compliance checks
- Share knowledge so staff can be your eyes and ears
- Let them develop checklists and ways to use them
Beyond blame

A system approach

Beyond blame

- Medication Errors
  - Labeled container and syringe
  - Not following normal routine
  - Sound alike/look alike medication alerts
- Impact on Staff as well as patient
  - Trust by others, trust of self
- Save syringe, have contents analyzed
- System errors. Communication.

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Management

- Develop program for all areas
- Review training, educating, implementing
- Integrate QA, IC, RM, Medication Management
- Data collection, analysis, action plan
- Reporting
- Evaluating

Management

- Supervise the indicators, collection of data, and statistical trending
- Coordinate with QAPI to conduct audits, studies, and projects to assist in changes to policies and processes and enhance education
- Analyze the risk of loss versus cost of reducing risk
- Recommend changes in risk control and risk financing based on changes in property or activities

Management

- Develop and implement educational programs to reduce or eliminate potential safety hazards
- Develop and maintain profiles on individuals and ensure integration into the credentialing and peer evaluation process
  - Transfers
  - Cancellation on day of surgery
  - Adverse events
  - Participation in time out, patient safety activities
  - Culture of Safety attitude
When an incident occurs: reporting the event

- Record only the direct medical care. Write only the facts.
- Do not write conclusions, opinions, admissions or accusations.
- Not part of the medical record and nothing in medical record that states an incident report was completed.
- No copies made of the incident report.

Analysis of the event

- Separate documentation of findings and analysis
- Understanding the cause
- When to do a Root Cause Analysis
- How to do a RCA
- When to peer review and what to do with the information
- Blame-free environment to encourage reporting and thoughtful, open-minded analysis

Root cause analysis or roots of causes

- System or process approach – not a blame game
- Determination of human and other factors
- Determination of related processes and systems
- Analysis of underlying cause and effect systems through a series of why questions
- Identification of risks and their potential contributions
- Determination of potential improvement in processes or systems
Root cause analysis

- Action plan for improvement or correction for each root cause or contributing factor.
- At minimum, a suggested corrective action, a date of implementation, a team appointed to carry out the action, how and when each action will be evaluated, and the date of evaluation.
- (Sounds like a PI process???)

Staff support

- A system in place to support staff involved in medical errors.
- Supportive environment that includes a non-punitive reporting system and counseling.
- Plan in place before needed

Disclosing an error to the patient

- When
- How: In person, with provider, tailored to the patient’s level of understanding.
- Recorded (but, not in medical record)
  - Time, date, place of discussion
  - People present and relationships
  - The event that was discussed
  - Relevant information provided
  - Offer of assistance, further meetings to respond to late questions or pent up anger
  - The family’s and patient’s response
Managing the data

- Log
  - Look for trends: Staff, day of week, type of event
  - Reminders for follow up, discharge summary
  - What should be peer reviewed this quarter, immediately or routine
  - What is reportable to government agency

2014 Quarterly-Event Log-ASC

Let me share my day with........
§ 416.43 (a) (2) The ASC must measure, analyze, and track quality indicators, adverse patient events, infection control and other aspects of performance that includes care and services furnished in the ASC.

Interpretive Guidelines:
- The severity of problems. For example, any single instance of a transfer of a patient to a hospital represents a serious adverse, unplanned outcome of the surgical procedure, and it would be appropriate for an ASC to track and evaluate all such cases, due to their severity, even if they are low volume incidents.

Interpretive Guidelines
- ASCs must track all patient adverse events, in order to determine through subsequent analysis whether they were the result of errors that should have been preventable, to reduce the likelihood of such events in the future. ASCs are also expected to identify errors that result in near misses, since such errors have the potential to cause future adverse events.
§ 416.43(c) Standard: Program Activities

- (2) Performance improvement activities must track adverse patient events, examine their causes, implement improvements, and ensure that improvements are sustained over time.
- (3) The ASC must implement preventive strategies throughout the facility targeting adverse patient events and ensure that all staff are familiar with these strategies.

Interpretive Guidelines:

CMS does not expect ASCs to engage in sophisticated statistical modeling of data, but calculation of incidence rates should be within the skill set of individual(s) conducting the analysis. On the other hand, CMS does expect ASCs to conduct thorough analyses that focus on systemic issues. For example, if the ASC’s adverse event tracking system identifies a medication error that resulted in serious injury to a patient, the ASC would not be taking the type of systems approach mandated under the QAPI regulations if it states that the event was caused by the staff member who administered the medication incorrectly, and that its method for improving performance was to fire that staff member. An acceptable analysis would look at the root causes that facilitated the error by the staff member.

Interpretive Guidelines:

- Ask the ASC how it trains staff on ways to prevent adverse events from occurring.
- Ask ASC staff what they know about the ASC’s QAPI program, focusing in particular on staff awareness of policies and procedures for preventing adverse events.
CMS: §416.43(e) GB responsibilities.

- The governing body must ensure that the QAPI program
  (1) is defined, implemented, and maintained by the ASC.
  (2) Addresses the ASC’s priorities and that all improvements are evaluated for effectiveness.
  (3) Specifies data collection methods, frequency, and details.
  (4) Clearly establishes its expectations for safety.
  (5) Adequately allocates sufficient staff, time, information systems and training to implement the QAPI program.

CMS

Is designed to establish clearly the governing body’s expectations that patient safety is a priority, not only by the tracking of all adverse events, but also by the program’s processes for analyzing and making changes in ASC operations to prevent future such events.

Governing Body responsibilities

- Medicare
  - Oversight and accountability for the QA and PI program
  - Ensure policies and procedures are administered to provide quality care in safe environment
Report to the Board

- Analysis of trends identified through incident reports, occurrence screens, indicators
- High risk, problem prone areas reviewed and trends from review
- Safety audits, findings, action plans
- Insurance coverage audits
- Documentation audits
- Patient complaints, grievances, outcomes
- Any subpoenas, claims, attorney correspondence

Questions?

- Which came first, risk management or quality improvement?
- Can you have risk management without quality improvement? Or, vice versa?
- Should we do a root cause analysis on near misses?
- Is it best to report detail or summarize reports to the governing body?
- What information is protected by law? And, how?

Resources

- VA National Center for Patient Safety at www.patientsafety.va.gov
  - Patient Safety Improvement Handbook
  - HFMEA (Healthcare Failure Mode & Effect Analysis) on portable battery operated Glucometer