Three Blind Mice: Achieve a Shared Vision for Compliance, Risk and Quality

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Compliance Partners

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Objectives

- Obstacles to creating a unified approach to healthcare compliance, risk, and quality initiatives
- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos

Poll Question 1: Who's in the room?

1. Compliance Professional
2. Risk Professional
3. Quality Professional
4. Privacy Professional
5. General Counsel
6. Consultant/Vendor
7. Other

Poll Question 2: Which area is your primary focus?

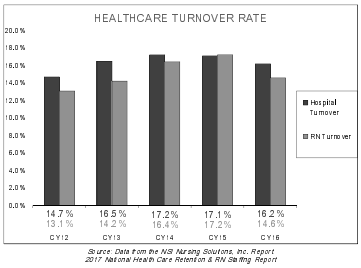
1. Compliance
2. Quality
3. Risk
4. Other

Obstacles to Creating a Unified Approach

1. Limited Resources
2. Adaptability
3. Track Record
4. Regulations
5. Culture
6. Silos

Limited Resources

- "Quick fix"- Process are only surface level versus engrained into the culture and operations
- Implementation and scalability of multiple "best practices" are unsustainable
- With staff turnover, new process are never fully accepted and implemented

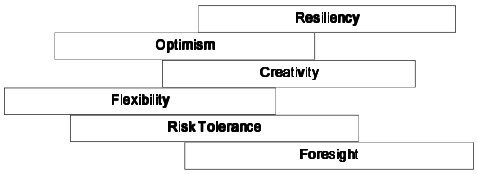


Source: Data from the NSI Nursing Solutions, Inc. Report 2017 National Health Care Retention & RN Staffing Report

Adaptability

Adaptability is not an inborn trait; it's a **skill** people learn

- Departments that hard-code processes or technologies cannot react to change
- Adaptability requires mastery of many skillsets



Adaptability

Traditional

Hire for other necessary skills and experience and hope employee is an adaptable worker

Future

Intentional Workforce Diversification

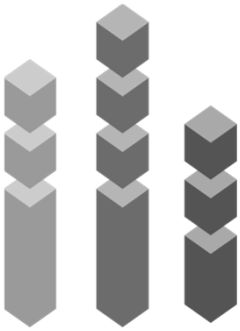
- Support employee moves inter-departmentally; Retrain valuable employees
- Focus on creating a multi-generation teams with diverse personality profiles

Education and Training Programs

CEB 2013, From Awareness to Application – Reduce Risk through Effective Compliance and Ethics Training

Poll Question 3:
What is your primary training method?

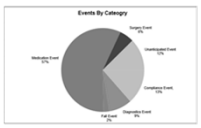
1. Technology Based (LMS)
2. Classroom/Instructor-Led Training
3. Group Discussion
4. Email Distributions
5. Other

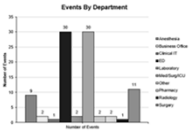


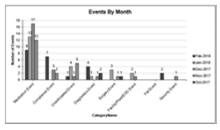
Track Record

Lack of Measurement

- How are you measuring and communicating success?
  - Why should you always communicate success? Lessened perception of program's impact can decrease funding and executive support
- What metrics (time, budget, effort, etc.) can be measured today that can be monitored over time to demonstrate improvement?







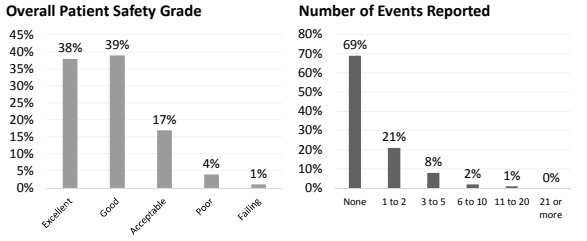
Track Record: Dashboards

Patient Safety Culture Survey

Dimensions of Culture

- Teamwork within units
- Supervisor/manager expectations & actions promoting patient safety
- Organizational learning – continuous improvement
- Management support
- Overall perceptions
- Feedback & communication about error
- Communication openness
- Frequency of event reporting
- Teamwork across units
- Staffing
- Handoffs & transitions
- Nonpunitive response to error

Patient Safety Culture Survey Results

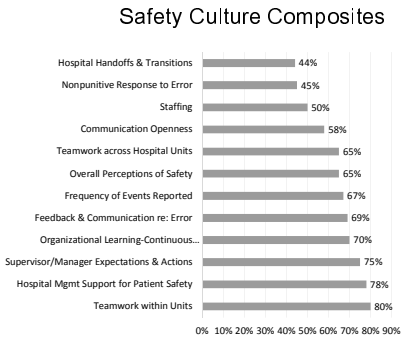


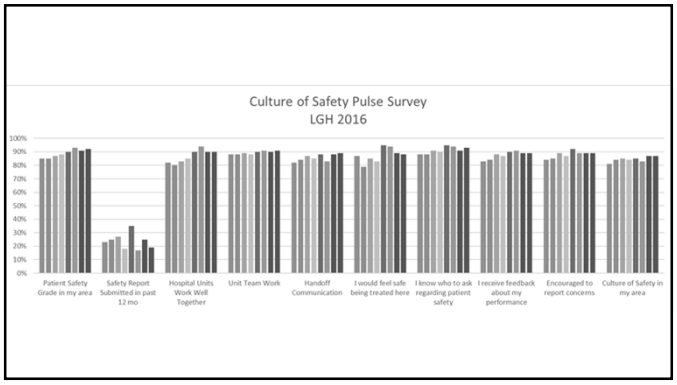
Wins

1. Teamwork within units
2. Hospital Management Support for Patient Safety
3. Supervisor/Manager Expectations & Actions

Opportunities

1. Hospital Handoffs & Transitions
2. Non-punitive Response to Error
3. Staffing





Regulatory Burden

Healthcare is one of the most **complex** and **heavily regulated** industries in US with more than 200,000 pages of laws, regulations, and standards

$39 BILLION

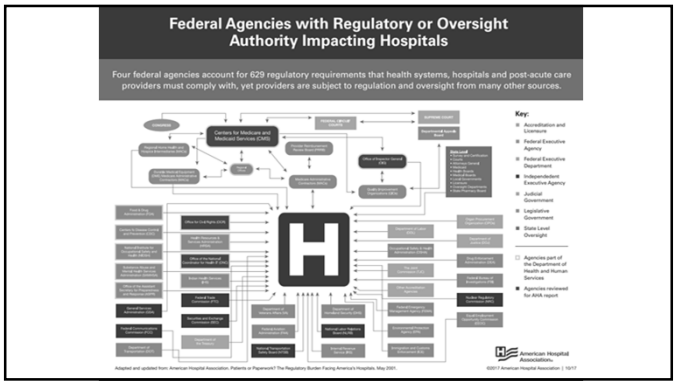
Spent by health systems, hospitals, and post-acute care providers each year on non-clinical regulatory requirements

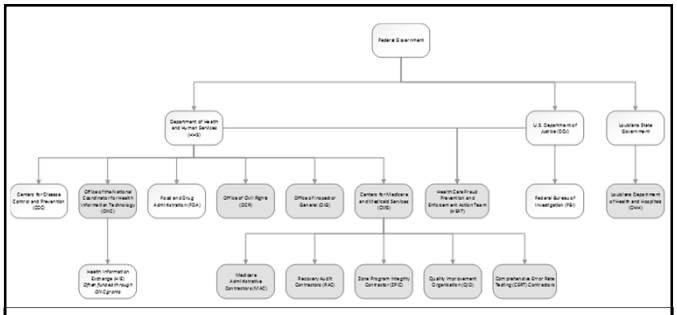
$7.6 MILLION

Per community hospital spent annually to comply

- This number rises to $9 million for hospitals with post-acute care
- For the largest hospitals, cost can exceed $19 million annually

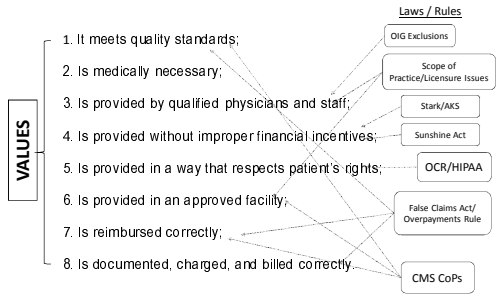
Source: Data from the American Hospital Association Report, Regulatory Overload - Accessing Regulatory Burden on Health Systems, Hospitals and Post-acute Care





Regulatory Agencies

Healthcare is "compliant" if…



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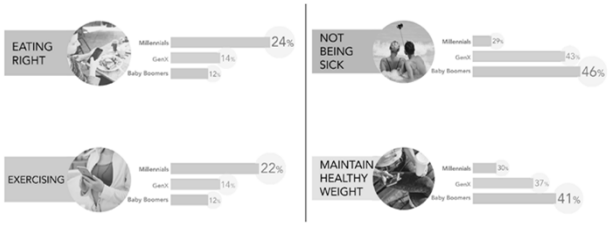
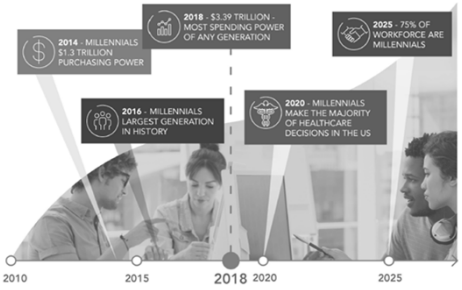
Culture: How Generations Define "Healthy"



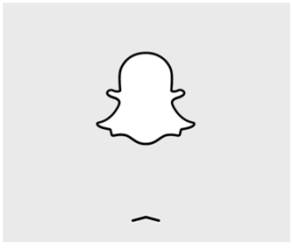
Source: MobileSmith Report: How Millennials are Redefining Healthcare Today: Are You Behind?

The Millennials

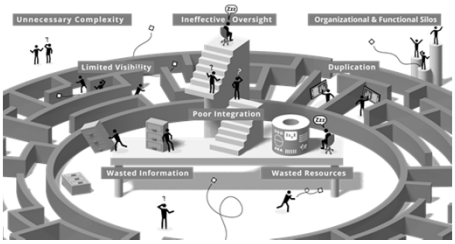


Source: MobileSmith Report: How Millennials are Redefining Healthcare Today: Are You Behind?

Do you snapchat hand hygiene?



Siloed Roles



Poll Question 4:
Who owns Joint Commission accreditation at your organization?

1. Compliance
2. Risk
3. Quality
4. Other

Poll Question 5:
Who owns Conditions of Participation?

1. Compliance
2. Risk
3. Quality
4. Other

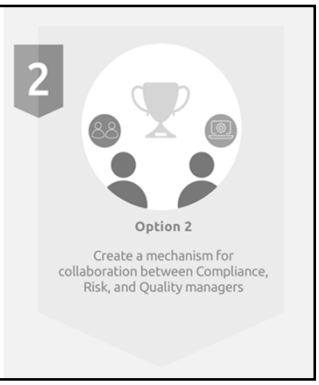
SILOS: Redesigning Systems

Poll Question 6: Which one are you?

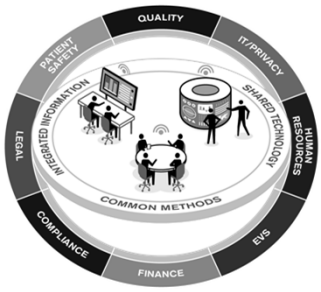
1. Option 1
2. Option 2

Enterprise Risk Management

By collaborating to address overlapping issues and functions, leaders are more efficient in addressing shared interests and better able to focus on their distinct functions.



Enterprise Risk Management (ERM)



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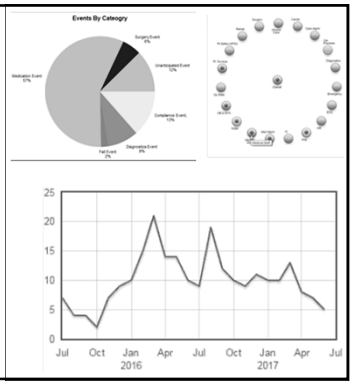
Technology

- Incident reporting
- Performance improvement tracking
- Governance Risk and Compliance (GRC) Platforms



Part II

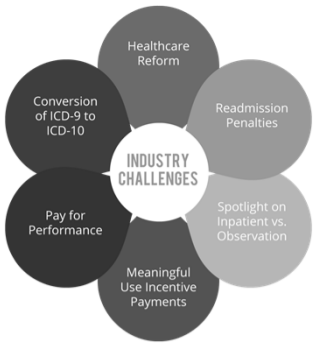
- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos

What is Enterprise Risk Management?

An interdisciplinary process through which an organization identifies, analyzes, prioritizes, and addresses the risks and opportunities that can affect the achievement of its strategic objectives, whether in positive or negative ways.

-American Health Lawyers Association, Enterprise Risk Management for Healthcare: Where & How to Begin

Traditional **Risk Management**	***Enterprise*** **Risk Management**
Risk = negative outcome imposed by an external or third-party force	*Risk = any issue affecting the organization's ability to meet its objectives*



Enterprise Risk Management (ERM)

- Utilizes a process or framework for **assessing**, **evaluating**, and **measuring** all of an organizations risks
- Any event that can adversely affect the objective/organization
  - Asset preservation
  - Failure to grow
  - Failure to execute on opportunities
- Consider designation of Chief Risk Officer

Areas of Risk

Medicare Compliance	Internal Financial Controls	HIPAA Privacy
Data Security	General Liability / Property & Casualty	Human Resources
Safety & Security	Regulatory	Healthcare Fraud & Abuse

Leading Trends for Effective ERM

- Increased focus on risk "intelligence" and risk assessment
- Analytics and other predictive tools for early detection of – and response to – emerging risks
- More frequent and dynamic assessment of top risks
- Management-level and Board-level accountability for the ERM process and for each key risk
- Integration of risk management and strategy / major initiatives
- Improved discipline and better documentation
- Key Risk Indicators vs. Key Performance Measures

Poll Question 6: Do you have an enterprise risk function?

1. Yes
2. No

ERM Committee

Responsibilities

- Provide education/in-services regarding changes in rules and regulations of relevant agencies
- Provide clarification and guidance on current regulations
- Assess processes to determine if facilities are in compliance with current regulations
- Standardize processes across organization, as appropriate
- Share methods, technology, and best practice
- Create toolkits for continued readiness
- Develop and monitor Key Risk Indicators

Agencies/Areas Monitored

The Joint Commission (TJC)	Centers for Medicare and Medicaid Services (CMS) Conditions of Participation	Medicare Compliance (Billing/Coding)	Office of Inspector General (OIG)
Department of Health and Hospitals (DHH)	HIPAA / Privacy	Department of Insurance	Office of the National Coordinator (ONC) IT Security

ERM Committee

Functions

- Define the scope of the program
- Approve key policies & procedures
- Require periodic, substantive reporting by management
- Ask questions
- Oversight of external auditor, internal audit function, & compliance program
- Monitoring effectiveness of internal controls processes
- Approve and monitor Key Risk Indicators

ERM Committee

01 **Compliance**	**02** **Quality**	**03** **Legal**	**04** **Finance**
05 **Patient Safety**	**06** **Human Resources**	**07** **IT/Privacy**	**08** **EVS**

Key Performance Indicators (KPIs)

Key performance indicators (KPIs) are metrics used to measure key business processes that reflect strategic performance:

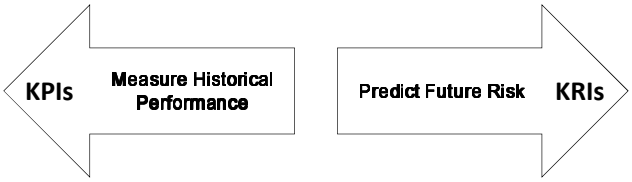
Inpatient flow
- Inpatient raw mortality rate
- Patient vs Staff Ratios
- Harm events per 1,000 patient days
- Readmission rate
- Occupancy rate
- Average length of stay
- Average cost per discharge

Revenue cycle
- Total operating margin
- A/R days due to coding
- Total A/R days outstanding
- Average cost per discharge
- Cash receipt to bad debt
- Claims denial rate
- Days of cash on hand

Key Risk Indicators (KRIs)

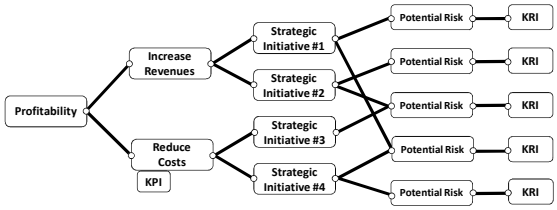
Key Risk Indicators (KRIs) are critical predictors of unfavorable events that can adversely impact organizations. They monitor changes in the levels of risk exposure and contribute to the early warning signs that enable organizations to report risks, prevent crises, and mitigate them in time

Relationship between KPIs and KRIs



Developing Key Risk Indicators

Identify relevant metrics linked to organization's objectives



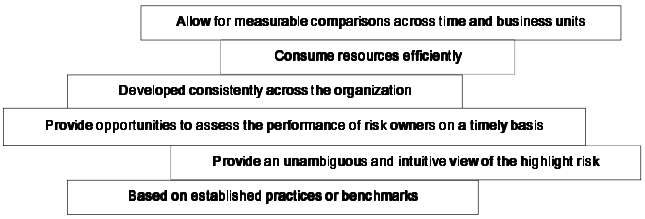
Source: COSO Report: Developing Key Risk Indicators to Strengthen Enterprise Risk Management

Developing Key Risk Indicators

Analyze a risk event that has affected the organization in the past (or present) and then work backwards to pinpoint intermediate and root cause events

Source: COSO Report: Developing Key Risk Indicators to Strengthen Enterprise Risk Management

Core Elements of Well-Designed KRIs



Key Risk Indicator Assignment

- Identify 2-3 Key Risk Indicators for your area:
  - Must be a predictor of risk
  - Can be simple
  - Must be measurable and reportable monthly
  - Data must be available (not a labor intensive process)
  - May be something that you are already monitoring
- Determine low, moderate, and high risk scores
- Identify responsible person

ERM Committee KRI

Compliance
- One Day Stays
- Medical Necessity
- Meaningful Use

Quality
- Surgical Site Infections
- CLABSI/CAUTI

Legal
- Dollar Amounts of Settlements
- Number of New Lawsuits
- Accrued Reserve Dollars for Settlements

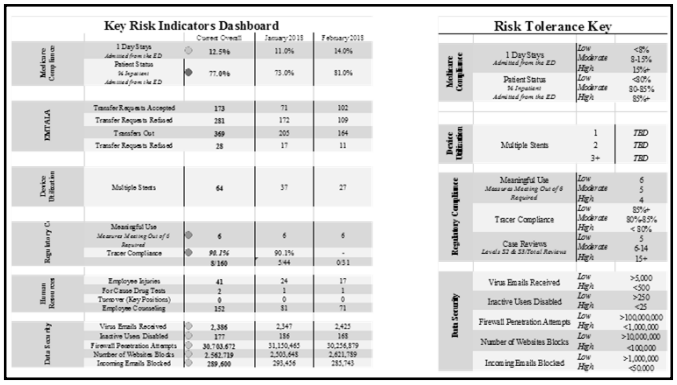
Finance
- Internal Controls
- Executive Expenses
- Payroll Testing

Patient Safety
- Barcode Scanning Rates
- Hand Hygiene
- Universal Protocol
- Opioid Prescription Reduction

Environmental
- Generator Checks
- Emergency Preparedness

Human Resources
- Drug Diversion
- Employee Incidents
- Turnover % in Key Position

IT/Privacy
- Virus Email Received
- Inactive Users Disabled
- Firewall Penetration Attempts



Key Risk Indicators Dashboard

		Current Overall	January 2018	February 2018
Medicare Compliance	1 Day Stays *Admitted from the ED*	12.5%	11.0%	14.0%
	Patient Status *% Inpatient* *Admitted from the ED*	77.0%	73.0%	81.0%
EMTALA	Transfer Requests Accepted	173	71	102
	Transfer Requests Refused	281	172	109
	Transfers Out	369	205	164
	Transfer Requests Refused	28	17	11
Device Utilization	Multiple Stents	64	37	27
Regulatory C	Meaningful Use *Measures Meeting Out of 6 Required*	6	6	6
	Tracer Compliance	90.1% 8/160	90.1% 5/44	- 0/51
Human Resources	Employee Injuries	41	24	17
	For Cause Drug Tests	2	1	1
	Turnover (Key Positions)	0	0	0
	Employee Counseling	152	81	71
Data Security	Virus Emails Received	2,386	2,347	2,425
	Inactive Users Disabled	177	186	168
	Firewall Penetration Attempts	30,703,672	31,150,465	30,256,879
	Number of Websites Blocks	2,562,719	2,503,648	2,621,789
	Incoming Emails Blocked	289,600	293,456	285,743

Risk Tolerance Key

Medicare Compliance	1 Day Stays *Admitted from the ED*	*Low* *Moderate* *High*	<8% 8-15% 15%+
	Patient Status *% Inpatient* *Admitted from the ED*	*Low* *Moderate* *High*	<80% 80-85% 85%+
Device Utilization	Multiple Stents	1 2 3+	*TBD* *TBD* *TBD*
Regulatory Compliance	Meaningful Use *Measures Meeting Out of 6 Required*	*Low* *Moderate* *High*	6 5 4
	Tracer Compliance	*Low* *Moderate* *High*	85%+ 80%-85% < 80%
	Case Reviews *Levels S2 & S3/Total Reviews*	*Low* *Moderate* *High*	5 6-14 15+
Data Security	Virus Emails Received	*Low* *High*	>5,000 <500
	Inactive Users Disabled	*Low* *High*	>250 <25
	Firewall Penetration Attempts	*Low* *High*	>100,000,000 <1,000,000
	Number of Websites Blocks	*Low* *High*	>10,000,000 <100,000
	Incoming Emails Blocked	*Low* *High*	>1,000,000 <50,000

TEMPLATE

Meeting Agenda

I. WELCOME (5 minutes)
- Executive Leader

II. RULES/REGULATIONS EDUCATION AND UDPATES (10 minutes)
- CoPs/TJC
- CMS
- HIPAA
- ONC
- OIG

III. POLICY & PROCEDURES (10 minutes)
- Patient Status Changes
- Sentinel Event
- Texting

IV. EDUCATION/POLICY REVIEW REGARDING PEC/CEC (20 minutes)
- In-service/Education by Subject Matter Expert

V. KEY RISK INDICATORS (10 minutes)
- Sandy Keller, Vice-President/LGH Corporate Compliance & Regulatory

— BREAK —

V. BREAK-OUT SESSIONS (45 minutes)

COMPLIANCE	INFECTION CONTROL & RISK	REGULATORY/ ACCREDITATION	INFORMATION SYSTEMS & HIPAA
• *Inpatient Only Procedures* • *Two-Midnight Rule* • *Medicare Rebilling Process Part A to Part B*	• *Infection Prevention Risk Assessment and Plan*	• *Contracted Services Evaluation*	• *Current HIPAA Audit Process*

V. WRAP UP (15 minutes)
- Team Discussion

Reporting Key Risk Indicators

Operational Managers

All KRIs within their scope, need real-time reporting

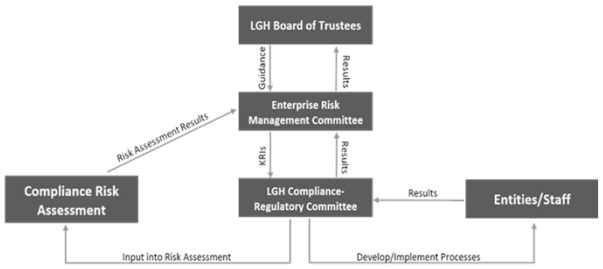
Senior Management

KRIs for risks and opportunities with significant potential impact to the organization, less frequent (e.g. monthly)

Board of Directors

Only most significant KRI data to be confident that risk management is functioning as designed and approved, aggregated data for strategic evaluation

LGH: ERM Evolution



Part III

"The most important distinguishing characteristic of high-reliability organizations is a **collective preoccupation with the possibility of failure**."

-James Reason

High Reliability

"Collective mindfulness' in which all workers look for, and report, small problems or unsafe conditions before they pose a substantial risk to the organization and when they are easy to fix."

-Weick and Sutcliffe 2007

5 Traits of High Reliability Organizations

01
Sensitive to operations

02
Reluctant to accept "simple" explanations

03
Preoccupation with failure for problems

04
Defer to expertise

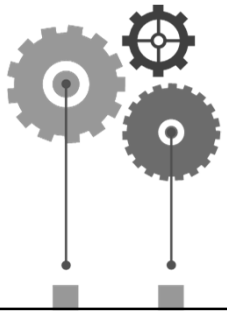
05
Resilient

Typical Healthcare Improvement Model

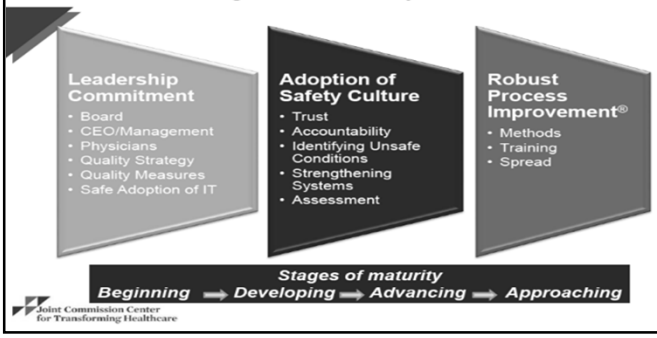
Usual Improvement Approach

Best practices, toolkits, protocols, checklists

"One-size-fits-all"



High Reliability Model



Leadership Commitment

A RADICAL COMMITMENT TO TEAMWORK

The traditional social structure of health care organizations is extremely hierarchical. To achieve high reliability, health care organizations must commit to a kind of teamwork that erases the old hierarchical structures completely.

Robust Process Improvement

Systematic Approach to Problem Solving

- Adoption of RPI tools accepted fully throughout organization
- Training in RPI is a high priority for all staff
- RPI tools utilized for all improvement work
- Patients and employees are engaged in redesigning care processes

Throughput Huddle

What is it?

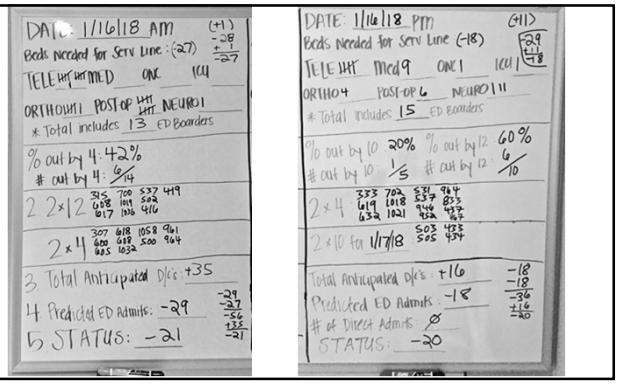
Multidisciplinary team that meets twice a day to discuss throughput, wins, barriers, and concerns for the shift

Why do we do it?

- Drives high reliability/safety
- Drives communication
- Capture wins & connect staff
- Drives reward and recognition

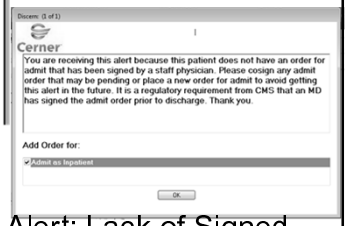
How?

- All disciplines report to same room; 9:00AM and 3:30PM
- Use Capacity Management System on projector
- Use Dry Erase Board LIVE
- Same sequence for reporting



Emergency Department **Reports on** • # of ED boarders • # of admits from previous day • # of admits for that day of the week • Status of admits that day • Any external issues	**Food and Nutrition** **Reports on** • Delays in patient meal delivery • Down equipment that may impact meal • Dietitian staffing	**Pharmacy** **Reports on** • Medication shortages & duration • Medication shortages resolved • Medication delivery issues • Equipment issues & delays
Surgery **Reports on** • # of surgery beds needed per service line **Wins so far** • Decreased PACU boarding • Less disruptions to progression of surgery cases	**Transport** **Reports on** • Total TAT (turn around time) for the day vs. goal • Delays (i.e. staffing issues, elevator, equipment) • If help needed between certain times	**Laboratory** **Reports on** • Lab instrumentation – working/not working, delays, and duration • Manpower – staffing shortages for techs and phlebotomists • Supply shortages or device difficulties
ICU **Reports on** • Current bed status in ICU • Patients move out of ICU (and to where) • Patients to bed in ICU	**Radiology** **Reports on** • Equipment down & duration • Delays in any radiology modality (CXR, CT, MRI, US, Nuc Med) • How many procedures in IR and anesthesia cases • Any staffing shortages	**Inpatient Units and Care Management** **Reports on** • Potential discharges (2x10s, 2x12s, 2x4s) • Needs prior to discharge • Delays in discharge • Bed availability at post acute facilities

eForm Database



Alert: Lack of Signed Order

What is a "Just" Culture?

A Just Culture exists when team members trust each other, are rewarded for providing information about adverse outcomes and events, and are clear about their responsibilities regarding safe and compliant behavioral choices.

Most importantly, there is a *shared* accountability for risk avoidance.

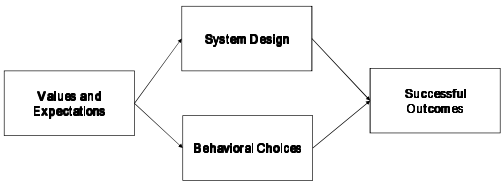
Types of Behavior Involved in Errors

Human Error: an inadvertent action; inadvertently doing other than what should have been done; slip, lapse, mistake

At-Risk Behavior: a behavioral choice that increases risk where risk is not recognized, or is mistakenly believed to be justified

Reckless Behavior: a behavioral choice to consciously disregard a substantial and unjustifiable risk

Recognize the Factors that Lead to Outcomes



Attributes of a Fair and Just Culture

- Human errors are accepted as system flaws, not character flaws
- Emphasizes learning over blaming
- Promote an open discussion of near misses
- Organizational commitment to a fair and just culture for ALL team members
- Consequences for blatant disregard for risk or organizational policy
- Utilization of the Just Culture decision guide

Just Culture

- Just Culture is about a proactive learning culture where it's not seeing events as things to be fixed, but seeing events as opportunities to improve the organization's understanding of risk.
  - Fosters a cycle of trust, reporting, and improvement
  - Eliminates intimidating and disrespectful behaviors
  - Has a consistent and transparent process for evaluating accountability
- Just Culture is about changing staff's perspective
- We want our people to:
  - Looking for the risks around me
  - Reporting errors and hazards
  - Helping to design safe systems
  - Making safe choices
    - Following procedure
    - Making choices that align with organizational values
    - Never signing for something that was not done

"People make errors, which lead to accidents. Accidents lead to deaths. The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue."

-Don Norman Author,
The Design of Everyday Things

Create a Culture of Coaching

"A coach is someone who can give correction without causing resentment."
-John Wooden

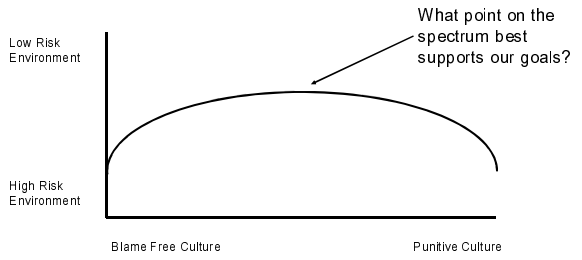
"The single greatest impediment to error prevention is that we punish people for making mistakes."

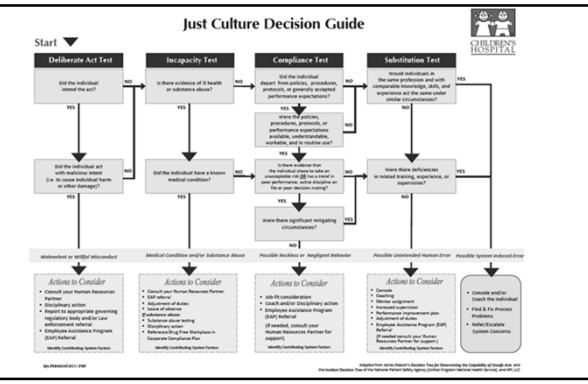
-Lucian Leape, M.D.

There is an **inverse** relationship between discipline and reporting.

Discipline ⇧ Reporting ⇩

Balanced Accountability





Managing the Three Behaviors

Human Error	At-Risk Behavior	Reckless Behavior
Product of Our Current System Design and Behavioral Choices	*A Choice: Risk Believed Insignificant or Justified*	*Conscious Disregard of Substantial Unjustifiable Risk*
Manage through changes in: • Choices • Processes • Procedures • Training • Design • Environment	Manage through: • Removing incentives or at-risk barriers • Create incentives for healthy behaviors • Increase situational awareness	Manage through: • Remedial action • Disciplinary action
Console	**Coach**	**Discipline**

Just Culture Doesn't *Only* Support Safety Culture

	Compliance	Risk	Quality
• Encourage Reporting • Support Learning Organization • Focus on Systems v. Individuals • Coaching v. Punishing • Root Cause Analysis • Welcome and Embrace Surveillance • Encourage Accountability and Ownership			

Conclusion

- Obstacles to creating a unified approach to healthcare compliance, risk, and quality initiatives
- Achieving integration through the development of shared goals
- Leveraging technology and data to break down communication silos