OBJECTIVES

Describe the elements for robust risk management program.

Develop a proactive risk management strategy for your hospice.

Recognize the benefits to the patients and the agency by having a proactive risk management program.
A FEW TRUTHS ABOUT RISK MANAGEMENT

No organization, no matter how good or how diligent, can plan for every aspect of risk and mitigating risk.

You can have a “healthy” risk management environment or an “unhealthy” risk management environment.

Risk Management is not about hiding information, being unfair to employees or to patients/families or to the agency, but focuses on transparency, improvement and accountability.

Proactive Risk Management environments have few legal issues than those who are in a Reactive Risk Management environments.

Risk Management is EVERYONE’S responsibility and job.

It is naive to think that people will do the right thing.

- Human Error, Reckless Behavior and Risky Behaviors and Reckless Choices will always be present - even in your very best.

Good risk management plans and strategies try to lessen human, errors, risky behaviors and reckless choices and allow for the risk to be identified in the correct category.

We need to set our practices and policies to let people be successful and safe.

Why bother with Risk Management?

- Increase risk awareness – What could affect the achievement of objectives? What could change? What could go wrong? What could go right?
- Increase understanding of risk – sensitivity. What makes my risks increase/decrease/disappear?
- Improve outcomes – achievement of objectives (corporate, clinical, etc.)
- Enhance accountability, transparency and responsibility.
- Promote a “healthy” risk culture – it’s safe to talk about risk. Open and transparent.
- Develop a common and consistent approach to risk across the organization.
- Is proactive… not reactive – Prepare for risks before they happen. Identify risks and develop appropriate risk mitigating strategies.
ENTERPRISE RISK MANAGEMENT (ERM)

Why Enterprise Risk Management
In line with Just Culture – a philosophy that looks at accountability for both systems and people.

Looks at Risks across the organization. Risk Management is not just clinical risk.

Gives us a better picture of risks throughout the organization.

ERM Model and Domains
Checklist for Successful ERM Process

- Infrastructure/Accountability
- Robust risk identification
- Accurate identification of key risk indicators
- Metrics are actionable
- Mitigate, manage, monitor
- Defining risk appetite and risk tolerance/capacity
- Risk domain owners accountable
- Evaluation of internal and external risks
- Early warning systems—no surprises
- Modeling to forecast risk
- A process not a program

ERM at the Event Level

Incident Event Reporting:
- Incident identifies a potential or actual event
- Event identified and tracked
- Event report developed by location or specialty
- Reporting process ensures consistent reporting
- Reporting process includes near misses

Adverse Event:
- Adverse event identified and reviewed by quality of care steering committee
- Sentinel event/root cause analysis
- Metrics & benchmarks
- Trend reports provided to location quality & safety committee

Claim / Lawsuit:
- Claim directed to category manager/quality & risk
- Serious events reviewed by weekly quality of care steering committee
- Sentinel event/root cause analysis
- Metrics & benchmarks
- Trend reports provided to location quality & safety committee

When there is an Event or Near Event

5-Prong Approach of Capturing Information

- Who
- What
- Where
- Why
- When

Anyone and everyone should be able to report this basic information
Event Examples
Using the 5 Prong Approach

Jane Smith (who) was working on the inpatient unit (where) and administered 10 mg of morphine at 1400 to Tom Jones. Mr. Jones was supposed to receive insulin and not morphine. The patient began vomiting and experienced high blood sugar. At 1700 we correctly administered insulin to the patient and notified the physician (what/when). Jane Smith was in a rush and grabbed the wrong medication and, she failed to double check the medication in the medication room or perform the 5 rights before administering drug to the patient (why).

Event Examples
Using the 5 Prong Approach

John Thompson is a patient who had recently been admitted to Sunnyvale Hospice. On January 31st, Missy, the RN Case Manager asked Bill, the hospice chaplain, to visit Mr. Thompson to address spiritual concerns and his religious concerns about not continuing aggressive treatment. Bill goes to see Mr. Harvey Thomas, another hospice patient, and in the middle of the conversation realizes he has the wrong patient. Bill was able to correct the situation and offered to visit with Mr. Thomas again in the future if he and his wife finds it helpful. Bill went to see Mr. Thompson afterwards and at 1300 on February 1st, Bill notifies his supervisor and fills out an incident report and completes documentation in the EMR for each patient. He follows up with the respective RN-Care Manager.

Characteristics of a Good Event Follow-Up

Be Specific
Factual/Objective
Define Action Steps
- How will you measure if those action steps are appropriate?
Indicate what you have done and not what you will do.
Template Language for Follow-Up Documentation

The following steps were taken in the investigation process in accordance with established policies and procedures. The investigation yielded the following findings. Based on the findings from the investigation appropriate follow-up has been done with the patient and/or staff. Moreover, I have determined the following action steps are appropriate.

Leaders Responsibilities When Investigating Events

Investigate events within 7 days.

Follow-up should NOT be "I will speak with Jane Smith."

Follow-up SHOULD be "I have spoken with Jane Smith and the following action plan is in place."

Leaders should start your investigation, but you should have a separation between the initial investigator and Risk Management.

If the event is Critical or Sentinel you will need a complete case fairly quickly. What are your Risk Management protocols? Does your insurance carrier have requests to be notified? Does your insurance carrier have a resource to help you investigate?

Equipment Dos & Do Nots

<table>
<thead>
<tr>
<th>DO NOT</th>
<th>DO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not throw the equipment or supplies away.</td>
<td>Save equipment and packaging.</td>
</tr>
<tr>
<td>Do not use on another patient</td>
<td>Place the equipment and packaging aside and save for Risk Management.</td>
</tr>
<tr>
<td>Do not give the malfunctioning supplies or equipment to the company representative.</td>
<td>Call Risk &amp; Place an Incident Report.</td>
</tr>
</tbody>
</table>
PATIENT GRIEVANCES

Patient Grievance v. Staff Concerns

**PATIENT GRIEVANCE**

Issues with care identified by 
PATIENTS or a PATIENT’S 
REPRESENTATIVE.

When a staff person is approached 
by a patient or patient 
representative with a 
complaint/grievance, they must 
follow your Grievance Resolution 
Policy process.

**STAFF CONCERNS**

Issues with care identified by STAFF 
(i.e. nurses, physicians, allied health, 
etc.)

These types of concerns are routed 
as appropriate depending on the 
individual involved in the concern. 
These types of quality or behavioral 
issues are NOT subject to your 
Grievance Resolution Policy process.

Grievance Definition – Medicare & Medicaid

A patient grievance is a formal or informal written or verbal complaint 
that is made to the provider by a patient, or the patient’s 
representative, regarding patient care (when the complaint is not 
resolved at the time of the complaint by staff present), abuse or 
neglect, issues related to the provider’s compliance with CMS 
Conditions of Participation, or a Medicare beneficiary billing complaint 
related to rights and limitations provided by 42 CFR §489.
Grievance Definition Continued

If a patient care complaint cannot be resolved at the time of the complaint by staff present, is postponed for later resolution, is referred to other staff for later resolution, requires investigation, and/or requires further action for resolutions, then the complaint is a grievance for the purposes of these requirements.

A complaint is considered resolved when the patient is satisfied with the action taken on their behalf.

What is a Grievance?

A written complaint is always considered a grievance.

All verbal or written complaints regarding abuse, neglect, patient harm or provider compliance with CMS requirements are considered grievances.

When the patient or the patient’s representative requests that his or her complaint be handled as a formal complaint or grievance or when the patient requests a response from the provider, the complaint is considered a grievance.

Situations where a patient or a patient rep telephones the provider with a complaint regarding the patient’s care or with an allegation of abuse or neglect, or failure of the provider to comply with one or more COPs, or other CMS requirements, this is considered a grievance.

What Isn’t a Grievance?

Billing issues are not usually considered grievances.

- However, a Medicare beneficiary billing complaint related to certain rights and limitations is considered a grievance. **This is primarily seen in hospital stays.**

Verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.

Information obtained from patient satisfaction survey usually do not meet the definition of a grievance.

- HOWEVER: if a patient writes or attaches a written complaint on the survey and request resolutions, then the complaint meets the definition of a grievance.
Bill Write Off Process

First and foremost, NEVER tell a patient or family member that the agency is going to write-off their bill or that we are responsible for their bill.

If a patient requests that their bill be written off or has questions about having to pay their bill due to a situation that happened related to their care, such as a fall, the appropriate response is, “You will be billed for services that are provided to you by our agency. If you have additional questions I can provide you with the number of our Risk Management Officer.”

An alternate response could also be, “I don’t have enough information to make that determination, but I can provide you with the Risk Management Department’s phone number and they will be able to help answer your questions.”

Bill Write Off Process

What is your policy for bill write-off?

Do you have a clear, clean reason to write off the bill? Is it documented and has that decision been vetted appropriately through the organization?

Some people will always want free services – does bill write off truly address the issue?

- If not, then don’t write off the bill.

<table>
<thead>
<tr>
<th>Grievance Type</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse or Neglect by Provider</td>
<td>Allegations of physical, sexual or emotional abuse by any type of staff or provider.</td>
</tr>
<tr>
<td>Specific Quality of Care Issues</td>
<td>My provider failed to appropriately explain the risk and benefits of a procedure or treatment to me. Versus I didn’t like my doctor/RN/CNA, etc. (Not entered as a grievance, but entered as a complaint and assigned to leaders to resolve.)</td>
</tr>
</tbody>
</table>

Joint Commission Quality Standard

Any complaint that is received where a specific resolution is sought is considered a grievance.

EXAMPLE: A patient or family member asks that X is done to resolve the grievance.

Patient or family asks that the physician apologize or that they receive a call from senior leadership.

CMS Standard & Joint Commission Standard

Any complaint where the individual requests that the complaint be handled as a grievance.

A patient or family member calls and specifically requests that we handle the concern or complaint as a grievance.

CMS Standard

Any written complaint received by the organization. (For these purposes an email or fax is considered written.)

A patient or family member writes a letter addressed to CEO (head of the organization) referencing issues/problems with their care provided.

Bill Write Off Process

First and foremost, NEVER tell a patient or family member that the agency is going to write-off their bill or that we are responsible for their bill.

If a patient requests that their bill be written off or has questions about having to pay their bill due to a situation that happened related to their care, such as a fall, the appropriate response is, “You will be billed for services that are provided to you by our agency. If you have additional questions I can provide you with the number of our Risk Management Officer.”

An alternate response could also be, “I don’t have enough information to make that determination, but I can provide you with the Risk Management Department’s phone number and they will be able to help answer your questions.”

Bill Write Off Process

What is your policy for bill write-off?

Do you have a clear, clean reason to write off the bill? Is it documented and has that decision been vetted appropriately through the organization?

Some people will always want free services – does bill write off truly address the issue?

- If not, then don’t write off the bill.
RCA: ROOT CAUSE ANALYSIS

"An objective, thorough and disciplined methodology employed to determine the most probable underlying causes of problems, complaints and undesired events within an organization, with the aim of formulating and agreeing corrective actions to at least mitigate, if not eliminate, those causes and so produce significant long-term performance improvement." - Vassilis 

How Is An RCA Done?

Teams identify all possible causes.

The actual root causes are identified and verified.

Corrective action(s) are identified to reduce or eliminate the problem.
RCA Tools

- Cause and Effect Diagram
- Scatter Diagram - prove cause-effect relationship
- Control Chart - process stable?
- Five Whys
- Tree Diagram
- Change Analysis
- Barrier Analysis
- Event and Causal Factor Analysis
- Management Oversight & Risk Tree Analysis (MORT)

APOLOGY & DISCLOSURE

"APOLOGIZE AND LEARN WHEN WE’RE WRONG, EXPLAIN AND VIGOROUSLY DEFEND WHEN WE’RE RIGHT, AND VIEW COURT AS A LAST RESORT."

We care deeply about our patients, and we take it very seriously when one of them is injured, concerned or unhappy about the care we have provided. We also care deeply about our staff, and we want to support and protect them so they can continue to do great work. And, we want to create as safe an environment as possible for both patients and staff.
Why Don’t We Apologize & Disclose?

Fear of retribution from the recipient of the news.
Fear of retribution from colleagues or peers.
Fear of conducting the conversation poorly.
Fear of having to handle the patient’s as well as their own emotions.
Belief that disclosure is unnecessary.
Belief that disclosure is primarily a factual conversation and not a complex interpersonal conversation.
Belief that the outcome is not related to action on the part of the discloser.
Belief that the outcome would potentially have occurred without the error or intervention.

Disclosure GAP

90% of Doctors support the principle of disclosure

BUT

Only 30% actually do disclose

Barriers to Disclosure

- Skeptical of benefits
- Unnecessary distress to patient and family
- Patients unlikely to find out
- Lawsuits
- Lack of training in error disclosure

NEJM 2004
**Benefits of Disclosure**

Staying engaged with patients and restoring trust results in better outcomes for both patients and clinicians.

Studies show it reduces the risk of litigation significantly.

*It’s the right thing to do.*

---

**Full Disclosure Policy, University of Michigan**

---

---
DISCLOSURE PROTOCOL

1. Statement of what happened (objective statement of the event/outcome).
   - Clear conveyance of regret.
   - Identification of steps already taken to prevent recurrence.
   - Discussion of any change in the patient’s care plan and addressing of any areas of particular concern to the patient.
   - Discussion of whom the patient or family will hear from next in the organization and what (if any) steps they will need to take.
   - An offer of support services to the patient and applicable family members.

2. Accommodations for special communication needs. Advice on dealing with special situations where language barriers, disabilities or other communication challenges may be encountered, including the identification of accommodation resources such as interpreters.

3. Support services available to the patient. A list of resources that could be given to the patient or family for pastoral care, social services or other support services available.

4. Steps for followup conversations. Advice on how to leave the door open for future conversations with the patient or family on the issues being addressed, including contact information for the patient or family plus contact information for future provider support or questions.

5. Documentation of the conversation. Appropriate location, timing and technique to ascertain that the documentation reflects the content of the conversation, any treatment plans discussed, the participants, the level of understanding exhibited by the patient and the next steps to be taken by the patient and any providers or the facility staff.

FEARED

FEARED to remind providers and administration of the steps involved in disclosure conversations.

These steps include:
- Get all of the Facts.
- Express Empathy and Educate.
- Search for sources of Anger.
- Have patients Relate back their understanding of the explanation.
- Evaluate the Extended family response.
- Document the conversation.
The Steps for Discussion

1. Preparation - check-in
2. State what happened simply
3. Apology
4. Take responsibility
5. Assurance/Problem Solving
6. Invite questions
7. Make follow up plan together
8. Document
9. Debrief

WHO of Apology & Disclosure

Who should be involved in the process?
- The Physician
- Nurse
- Administrator
- Risk Management
- Social Worker
- Chaplain
- Any team member actively involved

WHEN of Apology & Disclosure

When should Disclosure be made?
- Initial communication should take place promptly—ideally within 24 hours after the discovery of an adverse event.
WHERE of Apology & Disclosure

Where should Apology and Disclosure take place?
- Make effort to ensure appropriate privacy and freedom from distraction, with a level of comfort for all present. Initial contact may simply be notice that a meeting is necessary to discuss the situation and outcomes.

HOW of Apology & Disclosure

How should Disclosure be made?
- Listen with complete attention/no interruption
- Determine patient's level of understanding and speak accordingly
- Ensure patients know treatment options available, and understand potential risks/benefits
- Treat as "whole" people, not set of symptoms
- TELL PATIENTS THE TRUTH!!!

WHAT of Apology & Disclosure

What should an apology include?
- Straightforward statements, not medical jargon
- Speak softly and slowly
- Make eye contact
- Invite and answer all questions as honestly as possible
- Be guided by patients' questions and follow-up after initial meeting
WHY of Apology & Disclosure

**Why should an apology be made?**
- Indicates respect and caring for another person — and yourself
- Indicates you are capable of accepting responsibility for your actions
- Sincere apology often quiets frustration and anger!

The Healing Aspects of APOLOGY

**Key Ways an apology heals:**
- Restores patient’s (family’s) dignity and self-respect.
- Provides assurance of shared values, re-establishing trust.
- Assures patient (family) that they are not at fault.
- Assures patients (family) that they are safe.
- Demonstrates that health care providers is also suffering.

How Apologies Fail

“If there was an error...”

“There was a mistake, but...”

“The mistake certainly didn’t change the outcome...”

“Sometimes these things happen...”
Case Studies

Case Study 1: Mrs. Jones’ Medication

Mrs. Jones is a 67-year-old patient with pancreatic cancer and beginning to transition. Her pain has been increasing the last two days. The RN brought medication for the new order - 0.25 mL every hour until the patient is comfortable or 5 doses are reached. At 5 doses, the doctor is to be called. The RN educates the husband, a college professor, who is very busy and at times seems hesitant to provide care and says, “I thought hospice was going to do that?” As the RN leaves, the CNA arrives and the RN tells her to call if they need anything.

Mr. Jones tells the CNA he has a conference call, and as she is in nursing, he needs her to give the next two doses. The CNA calls the RN, who does not answer, for direction (over the course of the day she will try to call two additional times). Mrs. Jones is hurting and says she needs a dose - she said the RN said it was 2.5 mL up to 5 requested doses. She is crying and in obvious pain. The CNA draws up the medication and gives the requested doses 3 times in an hour period. The RN calls the CNA back, asking if she needs help. The CNA tells her what she’s done so far and that the patient has started to be minimally responsive. Mr. Jones walks in and becomes upset, screaming at the CNA, “you are trying to kill my wife! What have you done?”

Case Study 2: No, The Other One

Jan has recently started as a Nurse Practitioner for Hospice of Home. She picks up her caseload for the day, which includes visiting June Cleaver at Sunnyvale Nursing Home. After her visits, she returns to the office and wants to talk to Dr. White about her visits. She reports she had a delightful visit with Mrs. Cleaver, who was sitting on the edge of the bed and feeling well today. Dr. White says, “there has been a mistake, Mrs. Cleaver has not been able to respond in months and she is physically unable to get out of bed.” It is discovered that Jan has seen the other patient in Mrs. Cleaver’s shared room - who frequently answers as if she is Mrs. Cleaver. Jan documented in Mrs. Cleaver’s chart at Sunnyvale and the hospice EMR, but she did not make any changes to the POC.
Case Study 3: Texting As You Go

Ronald is a long-term nurse at Hospice of Home and one of the best employees they have. As he is finishing his day, Ronald has one more stop before he goes home - to drop off some supplies for a co-worker. The co-worker had text him the patient's address so he could put it in his GPS. As he is driving down the road, he sees he is passing a car that is on the side of the road. As he looks up from the phone, he notices he has passed a car that is on the side of the road. In the rearview mirror, Ronald realizes that there is someone in the road next to the car.

The car on the side of the road has had a flat tire. The young lady has been trying to change her tire and remembers her dad saying it has to be on a level surface - so she pulls the car off very close to the lane, rather than off the shoulder. Her right leg is sticking out behind her as she is trying to get the tire off. As Ronald drives by, his tires manage to hit her leg, crushing it.

Ronald stops and turns around, calls 911 and he begins care. Ultimately, they have to amputate her leg.

Case Study 4: Falling All Over Ourselves

Mr. Peterson is an 87 yr old man with COPD and is on hospice living in a nursing home. He has had seven falls in a two week period. The nursing home has told the hospice nurse that they are hesitant to initiate anything that would be considered a restraint. They have asked the nurse to not report the falls, the nursing home staff is working on a plan and promise to talk about it at the next POC meeting, the following Monday. The nurse has documented all the falls in the hospice EMR, but did not complete an incident report or make a report on the falls. The nurse says in the IDT “there have been several falls, but the nursing home is actively working on it.”

State comes into the hospice and picks Mr. Peterson’s chart and goes to the nursing home - who does not have matching fall reports. They, in fact, have no fall reports and no plan of care for falls that can be produced. Both the hospice and nursing home are cited with a deficiency and a neglect report is called in on the case, citing failure of all care providers.

It is later discovered that Mr. Peterson’s daughter, Debbie, is the one who called and made a report to state – saying her father is falling more and no one seems concerned about it.

Case Study 5: Social Notes

A social worker does needs worksheets and financial assessments when she meets with patients and families. The notes include PHI and financial information, often with copies of documents from the families. After she meets with them, she puts the notes in the EMR. After she enters it in the EMR, she puts the worksheets in her “shred box” which is next to her desk. She carries her “shred box” down to the secure bin every Friday before she leaves for the week.

On Thursday evening, the new housekeeper notices a box by the trashcan and throws the box of papers away. The next morning, they are found blowing up and down the alley.
Case Study 6: Bad Billing Bites

Loving Ya Hospice was started as a family hospice and many of the family works there. Joan is the owner’s sister-in-law and has been the lead biller for the last seven years of the agency’s history. Alex serves as the owner/administrator.

CVCD Insurance called and is questioning the billing on a patient that has been on service for a little more than a year. Mrs. Miliam has Medicare, a secondary policy with CVCD and a long-term care policy she bought years ago from CVCD. The secondary policy has a rider that covers hospice care if it is not covered or completely covered.

In an audit it is found that Loving Ya Hospice has been billing routine rate to Medicare and to the secondary policy and has also been billing CVCD a daily nursing home rate under the LTC policy. Mrs. Miliam lives in an ALF, not a nursing home. The ALF per diem is $25 less a day than for nursing home.

CVCD’s audit indicates that Loving Ya Hospice has been overpaid and owes CVCD $65,175. CVCD has given Loving Ya 15 days to pay full restitution and notifies them that a letter will be going to Mrs. Miliam and her POA since this may delay future coverage until it is resolved.

Joan tells her brother-in-law Alex, the administrator, that she billed as she always has, per her notes from when she started. She gives them reference notes she has on billing and it is full of billing mistakes. She tells Alex she does not believe the hospice account has an extra $65,000 and they will have to refund the money out of their personal account. Alex is now very concerned that there are other billing mistakes.

How Consistent Are You?

- How many of you had policies that would have addressed the root problem(s)?
- How many of your staff would say you have policies to cover the issue?
- Do you look at system/process issues versus employee/attitude issues?
- If the system fails the staff, is it fair to hold the employee accountable?
- Assuming there is a system failure and you decide post-event to fire the employee, do you have a new risk?
- Change the outcomes or the people involved in the case – does that change how the correction is addressed?
- Do you have your policy and protocols developed to identify, investigate and recover from risk management issues?

How Consistent Are You?

- Is your agency Proactive or Reactive?
- Do you have a reward/recognition program for employees that discover or mitigate a risk?
- What is required of your insurance carrier? Do you review this at least annually?
- Governance – what is your reporting mechanism to the board?
- Partners – Do you work with your community partners on risk issues?
- Nursing Homes, ALF, Private Care Homes – How do you work together for the patient?
- Hospitals – What happens if one of your patients is harmed, upset or an accident happens?
Questions, Comments & Discussion

CHARLEY J. WASSON, MS
CWASSON@COVHIS.ORG
806-795-2751