INTEGRATED RISK ASSESSMENT
Compliance-Risk-Quality
CRQ

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Cincinnati, Ohio

Integrated Risk Assessment

Why integrate CRQ?
- Risks cross functional domains
- Facilitates collaboration
- Resources are limited-focus team on priorities
- Internal expertise resides in “silos”
  - Quality-Patient Safety
  - Operations Management (Nursing-UM-CMO)
  - Risk Management
  - Physicians-Medical Staff
  - Audit (Internal and Compliance)
  - Compliance
  - Accreditation
Integrated Risk Assessment

Why Integrate?
- Enable effective mitigation strategies to achieve high value:
  - Decreased cost of risk
  - Regulatory compliance
  - Loss prevention
  - Revenue protection
- Industry benchmarks: risk masters integrate!
- Congruent with ERM
- Compliance masters assure management establishes strong controls!

CRQ Functional Intersection

- Government enforcement
- Payment methodologies
- Accreditation
- Claims
- PI
- Standards compliance
- Monitoring-Investigation
- Assess data/identify trends
- Education/training
- Physician engagement
Common Elements-CRQ

- Continuous Improvement
  - Exceed Expectations
- Reduce Defects,
  - Errors, Waste
  - And Expenses
- Prevent Claims-Loss-
  - Non Compliance

- Processes impacted by regulatory and payment priorities
- Policy-procedure execution
- Credentialing, competency, licensing, CoPs, Coding
- Systems to detect and correct quality-safety problems
- Governance, leadership
- Utilization monitors, placement, emerging trends, risks, billing

Value Drivers

- Continuous Improvement
  - Exceed Expectations
  - Protect Revenue
- Reduce Defects,
  - Errors, Waste
  - And Expenses
- Prevent Claims-Loss-
  - Non Compliance

Interdisciplinary Systems and Controls

- Protection, Reinvestment, Satisfaction
- % Effective
Domains

- Classify systems by function, not oversight
- Facilitate sorting of risks
- Facilitate identification of processes that cross departments
- Organize reporting of risk mitigation, compliance/control effectiveness

Compliance Risk Domains

- Oversight
- Financial incentives-relationships
- Access - medical necessity
- Quality-patient safety-patent rights
- Documentation and coding
- Billing and reimbursement
- Privacy and security
Quality Domains

- Oversight
- Medical Necessity
- Outcomes
- Effectiveness-efficient use of resources
- Operating values
- Safety, rights and efficacy
- Medical Staff
- Technology management

How do we start?

Oversight:

- CRQ stakeholders officiate
- Interdisciplinary committees
  - Evaluate risks; discern interconnected patterns
  - Monitor-analyze-manage
  - Standardize assessment and reporting
  - Prioritize performance improvement, actions
  - Collaborate with ERM activities
How do we start?

Common data base
- Standardized
- Shared
  - Event reporting database
  - Risk assessment
  - Report writers and tools
  - Audits
  - Notices
- Classify events into domains
- Incorporate all inputs (to sort data at later date)
- Stores the interactions matrix

How do we start?

Risk assessment
- Define Domains
- Identify critical path processes under domains
  - Benchmark to validate
- Assess process controls and risks
  - Evidenced based preferred
    - Tracer, Probes, Documentation
  - Subjective-requires validation
    - Audit, data, control results
- Score findings (risk priority)
How do we start?

Create a culture of risk awareness and doing the right thing:

- Transparency in reporting
- Congruence with objectives
- Governance oversight and endorsement
- Education and interaction with staff/physicians
- Interdisciplinary evaluations and assessments
  - Credible source of information
  - Meaningful to operators

How do we report?

Dashboard and Assessment report

- Board knowledge of risk and mitigation
  - Fiduciary
  - Quality/Patient Safety
  - Compliance and audit
- Key Metrics-Quantitative-add value
- Measure effectiveness over time
- Identify emerging risks in key domains
- Identify key interactions impacting mitigation
- Management ownership
**Planning Tools**

**Heat/Environment Map**
- Ranks by likelihood and consequence
- Aids in identifying risk response gap
- Aids in prioritizing response (MAAT)
  - Mitigate, avoid, adapt, accept, transfer
- Does not identify other interconnections that impact consequences or effectiveness

**Interaction matrix**
- Identifies connections and cumulative risks
  - Critical paths causing system failure
  - Micro connections in process and departmental risks
- Determines response effectiveness-systemic
  - Mitigation and planning
  - Efficiency and effectiveness
- Risk domains in concordance with ERM-system objectives
  - Joint responsibility- stakeholders
  - Promotion of idea exchange
**Actions Post Assessment**

- **Monitor**
  - Management owns monitors

- **MAAT**
  - Mitigate, Avoid, Adapt, Transfer

- **Analyze**
  - Audit-full audit or expanded probe
  - Assess impact on objectives/safety/claims
  - Test against interactions map

**Assessment Steps**

- Assess key elements of processes under domains
- Assign effectiveness benchmark (75% or greater)
- Include internal and external drivers in formula (environment)
- Assess against the environment
- Assess for interactions
- Determine the GAP (Residual Risk)
ED Case Study

Emergency Room Processes

- Patient Arrives ED short of breath
- Short staff
- No Monitored Bed
- Found Unresponsive
- Door to Triage > 1 hour; MSE delayed
- Lab work late
- > 30 Min between observation of pt

Compliance and Risk Implications

- Delayed MSE
- Short Staffed
- No monitored bed
- Lab work late
- Observation delayed
- Death

- EMTALA
- Patient safety-regulatory
- CoP
- Quality
- Patient safety-quality
- Claim; SE; Billing SE
Interactions diagram

Financial Shortfall ?  
Short staffing  
Sentinel Event  
No monitored Bed  
Delayed lab  
Strategic ?

Interactions-System
# Risk Assessment

<table>
<thead>
<tr>
<th>DOMAIN - EFFICACY</th>
<th>Standard</th>
<th>Findings (Hypothetical)</th>
<th>Process Summary</th>
<th>Adequacy Score%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAFETY</td>
<td>Bed Use-Diversion</td>
<td>Bed Use-Diversion</td>
<td>77%</td>
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</tr>
</tbody>
</table>

| Bed Use-Diversion | Effective collaboration/use of data (with other units) to place ED patients efficiently and expedite incoming transfers. | Access of the transfer center dashboard to nursing supervisors, PI project to increase efficiency, reduce diversions | 75% |
| Is bed occupancy tracked to assure prompt movement of patients to appropriate level of care to manage capacity? | Management makes the decision based on objective factors affecting capacity and capability | Diversion is monitored, action plans in place to decrease frequency | 70% |
| Is there a management process in place to determine when the ED is at capacity and must divert? | Effective oversight of EMS notifications and diversion management (planned checks) | Process in place, involves management and physicians and transfer center. Notification logs through transfer center call center to EMS. | 98% |

## Assessment (Continued)

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</thead>
<tbody>
<tr>
<td>SAFETY</td>
<td>Medical Records</td>
<td>Medical Records</td>
<td>92%</td>
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</tr>
</tbody>
</table>

| Medical Records | Evidence that process in place to store all logs and records; disposition of all patients, including outside transfers monitored | No finding-process in place; reporting of dispositions at dept and quality meetings; arrivals justified and tracked daily | 98% |

| Are procedures in place to assure proper disposition and transfer of records for those patients being transferred from the facility? Are EMS staff trained to properly access and maintain records? | Evidence that complete copy of records follow patient | No finding-process in place-probed 10 records | 80% |

| Do patients who refuse to consent to treatment and/or transfer sign the appropriate forms? Are these forms kept with the medical record? | All consents (or refusal to consent to treatment) on records | Sample periodically for quality review-5 probe no finding | 85% |
## Assessment (Continued)

<table>
<thead>
<tr>
<th>Hypothetical</th>
<th>Standard</th>
<th>Findings</th>
<th>Process Summary</th>
<th>Adequacy Score %</th>
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<tr>
<td>Policies</td>
<td>Policies</td>
<td>Policies</td>
<td>Policies</td>
<td>Policies</td>
</tr>
<tr>
<td>Are policies and procedures available for all staff to access?</td>
<td>Policies are available for all staff and physicians, evidence in employee file of training and competency</td>
<td>Manuals available, staff files indicate competencies, EMTALA training not completed</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Are policies up to date and reflective of regulatory requirements?</td>
<td>Policies current and comprehensive, education on file</td>
<td>EMTALA policy updates in progress</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td>Throughput OA</td>
<td>Throughput OA</td>
<td>Throughput OA</td>
<td>Throughput OA</td>
<td>Throughput OA</td>
</tr>
<tr>
<td>Are EMTALA monitors defined in the Dept Quality plan and in place? Are results reported through quality and action plans initiated when there are deficiencies?</td>
<td>Monitors defined based on EMTALA risk, data is gathered, studied and appropriate responses are initiated</td>
<td>Monitors need developed: LVES; capacity/diversion management; reconciliation - entrance log vs disposition; checking on documentation of review at quality meetings (in the context of EMTALA compliance):-10 charts reviewed; NI</td>
<td>60%</td>
<td></td>
</tr>
</tbody>
</table>

### Formula

\[
\text{Priority Score} = (\text{Sensitivity} + \text{Materiality} + \text{Complexity}) \times \text{Likelihood} \times \text{Detectability} = \text{Vulnerability} \times \% \text{ Effective} \times \text{Response to Environment} = \text{Risk}
\]
### RISK PRIORITY CALCULATION

<table>
<thead>
<tr>
<th>Effectiveness Rating</th>
<th>Risk Priority Rating vs Prior Sensitivity</th>
<th>Materiality</th>
<th>Completeness</th>
<th>Impact Likelihood</th>
<th>Vulnerability</th>
<th>Sensitivity</th>
<th>Controls</th>
<th>Priority Score</th>
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<tr>
<td>75% Bed Use/Discharge</td>
<td>10.5 10.52</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>2</td>
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<tr>
<td>75% Medical Records</td>
<td>10.5 9.65</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>2</td>
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<tr>
<td>75% ED Log. Registration</td>
<td>11.5 8.85</td>
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<td>2</td>
<td>2</td>
<td>6</td>
<td>3</td>
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<tr>
<td>75% Coding and Charging</td>
<td>28.35 21.85</td>
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<td>3</td>
<td>3</td>
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<td>85% HIPAA Privacy Security</td>
<td>3.55 3.55</td>
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<td>9</td>
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<td>54</td>
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<tr>
<td>75% Drugs and Stocking EMS</td>
<td>5.75 5.75</td>
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<td>5</td>
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<td>50% Transports</td>
<td>3.5 3.5</td>
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- **Sensitivity**: Materiality, Completeness rated 1 lowest, 4 highest
- **Impact**: Likelihood plus Materiality plus Completeness
- **Likelihood**: 1 = easy to detect, 2 = medium, 3 = complex, 4 = complex, critical
- **Materiality**: 1 = trivial, 2 = moderate, 3 = significant, 4 = critical
- **Completeness**: 1 = complete, 2 = partial, 3 = insufficient, 4 = insufficient
- **Vulnerability**: Impact x Likelihood x Completeness
- **Controls**: Controls rated as 1 low, 2 adequate, 3 high, 4 highest

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#### Assessment-ED Process-Hypothetical

<table>
<thead>
<tr>
<th>Percentage Effective</th>
<th>Bed Use/Discharge</th>
<th>Medical Records</th>
<th>ED Log. Registration</th>
<th>Coding and Charging</th>
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<tr>
<td>100%</td>
<td>90%</td>
<td>80%</td>
<td>70%</td>
<td>60%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
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</table>
Dashboard Reporting by Risk Domain

HEAT MAP - Risk Matrix - ED Processes

A. Objective and Priority:
Enhance use of beds for Observation and perhaps inguinal beds
Assure proper transfers and transports in and out of the ED
E&M is coded accurately and used accurately (no duplication with procedures)
All chargeable procedures are captured and charged appropriately
Medical records accurately reflect services, are thorough and are stored for appropriate time inclu logs, consent
Supplies and drugs dispensed to EMS appropriate

B. Identify risks that may hinder achievement of the objective (assign each risk a number)
ED processes
- Risk 1: Patients in beds receive ongoing monitoring and care, documentation reflects care
- Risk 2: Proper transport/transfer adherence to EMTALA, medical oversight
- Risk 3: E&M staff reflect level of resource used, E&M not duplicated with charges, bill review monitored
- Risk 4: Charge captured for non E&M services and procedures; IV must have start and stop times
- Risk 5: Medical records support care charges, arrival, disposition, consent, stored appropriately
- Risk 6: Supplies and drugs may be taken and used by EMS and not logged

C. Identify the likelihood and consequence of the risk

Risk Matrix for Priority one: Likelihood

- Almost certain (5)
- Probable (4)
- Possible (2)
- Unlikely (1)
- Rare (1)

Consequence of risk

Insignificant (Minor) Moderate (2) Major (4) Catastrophic (9)

4. Graph out the risks on the grid
5. Determine process to address, educate and monitor

New number, in progress

Dashboard Reporting by Risk Domain

Compliance Oversight

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<th>Measure</th>
<th>2012</th>
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<th>2014</th>
<th>Measure</th>
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Financial Measures

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