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Don't Face the Risk Apocalypse:
Practical Approaches to Implementing and Integrating ERM and Compliance
with Quality

HCCA Compliance Institute - March 29, 2017



Quality and Compliance Starts with the
Patient Experience!



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We are the Patient Experience!



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SVP, ERM and Chief
Compliance Officer
JPS Health Network



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Chief Quality Officer
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Agenda


- About JPS Health Network
- JPS Organizational Culture
- Our ERM Journey
- The JPS Quality and Patient Safety Program
- Combining ERM and Quality
- Questions

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About JPS Health Network



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JPS Health Network is...

- Tarrant County's only Level 1 Trauma Center
- 2.3 million square feet of facility space
- 6,500 team members
- 11 residency and fellowship programs
- 573 bed acute care hospital
- More than 40 primary, specialty and school-based health centers
- Tarrant County's only Psychiatric Emergency Center

At John Peter Smith Hospital, in Fort Worth's Near Southside, we provide emergency services and trauma care as Tarrant County's only Level 1 Trauma Center; urgent care, inpatient care (including intensive care for infants and adults), emergency and inpatient psychiatric care and a full range of outpatient services located across Tarrant County.

JPS medical staff credentials
per our bylaws

650 MDs
109 DOs
17 DOs
5 PhDs
4 DPMs
1 DMD

and physicians with privileges

As our community grows
and industry standards, regulations, academic requirements and new technology emerge, JPS too must evolve to meet the demands.

Get the latest update at
www.jpshealthnet.org/bonds

223 emergency visits per day in 2009
312 emergency visits per day in 2015

\$1.7 billion in economic activity generated by JPS in 2014

14,489 geriatric patients cared for in 2015

54 languages can be heard in the halls of JPS on any given day

58 police officers in the Tarrant County Hospital District police department

9th largest employer in the county

5,000 BABIES are born at John Peter Smith Hospital EVERY YEAR

20,000 PATIENTS seen at the Psychiatric Emergency Center each year

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Organizational Culture: Tone at the Top




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JPS Rules of the Road
Own It
Seek Joy
Don't be a Jerk

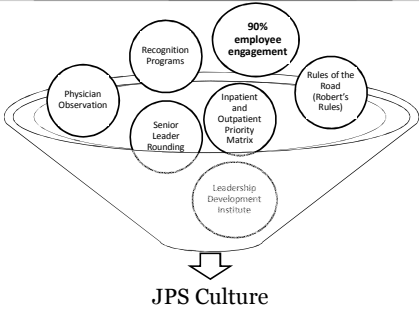


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Elements of culture leading to improved Quality and ERM programs




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JPS Culture

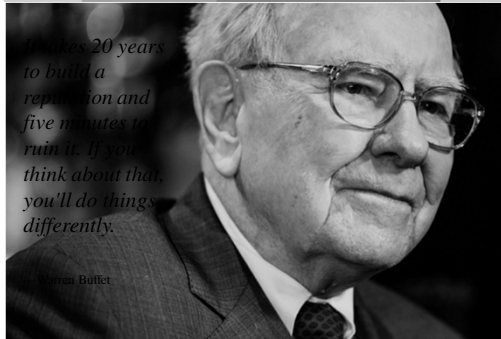
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Our ERM Journey

ERM Helps Manage Reputational Risk



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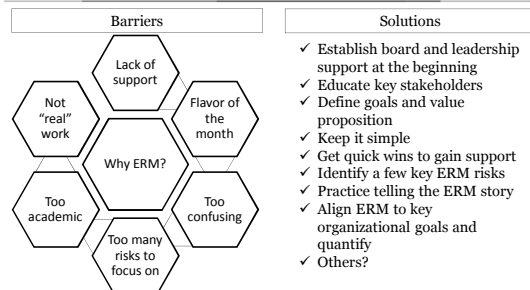
ERM Timeline



- SVP, ERM and Chief Compliance Officer position created in 2015 reporting directly to both the Board and CEO
- 9 JPS Board members appointed by the 5 elected County Commissioners
- Board meetings open to public and streamed live on the Internet
- Board wanted to develop an ERM program to give them more visibility on organization-wide risks. Board did not have a good understanding of ERM
- First ERM risk assessment conducted from September 2015 – January 2016
- Met with executive leaders and Board to prioritize top 10 ERM risks
- Currently building risk profiles for each of the top ERM risks and implementing GRC software
- Implementing ERM communication plan and reporting


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Overcoming ERM Organizational Barriers



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Strategic Alignment



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Mission

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Pillars
(foundational)

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Destination Metrics
(5-year goals)


Organizational Goals
(multi-year implementation)

Annual Key Performance Indicators
(annual work plan)

6,000 JPS Team Members
(organizational projects and initiatives)

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Connecting ERM with Strategy and Operations



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ERM Road Map

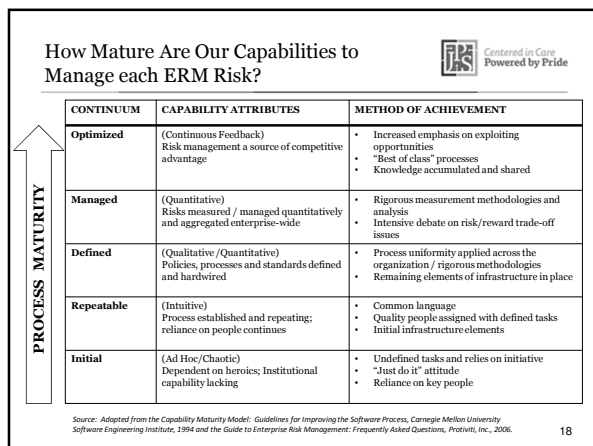
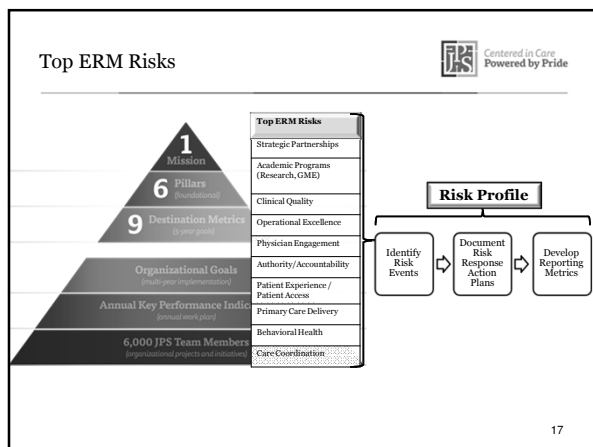
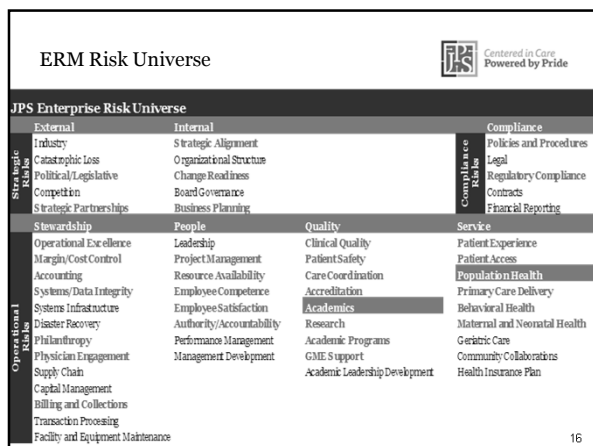


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Set Foundation	Establish oversight	Assess risk and develop responses	Determine desired future state	Quantify risks	Performance improvement
<ul style="list-style-type: none">• Risk universe• Risk definitions• Frameworks	<ul style="list-style-type: none">• Organizational oversight structure• Board oversight	<ul style="list-style-type: none">• Risk assessment• Risk responses• Pilot results• Risk owners	<ul style="list-style-type: none">• ID current state• Gap analysis• Management reporting	<ul style="list-style-type: none">• Risk quantification• Risk tolerances• Risk appetite	<ul style="list-style-type: none">• ID leading practices• Link risks to key metrics• Track performance improvement

Source: Adapted from the Guide to Enterprise Risk Management: Frequently Asked Questions, Protiviti, Inc., 2006.

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Risk Profile Elements




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- ERM Risk Name / Executive Risk Owners
- Risk Definition
- Risk Category (JPS Pillar / Strategic / Regulatory)
- Risk Drivers
 - External / Internal
- Risk Events
 - (Rating: Impact / Significance / Velocity)
- Risk Mitigation Strategies
 - (Effectiveness of Current & Proposed)
- Risk Maturity Current and Desired
- Risk Tolerance / Risk Appetite
- Evaluative Metrics

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Building Relationships and Support




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- Understand the business
 - Operational rounding
 - Off-site meetings and retreats
 - Goal setting and strategy meetings
 - Financial performance and incentives
- Understand the cultural and political environment
 - Backgrounds of board and senior leaders
 - Fast-paced or deliberative decision making process
 - Stated and hidden agendas
 - Key influencers
 - Historical organizational challenges

The effectiveness of an ERM program depends on the relationship the risk leader has with the board and senior leadership.

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2017 ERM Goals




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- ❖ Develop risk profiles for the top 10 ERM risks
- ❖ Implement GRC Software
- ❖ Develop ERM reporting package for the Board, Executives, and broader management
- ❖ Collaborate to transition the management of the top ERM risks to the risk owners
- ❖ Align ERM with JPS goal setting and budget processes


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The JPS Quality and Patient Safety Program



We are on our Journey to Excellence in our Quality and Patient Safety Program!



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Our Journey to Excellence

DESTINATION 

an important mile marker along Our Journey to Excellence




"PERFECTION IS NOT ATTAINABLE, BUT IF WE CHASE PERFECTION WE CAN CATCH EXCELLENCE."

VINCE LOMBARDI

© Lifhack Quotes

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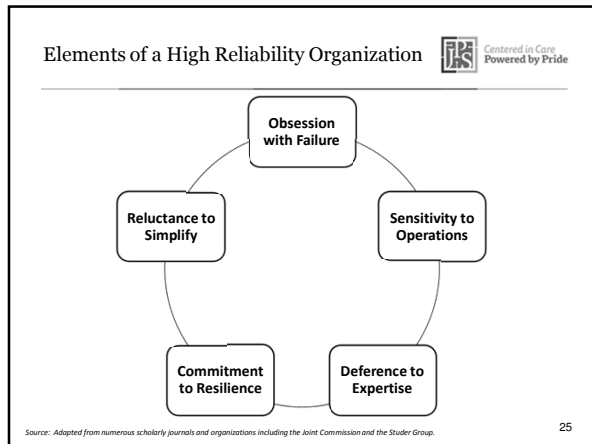
Excellence Begins with High Reliability

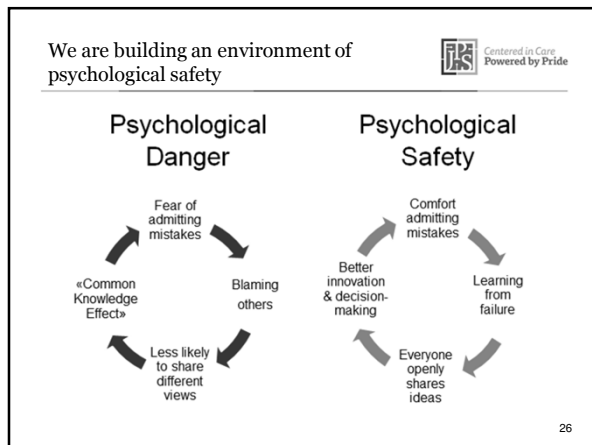



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THE POWER OF **ZERO:** STEPS TOWARD HIGH RELIABILITY HEALTHCARE

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Psychological safety begins with the right leadership behaviors  Centered in Care
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Leadership Behaviors for Cultivating Psychological Safety

- Be accessible and approachable
- Acknowledge the limits of your knowledge
- Show you are capable of making mistakes; be fallible
- Invite participation
- Failures are learning opportunities
- Be direct and clear. No uncertainty in communication.
- Set boundaries for behavior
- Accountability

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We celebrate patient safety wins along the way!

DESTINATION 0

an important mile marker along our journey to Excellence


✓ Across JPS there were zero central line blood stream infections (CLABSI) in over 7 months

✓ CDU had zero patient safety events for 7 months

✓ Clinical unit on P5 had no catheter associated urinary tract infections (CAUTI) for over a year

KEEP CALM AND PREVENT CLABSI

KEEP CALM AND PREVENT CAUTI



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How do we measure progress?

Quality Metrics

1. Reduce falls with injury score greater than 4
2. Reduce annual catheter associated urinary tract infections (CAUTI(s))
3. Reduce annual central line blood stream infections (CLABSI(s))
4. Reduce 30 day all cause readmission rate
5. Reduce hospital acquired pressure injuries greater than or equal to Stage 3
6. Decrease annual surgical site infections
7. Reduce selected patient safety and adverse events
8. Improve procedural safety
9. Increase percentage of patients having a post discharge follow up appointment within 14 days
10. Maintain an annual average ED boarding hour target per bed requests

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How do you achieve a safe system?

EIGHT RECOMMENDATIONS FOR ACHIEVING TOTAL SYSTEMS SAFETY

1. ENSURE THAT LEADERS ESTABLISH AND SUSTAIN A SAFETY CULTURE

Improving safety requires an organizational culture that enables and prioritizes safety. The importance of culture change needs to be brought to the forefront, rather than taking a backseat to other safety activities.

2. CREATE CENTRALIZED AND COORDINATED OVERSIGHT OF PATIENT SAFETY

Optimization of patient safety efforts requires the involvement, coordination, and oversight of various governing bodies and other safety organizations.

3. CREATE A COMMON SET OF SAFETY METRICS THAT REFLECT MEANINGFUL OUTCOMES

Measurement is foundational to advancing improvement. To achieve safety, one must establish standard metrics across the care continuum and ensure they are clearly defined, measure what is most important, and measure what is most meaningful.

4. INCREASE FUNDING FOR RESEARCH IN PATIENT SAFETY AND IMPLEMENTATION SCIENCE

To make substantial advances in patient safety, both safety science and implementation science should be advanced to more completely understand safety hazards and the best ways to prevent them.

5. ADDRESS SAFETY ACROSS THE ENTIRE CARE CONTINUUM

Patients deserve safe care in and across every setting. Health care organizations need better tools, processes, and structures to deliver care safely and to improve the safety of care in various settings.

6. SUPPORT THE HEALTH CARE WORKFORCE

Workforce safety, morale, and wellness are absolutely essential to providing safe care. Physicians, technicians, and others need support to fulfill their highest potential as healers.

7. PARTNER WITH PATIENTS AND FAMILIES FOR THE SAFEST CARE

Patients and families need to be actively engaged at all levels of health care. At large, patient engagement is about the flow of information to and from the patient.

8. ENSURE THAT TECHNOLOGY IS SAFE AND OPTIMIZED FOR PATIENT SAFETY

Optimizing the safety benefits and minimizing the unintended consequences of health IT is critical.

Adapted from National Patient Safety Foundation

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ERM and Quality Collaboration
Success Stories



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❖ Data Governance

❖ Physician Engagement




❖ Academics




Source: Images courtesy of US News and World Report, OLAP.com, and Odgers Law Group


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Combining ERM, Quality, and Compliance



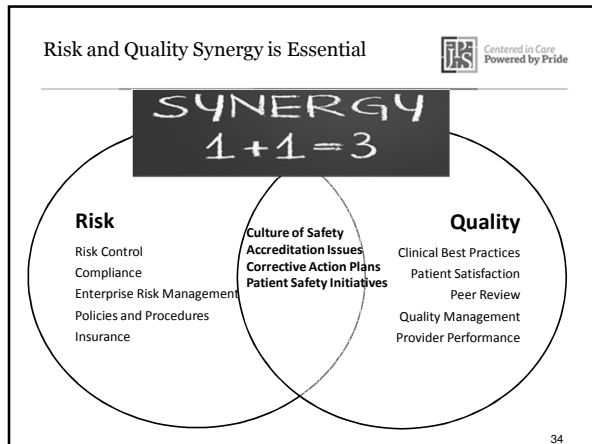
Integration is about tearing down silos!



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Clinical Quality ERM Risk Profile Summary

RISK DEFINITION	RISK OWNERS	PILLAR	MATURITY	TREND
Clinical quality failures, reflected through patient outcomes and satisfaction, significantly affect the organization's reputation, efficiency, compliance and accreditation status, and reimbursement	Frank Rosinia, M.D. James Johnson, M.D.	Quality	Current: Initial Desired: Defined	Establishing Baseline

TOP RISKS	RISK MITIGATION STRATEGIES
1. Inadequate Clinical Documentation (High)	1. Clinical Documentation Improvement initiatives
2. Inconsistent Care Coordination (High)	2. Improvements to inpatient access
3. Medical Errors (High)	3. Identify patient safety risks common to JPS patient population (falls/CAUTIs/CLABSI/SSI)
4. Resident Supervision (High)	4. Strategic Recruitment
5. Hospital-acquired infections (High)	5. Infection Control
6. Medical alarms are not responded to timely (Medium)	6. Continuing Education for all clinicians
7. Hospital readmissions (Medium)	7. New Leadership in Academic Affairs
8. Clinical Staff Competencies (Low)	
9. Patient falls/trauma (Low)	
10. Mortality (Low)	

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ERM Internal Communication Plan

The Quality ERM risk profile was presented to the following:

- CEO Senior Management Meeting
- Compliance Committee
- Patient Safety & Quality Committee
- Project Governance Committee
- Leadership Connection
- Medical Executive Committee
- Board Governance Committee

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ERM and Quality Collaboration
Success Stories




❖ Board Influence

❖ Quality Outcomes



Source: Images courtesy of Level Five Executive and Chan Soon-Shiong Medical Center at Windber
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ERM Lessons Learned




☐ Keep it simple and layer complexity over time
☐ Determine and advocate for appropriate resources for the ERM program
☐ Tell the ERM story in the context of the organizational culture
☐ Relate ERM to major business initiatives and the budget cycle
☐ Develop ERM champions at each level in the organization
☐ Utilize various forms of internal and external education
☐ Evaluate the use of technology to prioritize risks and implement program
☐ Don't be the only one telling the ERM story
☐ Develop an ERM reporting package for each key stakeholder group (board, executives, operational leaders, etc.)
☐ Don't get frustrated with implementing ERM more slowly than you expected...it's a marathon, not a sprint

What other communication approaches or tips have you found effective?

Adapted from Economic Cycle Research Institute: Patient Safety, Risk, and Quality, 11/18/14
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Quality and Risk Synergy
Lessons Learned



☐ Seek senior leadership support for aligning the patient safety, risk, and quality functions
☐ Alignment of quality and risk activities with strategic goals
☐ Assess current activities to clarify responsibilities and reduce duplication
☐ Establish structure to ensure patient safety activities are addressed in a coordinated manner involving the risk and quality functions
☐ Learn from each other
☐ Periodically evaluate the roles of quality and risk and change as needed

Adapted from Economic Cycle Research Institute: Patient Safety, Risk, and Quality, 11/18/14
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Victory comes from strong leadership
to foster an environment of change



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Questions



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