Don’t Face the Risk Apocalypse: Practical Approaches to Implementing and Integrating ERM and Compliance with Quality
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Quality and Compliance Starts with the Patient Experience!

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
JPS Health Network
Agenda

- About JPS Health Network
- JPS Organizational Culture
- Our ERM Journey
- The JPS Quality and Patient Safety Program
- Combining ERM and Quality
- Questions
Organizational Culture: Tone at the Top

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

Elements of culture leading to improved Quality and ERM programs

Our ERM Journey
ERM Helps Manage Reputational Risk

It takes 20 years to build a reputation and five minutes to ruin it. If you think about that, you'll do things differently.
—Warren Buffet

ERM Timeline

- SVP, ERM and Chief Compliance Officer position created in 2015 reporting directly to both the Board and CEO
- 9 IJS 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

Overcoming ERM Organizational Barriers

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Solutions</th>
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<tr>
<td>Not &quot;real&quot; work</td>
<td>Establish board and leadership support at the beginning</td>
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<td>Flavor of the month</td>
<td>Educate key stakeholders</td>
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<td>Too academic</td>
<td>Define goals and value proposition</td>
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<td>Too confusing</td>
<td>Keep it simple</td>
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<td>Too many risks to focus on</td>
<td>Get quick wins to gain support</td>
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<td>Identify a few key ERM risks</td>
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<td>Practice telling the ERM story</td>
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<td>Align ERM to key organizational goals and quantify</td>
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<td>Others?</td>
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Strategic Alignment

1. Mission
2. Vision (long range)

3. Organizational Goals
4. Risk universe
5. Risk definitions
6. Frameworks

7. Set Foundation
8. Establish Oversight
9. Define the risk and decision implications

10. Quantify risks
11. Performance Improvement

Risk Profile Elements

1. ERM Risk Name / Executive Risk Owners
2. Risk Definition
3. Risk Category (JPS Pillar / Strategic / Regulatory)
4. Risk Drivers
   ➢ External / Internal
5. Risk Events
   ➢ (Rating: Impact / Significance / Velocity)
6. Risk Mitigation Strategies
   ➢ (Effectiveness of Current & Proposed)
7. Risk Maturity Current and Desired
8. Risk Tolerance / Risk Appetite
9. Evaluative Metrics

Building Relationships and Support

• 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.

2017 ERM Goals

- 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
The JPS Quality and Patient Safety Program

Excellence Begins with High Reliability

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

—WEE LOMBARD

Excellence Begins with High Reliability

THE POWER OF ZERO: STEPS TOWARD HIGH RELIABILITY HEALTHCARE
Elements of a High Reliability Organization

- Obsession with Failure
- Sensitivity to Operations
- Deference to Expertise
- Commitment to Resilience
- Reluctance to Simplify

Source: Adapted from numerous scholarly journals and organizations including the Joint Commission and the Studer Group.

We are building an environment of psychological safety

**Psychological Danger**
- Fear of admitting mistakes
- Blaming others
- Less likely to share different views

**Psychological Safety**
- Comfort admitting mistakes
- Everyone openly shares ideas
- Better innovation & decision-making
- Learning from failure

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
We celebrate patient safety wins along the way!

Across JPS there were zero central line bloodstream 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.

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

How do you achieve a safe system?
ERM and Quality Collaboration Success Stories

- Data Governance
- Physician Engagement
- Academics

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

Combining ERM, Quality, and Compliance

Integration is about tearing down silos!
Risk and Quality Synergy is Essential

**SYNERGY**

1 + 1 = 3

**Risk**
- Risk Control
- Compliance
- Enterprise Risk Management
- Policies and Procedures
- Insurance

**Quality**
- Culture of Safety
- Accreditation Issues
- Corrective Action Plans
- Patient Safety Initiatives

**Culture of Safety**
- Clinical Best Practices
- Patient Satisfaction
- Peer Review
- Quality Management
- Provider Performance

Clinical Quality ERM Risk Profile Summary

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<tr>
<th>RISK DEFINITION</th>
<th>RISK OWNERS</th>
<th>FILLAR</th>
<th>MATURITY</th>
<th>TREND</th>
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<tbody>
<tr>
<td>Clinical quality failures, reflected through patient outcomes and satisfaction, significantly affect the organization’s reputation, efficacy, compliance and accreditation status, and reinforcement</td>
<td>Frank Rosina, M.D.</td>
<td>Quality</td>
<td>Current: Initial</td>
<td>Desired: Defined</td>
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**TOP RISKS**
1. Inadequate Clinical Documentation (High)
2. Inconsistent Care Coordination (High)
3. Medical Errors (High)
4. Resident Supervision (High)
5. Hospital-acquired infections (High)
6. Medical staff are not responded to timely (Moderate)
7. Hospital readmissions (Moderate)
8. Clinical Staff Competencies (Low)
9. Patient falls/traumas (Low)
10. Mortality (Low)

**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
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

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?

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
Victory comes from strong leadership to foster an environment of change.

Questions

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