RISK MANAGEMENT PLAN
2013

PROGRAM GOALS

The University of Mississippi Medical Center is committed to providing the highest level of safe patient services in an environment that presents minimal or no risk to its patients, visitors, volunteers, physicians and employees. The goal of preventing or reducing loss to the organization is supported through a formal, organization-wide risk management program that is an integral part of the organizational quality and patient safety plan.

OBJECTIVES

Consistent with the established organizational mission and vision, objectives of the risk management program are as follows:

- Protect the assets of the Medical Center, employees and staff.
- Encourage an organizational culture of safety.
- Facilitate prompt identification and response to safety and risk issues.
- Decrease the frequency and severity of any untoward events, and reduce financial losses associated with claims experiences.
- Assist in continually improving safe, accurate, and coordinated delivery of health care services.
- Assure safeguarding and confidentiality of all documents that are part of risk management proceedings, reports, and records as defined in state peer review and quality statutes.
- Monitor, evaluate, track and trend any potential liability exposure presented as patient/visitor incidents, patient complaints, employee incidents, claims and lawsuits.
- Provide an operational “linkage” with the medical staff credentialing process via case referral for peer review, ongoing professional performance evaluation and/or focused professional performance evaluation activities.
BOARD AND ADMINISTRATIVE ENDORSEMENT AND OVERSIGHT

THE ORGANIZATIONAL STRUCTURE TO SUPPORT RISK MANAGEMENT INCLUDES THE INSTITUTIONAL QUALITY BOARD, THE RISK MANAGEMENT COMMITTEE AND THE ENVIRONMENTAL HEALTH AND SAFETY COMMITTEE. THE QUALITY BOARD, SENIOR LEADERSHIP, AND MEDICAL STAFF SHALL WORK TO ESTABLISH, MAINTAIN, AND SUPPORT THIS COMPREHENSIVE, INTEGRATED PROGRAM.

THE RISK MANAGEMENT COMMITTEE WILL PROVIDE OVERSIGHT OF ACTIVITIES AND OUTCOMES OF THE RISK MANAGEMENT PROGRAM BY MONITORING PROGRESS TOWARD PROGRAM GOALS INITIATIVES. THE RISK MANAGEMENT COMMITTEE WILL RECEIVE AND REVIEW PERIODIC SUMMARY REPORTS REGARDING RISK OUTCOMES, DATA TRENDS OF PATIENT EVENTS AND CLAIMS FOR THE PURPOSES OF IMPROVING PATIENT SAFETY.

STRUCTURE AND SCOPE OF THE PROGRAM

OVERSIGHT, ACCOUNTABILITY, AND AUTHORITY:

- THE AUTHORITY AND ACCOUNTABILITY OF THE RISK MANAGEMENT PROGRAM IS VESTED IN THE INSTITUTION OF HIGHER LEARNING BOARD (IHL BOARD) WHO IN TURN DELEGATES THE RESPONSIBILITY FOR IMPLEMENTATION OF RISK MANAGEMENT FUNCTIONS TO THE VICE CHANCELLOR FOR HEALTH AFFAIRS.


- THE ASSOCIATE VICE CHANCELLOR FOR ADMINISTRATIVE AFFAIRS WILL FOCUS ON ENVIRONMENTAL/SAFETY/EMPLOYEE RISK MANAGEMENT CONCERNS, AND WILL ASSIST IN LEGAL LITIGATION ACTIVITIES WITH THE RISK MANAGEMENT COMMITTEE AND CLAIMS COMMITTEE.

- THE CHIEF MEDICAL OFFICER WILL FOCUS ON PATIENT CARE AND MEDICAL STAFF RISK MANAGEMENT/QUALITY ISSUES AND CONCERNS, WILL SERVE AS A MEMBER OF QUALITY BOARD AND SERVE AS THE GROUP’S LIAISON FOR RISK MANAGEMENT/PERFORMANCE IMPROVEMENT ACTIVITIES, AND WILL SHARE CONCURRENT INFORMATION AS APPROPRIATE WITH HOSPITAL AND INSTITUTIONAL COMMITTEES. THE CHIEF NURSING EXECUTIVE OFFICER, THE CHIEF EXECUTIVE OFFICER AND THE VARIOUS CLINICAL DIRECTORS WILL SERVE AS A LIAISON WITH CLINICAL DEPARTMENT PERSONNEL AND ADMINISTRATIVE PERSONNEL WITH RESPECT TO IDENTIFIED CLINICAL RISKS AND ONGOING PROBLEM SOLVING.

- THE MEDICAL DIRECTOR OF RISK MANAGEMENT WILL ASSUME DIRECT RESPONSIBILITY FOR RISK MANAGEMENT ACTIVITIES.
DUE TO THE NATURE OF THE MANY ACTIVITIES OF RISK MANAGEMENT, IT IS COMMON FOR THE EXECUTIVE LEADERSHIP OF UMHC TO LIAISON WITH HOSPITAL DEFENSE COUNSEL ON A CASE BY CASE BASIS IN ALL MATTERS WITH RESPECT TO MEDICAL MALPRACTICE CLAIMS AGAINST THE HOSPITAL, ITS EMPLOYEES, AND MEMBERS OF THE MEDICAL STAFF.

THE RISK MANAGEMENT CLINICAL COORDINATOR, COORDINATES ACTIVITIES OF THE RISK MANAGEMENT PROGRAM AND SERVES AS SYSTEM-WIDE RISK MANAGEMENT RESOURCE AND LIAISON TO STAFF, PHYSICIANS AND LEADERSHIP ON CLINICAL RISK AND MEDICO-LEGAL ISSUES, SUCH AS OCCURRENCE REPORTING, AND DISCLOSURE OF ADVERSE EVENTS. THE RISK MANAGEMENT COORDINATOR MANAGES THE INCIDENT REPORTING SYSTEM WHICH ENTAILS INVESTIGATION, TRACKING AND TRENDING OF EVENTS THAT POSE RISK, AND PROACTIVE IDENTIFICATION OF VULNERABLE PROCESSES FOR PATIENTS, VISITORS AND STAFF. IN ADDITION, THE RM COORDINATOR DEVELOPS RISK REDUCTION STRATEGIES IN COORDINATION WITH SAFETY/QUALITY TEAMS THROUGH CAUSAL ANALYSIS.

ADDITIONAL INVESTIGATIVE CAPABILITIES WILL BE PERFORMED BY APPROPRIATE WORK AREA LEADERS AS DIRECTED OR NEEDED.

SCOPE OF SERVICES:

- FACILITATE DATA COLLECTION INITIATIVES NEEDED TO ENSURE PATIENT SAFETY AND QUALITY OF CARE
- FACILITATE CORRECTION OF EXPOSURE RISKS IN THE CLINICAL COMPONENTS OF PATIENT CARE AS IDENTIFIED THROUGH RISK MANAGEMENT ACTIVITIES.
- ESTABLISH AND MAINTAIN OPERATIONAL LINKAGES BETWEEN RISK MANAGEMENT, PATIENT SAFETY AND QUALITY IMPROVEMENT FUNCTIONS RELATED TO PATIENT CARE.
- PROVIDE ACCESS TO EXISTING INFORMATION FROM RISK MANAGEMENT ACTIVITIES THAT MAY BE USEFUL IN IDENTIFYING CLINICAL PROBLEMS AND/OR OPPORTUNITIES TO IMPROVE THE QUALITY OF PATIENT CARE.
- REVIEW ANY PATIENT OR VISITOR ACCIDENT, INJURY, OR SAFETY HAZARD IDENTIFIED WITHIN THE HOSPITAL/CLINICAL SETTING.
- FUNCTION AS A LIAISON TO LEGAL COUNSEL FOR THE HOSPITAL.
- MAINTAIN ‘CONFIDENTIALITY’ IN ALL ACTIVITIES AS DICTATED BY THE IHL BOARD.
- COMMUNICATE RISK EXPOSURES THAT HAVE BEEN IDENTIFIED TO APPROPRIATE PARTIES.
- ENSURE ADEQUATE ADMINISTRATIVE SUPPORT FOR RISK MANAGEMENT FUNCTIONS BY ENSURING PROTECTION OF THE INSTITUTION AND ITS EMPLOYEES AGAINST LIABILITY, THROUGH:
  - REDUCTION OR MODIFICATION OF IDENTIFIED RISK EXPOSURES
  - PREVENTION OF PATIENT INJURIES, WHICH LEAD TO LIABILITY EXPOSURES THROUGH ANY OR ALL OF THE FOLLOWING AVENUES:
    1. INCIDENT REPORTING
2. DATA COLLECTION AND CAUSAL ANALYSIS
3. RISK DISCOVERY AND EVALUATION
4. RECOMMENDATIONS FOR CORRECTIVE ACTION
5. RISK MANAGEMENT EDUCATION FOR EMPLOYEES AND STAFF
6. SAFETY PROGRAM(S)
7. EFFECTIVE CLAIMS MANAGEMENT
8. CONSULTATION WITH PATIENT RELATIONS PERSONNEL
9. PROPERTY PROTECTION

- PARTICIPATION IN VARIOUS HOSPITAL ACTIVITIES INCLUDING:
  - ADMINISTRATIVE STAFF MEETINGS (C-SUITE)
  - MEDICAL STAFF OFFICE (CREDENTIALS)
  - PERFORMANCE IMPROVEMENT (ACCREDITATION)
  - EDUCATION (GME AND CLINICAL)
  - PATIENT ACCOUNTS (COMPLIANCE)
  - MORTALITY AND MORBIDITY CONFERENCES (MEDICAL STAFF)

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RISK MANAGEMENT PROCESS

THE VICE CHANCELLOR IS CHARGED BY THE IHL BOARD TO:
- IDENTIFY AND ANALYZE LOSS EXPOSURES
- EXAMINE AND EMPLOY RISK MANAGEMENT STRATEGIES TO REDUCE LOSS
- MONITOR, EVALUATE, AND IMPROVE THE RISK MANAGEMENT PROGRAM.
- INTEGRATE CLINICAL RISK FINDINGS WITH MEDICAL CENTER IMPROVEMENT INITIATIVES.
RISK IDENTIFICATION, ASSESSMENT, AND ANALYSIS:

- Data sources to identify organizational risks shall include, but are not limited to:
  - Incident reports, adverse events, near miss events, FMEA (PRA)
  - Incident investigation and causal analysis
  - External survey deficiencies
  - Medical staff credentialing
  - Provider practice management
  - Environmental safety assessments (slips/falls)
  - Patient complaints/grievances
  - Patient satisfaction surveys
  - Internal risk assessment surveys
  - Infection control and environmental surveillance
  - Employee satisfaction surveys
  - Claim data

- Event reporting:
  - The risk management program shall encourage a systematic occurrence reporting process through:
    1. I CARE reports
    2. Short on time I CARE reports
    3. Risk management confidential voicemail line
    4. Email to a risk management clinical coordinator

- All staff is required to complete a report when an event or situation occurs that is not consistent with the routine operation and procedure of the facility, the routine care of a patient or visitor, or routine activities of an employee or volunteer. Reporting expectations also include situations that do not result in injury and may have averted error or "near miss".

- The risk management department conducts reviews of all occurrences, responds immediately as needed, and completes follow-up action plans with managers and directors as appropriate. All occurrences are trended, analyzed, and reported at least quarterly in an appropriate forum to hospital leadership for action if necessary.

- Strategies for loss prevention and loss reduction are integrated into the organization’s quality/performance improvement processes in a manner consistent with the vision, mission, and strategic objectives of the organization.
POTENTIALLY COMPENSABLE EVENTS, ADVERSE EVENTS, SENTINEL EVENTS:

- WITHIN THE ORGANIZATION AND IN CONJUNCTION WITH PATIENT CARE PROVIDERS AND FACILITY LEADERS, THE RISK MANAGEMENT PROGRAM SHALL IDENTIFY UNEXPECTED OR UNANTICIPATED RISK EXPOSURES, EVENTS, OR OCCURRENCES THAT HAVE LOSS POTENTIAL. THIS INCLUDES UNSAFE CONDITIONS WHICH HAVE CAUSED INJURY OR HAVE THE POTENTIAL TO CAUSE INJURY. IN RESPONDING TO AN EVENT, THE RISK MANAGEMENT COORDINATOR MAY GATHER INFORMATION ABOUT THE EVENT, INCLUDE ANY PROCESS AND PROVIDERS INVOLVED, OBTAIN AND SEQUESTER PHYSICAL EVIDENCE RELATED TO THE OCCURRENCE, OBTAIN AND SEQUESTER DOCUMENTARY EVIDENCE AND SECURE THE SITE.

- THE RISK MANAGEMENT COORDINATOR, IN COORDINATION WITH INVOLVED DIRECTORS, MANAGERS, AND MEDICAL STAFF SHALL REVIEW THESE EVENTS, ADDRESS THEM IMMEDIATELY IF THEY HAVE CAUSED INJURY, OR AS NECESSARY TO PREVENT INJURY. THE RM COORDINATOR SHALL CONDUCT AN INVESTIGATION AND REPORT THE INFORMATION TO THE APPROPRIATE HOSPITAL LEADERS AND THE MEDICAL DIRECTOR OF RISK MANAGEMENT.

- ANY SENTINEL EVENT WILL BE REPORTED IMMEDIATELY TO THE VICE CHANCELLOR, THE CEO, AND THE MEDICAL DIRECTOR OF RISK MANAGEMENT.


- RISK REDUCTION STRATEGIES WILL BE IDENTIFIED WHICH MAY INCLUDE REFERRAL TO PEER REVIEW, INITIATION OF A ROOT CAUSE ANALYSIS, AND DEVELOPMENT OF AN ACTION PLAN BY THE APPROPRIATE MANAGER(S) OR DIRECTOR(S). THE RISK MANAGEMENT COORDINATOR WILL BE APPRISED OF ACTION PLAN(S), ASSURE TRACKING, TRENDING, REPORTING, AND FUTURE STRATEGIC PLANNING CONSIDERATIONS.

RISK TREATMENT AND CONTROL:

*Risk intervention, treatment, and risk control may be Reactive and Proactive.*

- REACTIVE RISK INTERVENTION AND TREATMENT SHALL INCLUDE BUT IS NOT LIMITED TO:
  - CRITICAL EVENT RESPONSE
  - INCIDENT INVESTIGATION
  - DISCLOSURE
  - INTERNAL CLAIMS MANAGEMENT AND LITIGATION SUPPORT
PROACTIVE RISK INTERVENTION AND TREATMENT SHALL INCLUDE BUT IS NOT LIMITED TO:

- Self-Insured Coverage and Risk Financing
- Contract Review
- Management of Risk and Safety Data
- Risk Surveys and Assessments
- Utilization of Performance Improvement Tools
- Facilitating Regulatory Compliance, Safety Standards, Governmental Laws, and Regulations
- Implement a Culture of Patient Safety
- Evidence-Based Clinical Protocol Development
- Adequate Staffing Levels and Mix
- Failure Mode, Effects Analysis

RISK MONITORING, EVALUATION, AND REPORTING:

- The CEO and CNO will report on all elements of his/her activities as the following elements dictate:
  - Quality and Quantity/Volume Indicators
  - Reports received in accordance with patient/employee safety
  - Dissemination of reports

  1. Safety
  2. Infection Control
  3. Quality Improvement/Patient Satisfaction
  4. Overall Risk Management Activities

- Identification of problems and actions taken
- Follow-up required to resolve problems identified
- Documentation on all activities to be shared with appropriate committees/individuals with reports to be given to various parties to include:
  1. Credentials Committee
  2. Executive Committee of the Medical Staff
  3. Quality Board
  4. All others as depicted in the attached organization chart, sharing authority and reporting channels. All items pertaining to patient and employee safety will be reported as volume indicators and monitored for increase or decrease in reported incidents and injuries.

- All items pertaining to medical malpractice, incidents, claims, and lawsuits will be reported to the Environmental Health and Safety Committee on a volume and generic basis. Specific information regarding medical malpractice, incidents, claims, and lawsuits will be reported to the Chief Legal Officer, the Medical Director of Risk Management, and the Vice Chancellor. All settlements are reported to the IHL Board for approval.

- Monitoring and evaluation of medical malpractice oriented incidents, claims, lawsuits and patient/employee safety activities will be reported to the Medical Staff Office.
IMPLEMENTATION OF CORRECTION ACTION WILL BE PERFORMED BY A MULTITUDE OF Personnel as the situation calls for. Hospital leadership will complete follow-up activities and direct corrective action in the resolution of identified problems. Reports on the same will be made to the quality board as needed.

CONFIDENTIALITY STATEMENT

All records, data, and information collected and then maintained by the risk management office are to be used strictly for peer/professional review as defined by the professional staff bylaws and board approved professional review as defined by the professional staff bylaws and board approved professional staff and system committees involved in quality improvement activities. Data, reports, or records, including minutes, collected for or by individuals to committees assigned peer review functions are confidential, not public records, and are not available for court subpoena in accordance with state and federal laws. No one shall have access to or the right to release documents collected or prepared by the risk management staff without authorization.
Appendix A

University Mississippi Medical Center
Institutional Quality Relationships

[Diagram of institutional quality relationships]