Regulatory & Organizational Elements of Clinical Excellence

LSU Health New Orleans
Enhancing Quality Improvement for Patients (EQuIP) Program
Objectives

- Describe the components of building and maintaining organizational excellence.
- Review regulatory requirements and how they can impact providers.
Quality “Assurance” vs. “Improvement”

**Quality Assurance**
- Operates according to institutional standards.
- Assumes quality exists.
- Looks at individual.
  - Changes individual conduct.
- Measures outliers.
- Danger of departmental silos.

**Quality Improvement**
- Use evidence-based standards.
- Looks at systems & processes.
  - Deemphasizes individual performance and culpability.
- Measures whole system to identify gaps.
- Promotes teamwork and interprofessional efforts.
Performance Improvement

1. Identify process to be improved
2. Collect and plot the data
3. Evaluate the data
4. Develop benchmarks (indicators)
5. Continuously collect and review data
6. Evaluate, clarify and understand the process
7. Modify system or process as needed
Organizational Excellence

- Quality Assurance
- Just Culture
- Performance Improvement
- Continuous Quality Improvement
- Patient Safety Initiatives
- Risk Management
Promoting a Just Culture

- **Definition:**

  “A just culture recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, “routine rule violations”), but has zero tolerance for reckless behavior ….. Frontline personnel feel comfortable disclosing errors – including their own – while maintaining professional accountability.”

*Italics added.*
Promoting a Just Culture

- Errors are treated as information for learning.
- Voicing concerns is accepted and safe.
- Caregivers seek assistance easily.
- Everyone accountable for increasing patient risks.
- Actions based on risks people choose to take, not the outcome of the event.

## Promoting a Just Culture

### Factors Affecting System Performance

<table>
<thead>
<tr>
<th>Factor</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Human factors</td>
<td>that are designed to reduce the rate of error</td>
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<tr>
<td>Barriers</td>
<td>to prevent failure</td>
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<tr>
<td>Recovery</td>
<td>to capture failures before they become critical</td>
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<tr>
<td>Redundancy</td>
<td>to limit the effects of failure</td>
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### Factors Affecting Human Performance

<table>
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<tr>
<th>Factor</th>
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</thead>
<tbody>
<tr>
<td>Information</td>
<td></td>
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<tr>
<td>Equipment/ Tools</td>
<td></td>
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<tr>
<td>Design/ Configuration</td>
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<td>Job/ Tasks</td>
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<tr>
<td>Qualifications/ Skills</td>
<td></td>
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<tr>
<td>Perception of Risk</td>
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<tr>
<td>Individual Factors</td>
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<tr>
<td>Environment/Facilities</td>
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<td>Organizational Environment</td>
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<td>Supervision</td>
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<td>Communication</td>
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Root Cause Analysis

An adverse event is only a symptom of underlying problems.

- RCA limited to authorized personnel and is strictly confidential.
- Action plans:
  - Including who is responsible for implementation of changes, oversight, time lines, and how effectiveness will be measured.

Root Cause Analysis

- What prompts an RCA?
  - Sentinel events
  - Near miss/close call: no adverse outcome BUT a recurrence of the event carries a significant chance of an adverse outcome.
  - “Adverse event” and “error” are NOT synonymous terms.

All RCAs must be:

Thorough
- Examine all systems, areas and processes directly associated with the event.
- Determine potential improvement(s) that reduce risk of similar events.

Acceptable
- Focus on systems and processes, not individuals.
- “Why?” then “Why?” then “Why?”
- Special causes (extraordinary event) & common causes (what always happens).

Credible
- Participation by organizational leadership and individuals closely associated with event.
- Internal consistency – no contradictions or obviously unanswered questions.
- Review relevant literature.

Organizational Excellence

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Risk Management: Past and Present

- Previous thinking: protecting the financial assets and reputation of the organization.
  - 1970s: medical malpractice crisis
  - 1980s: enshrined in federal law through COBRA
  - 1989: Mandated by Joint Commission

- Current thinking: Standard procedure often working hand-in-hand with QI and safety departments.
Risk Management in Hospitals

- Works for protection of patients, visitors, facility and staff.
- Protects an organization’s financial assets and reputation.
- Evaluates processes, functions and facilities to identify, evaluate and reduce risks for injury.
- Promotes awareness and commitment.

Risk Management in Hospitals

- Requires knowledge of:
  - Law and legal processes.
  - Clinical medicine.
  - Organization’s structure.
- Consistently reevaluate risks and procedures, making necessary changes.

**Risk Identification:** Identify legal risks

**Risk Prioritization:** Prioritizes identified risks

**Risk Analysis:** Determine proper response to identified risks

**Risk Control:** Manage recognized risk cases with goal of minimizing loss

**Risk Prevention:** Establish effective risk prevention

**Risk Financing:** Maintain adequate financial resources

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Risk Management in Hospitals

- Avenues of identifying risk:
  - Legal actions
  - Medical records requests
  - Patient complaints
  - Billing disputes
  - Incident reports
  - Screening for generic indicators
    - Access to general facility
    - Security
    - Readmissions
    - Infection control
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HIPAA: Privacy and Security

  - Confidentiality and patient privacy under the “Accountability” portion of the Act.
- Government and industry groups set uniform standards.

HIPAA: Privacy and Security

- Privacy Rule: controls authorization to access information.
  - May use PHI without consent for treatment, payment and operations.
  - Consent required for psychotherapy notes, marketing, fund raising, and research.

1. Names.
2. Address (including zip code).
3. Dates (birth, admission, discharge, death).
4. Telephone numbers.
5. Fax numbers.
6. E-mail addresses.
7. Social security numbers.
8. Medical record numbers.
9. Health plan beneficiary numbers.
10. Account numbers.
11. Certificate/License numbers.
12. Vehicle identifiers, serial numbers, license plate.
15. Internet Protocol (IP) addresses.
16. Biometric identifiers, incl finger and voice prints.
17. Full-face photographic images and any comparable images.
18. Any other unique identifying number, characteristic, or code.
HIPAA: Privacy and Security

- Security Rule: how to ensure the integrity, confidentiality and availability of electronic PHI.
  - Administrative safeguards: Chief Security Officers; policies/procedures; employee training.
  - Physical safeguards: limited or controlled access to PHI; securing data appropriately.
  - Technical safeguards: unique logins; encryption; access during emergencies.

How This Affects You

- Joint Commission, ACGME and hospitals mandate physician participation in improvement and review activities.
  - Healthcare organizations (e.g. HMOs, PPOs) mandate ongoing quality assurance monitoring of physician staff.
  - Work with risk management and compliance departments in lawsuits and complaints.
- Physicians play crucial role in maintaining privacy and security of data.
  - Employee training.
  - Mindfulness of requirements.
Improving processes and systems is a continual, interdisciplinary cycle.

Just cultures promote voicing concerns and give healthcare professionals the assistance they need to improve the organization.

Risk managers identify risks and work to avoid & remedy them.

Maintaining the privacy and security of patient information/data is everyone’s responsibility.
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