AHIA BOK:
Administrative Functions

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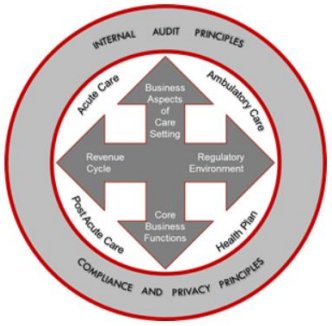
Learning Objectives for Today's Webinar

Overview of the AHIA Body of Knowledge (BOK): Administrative Functions Section

Walkthrough high level concepts, risk and control considerations for each sub-section of the Administrative Functions BOK

REMEMBER: You Can Earn The CHIAP Designation!!



AHIA Body of Knowledge: Administrative Functions This Exam Section Covers 6 Key areas:

- Organizational Governance
- Strategic Planning
- Risk Management
- Enterprise Risk Management
- Patient Safety
- Quality

ORGANIZATIONAL GOVERNANCE

Hospitals have several key governance structures:

- Traditional Business:
  - Board of Directors
  - Executive Leadership
  - Data Governance
- Physician Leadership
- Nursing Leadership

- Academic Leadership if AMC (Academic Medical Center)
- Local / State Government if Public (City, County, Veterans)
- Insurance Commissions for Payers

Board graphic source: www.ft.lk

ORGANIZATIONAL GOVERNANCE

Key Risks:

- ❑ Lack of formalized governance
- ❑ Lack of documented governance direction and policy
- ❑ Lack of Board / CEO engagement / oversight
  - ❑ Uncontrolled rogue CEOs or other executives
- ❑ Unaddressed / poor handling of significant adversities
  - ❑ Patient or human subject harm / deaths, IT breach, significant fraud, etc.
- ❑ Conflicts of Interest (kickbacks, inappropriate romantic relationships, etc.)
- ❑ Executive / Physician Leadership disconnect
  - ❑ Uncontrolled rogue physicians
- ❑ Physician / Nursing Leadership disconnect

ORGANIZATIONAL GOVERNANCE

Key Controls:

- ➢ Corporate Bylaws and Policy
- ➢ Board Structure & Key Committees
  - ➢ (E.g., Audit, Quality, etc.)
- ➢ Strategic Planning
- ➢ Planned Meetings
- ➢ Meeting Minutes
- ➢ Executive Sessions
- ➢ Morbidity and Mortality Conference
- ➢ Conflict of Interest Policy & Implementation
- ➢ Active Executive, Physician and Nursing interaction / collaboration

Bylaws graphic source: www.pinterest.com

ORGANIZATIONAL GOVERNANCE

Internal Audit Governance:

- The Board Audit Committee
- Formal Audit Committee and Internal Audit Charters
- Functional versus Administrative Reporting Relationships
  - IIA Ideal: Functional to Board | Administrative to CEO
- Routine reporting of audit results to executive leadership and the Board
- Ideally, Internal Audit risk assessment & audit planning support or align with organizational strategy

STRATEGIC PLANNING

A key component of governance that establishes corporate direction and related alignment of resources and includes:

- Vision, Mission and Core Values
- SWOT Analysis (Strengths, Weaknesses, Opportunities & Threats)
- Long-term Goals
- Functional and Periodic Objectives
- Action Plans
- Progress Measurement

Strategic planning in healthcare should address not only competition related objectives but also objectives related to the key components of today's presentation: risk, patient safety and quality.

Strategic planning is the responsibility of the CEO and executive leadership.

- However, every area of the organization can benefit from the process.
- The organizational units must align with and support organizational strategy.
- Each executive monitors achievement of strategic objectives elated to both their units / areas of responsibility as well as the impact on overall strategy.

Strategy graphic source: blog.hrps.org

STRATEGIC PLANNING

Key Risks:

- ❑ **Lack of a robust, meaningful strategy development process**
- ❑ **Lack of executive and management strategy ownership**
- ❑ **Strategic direction leads to failure, all or in part (wrong strategy)**
- ❑ **Failure to recognize external factors like regulatory change, social change, market change, etc.**
- ❑ **Inability to build the infrastructure, processes, etc. to properly support strategy achievement (failure to properly execute)**
- ❑ **Failure to recognize / respond effectively to market / industry disruption and market / industry innovations (e.g. COVID impact)**
- ❑ **Lack of a strategy**

STRATEGIC PLANNING

Key Controls:

- ➢ **Formal strategy adoption by the Board, CEO and executives**
- ➢ **Defined strategy development and related updates**
- ➢ **Identification of meaningful strategic objectives (e.g., application of SMART or other purposeful goal structures)**
- ➢ **Monitoring of progress against strategic objectives**

- ➢ **Monitoring of key factors identified as opportunities and threats (e.g., major market, regulatory, or supply chain changes)**

SMART Goals graphic source: www.chargify.com

RISK MANAGEMENT

Risk management typically refers to that function in a healthcare setting that addresses patient safety and worker protection risks, and insurable liabilities. The Risk Management function often reports up through the CFO.

A great source for information related to healthcare risk management is the American Society for Healthcare Risk Management (www.ASHRM.org).

Per ASHRM, risk management focuses on "developing and implementing safe and effective patient care practices, the preservation of financial resources and the maintenance of safe working environments."

Of primary emphasis / overriding priority is patient safety & clinical quality.

It often involves strategies and procurement decisions related to various insurances (D&O, hazard, malpractice, workers compensation, etc.).

RISK MANAGEMENT

Risk Management Risks:

- ❑ Patient harm
- ❑ Ineffective oversight / lack of oversight
- ❑ Ineffective data collection / reporting across the organization
- ❑ Staffing expertise
- ❑ Lack of or ineffective incident reporting
- ❑ Insufficient education and training
- ❑ Poor clinical quality control systems
- ❑ Poor, insufficient or missing medical record documentation

Risk graphic source: app.hedgeye.com

RISK MANAGEMENT

Risk Management <u>Controls</u>:

- **Centralized risk management: data collection, reporting and education**
- **Patient safety, quality and risk management alignment**
- **Applicable policies, procedures, protocols and guidelines**
- **Strong medical record organization / documentation practices**
- **Application of Root Cause Analysis to identified issues**
- **Insurance**

ENTERPRISE RISK MANAGEMENT (ERM)

ERM differs from traditional Risk Management:

- **COSO 2017 ERM Framework**

"**The value of an entity is largely determined by the decisions that management makes**— from overall strategy decisions through to day-to-day decisions. **Those decisions can determine whether value is created, preserved, eroded or realized**."

ERM is "the culture, capabilities, and practices, **integrated with strategy-setting and performance**, that organizations rely on to manage risk in creating, preserving, and realizing value."

ENTERPRISE RISK MANAGEMENT (ERM)

- **Organization-wide view of risk**
- **Defines risk as** "The possibility that events will occur and affect the achievement of strategy and business objectives."
  - **Thus, risk can be negative or positive: risk includes challenge as well as opportunity!**
- **ERM Goal: Influence executive decision-making and ideally all key decision-making**
- **Important to understand risk…**

ENTERPRISE RISK MANAGEMENT (ERM): RISK?

Where is the real risk?

Drowning?

Shark attack?

Mode of travel / rope strength?

Ability of the traveler?

Value at the other side?

Decision to walk across?

Tightrope graphic source: wmtoday.com

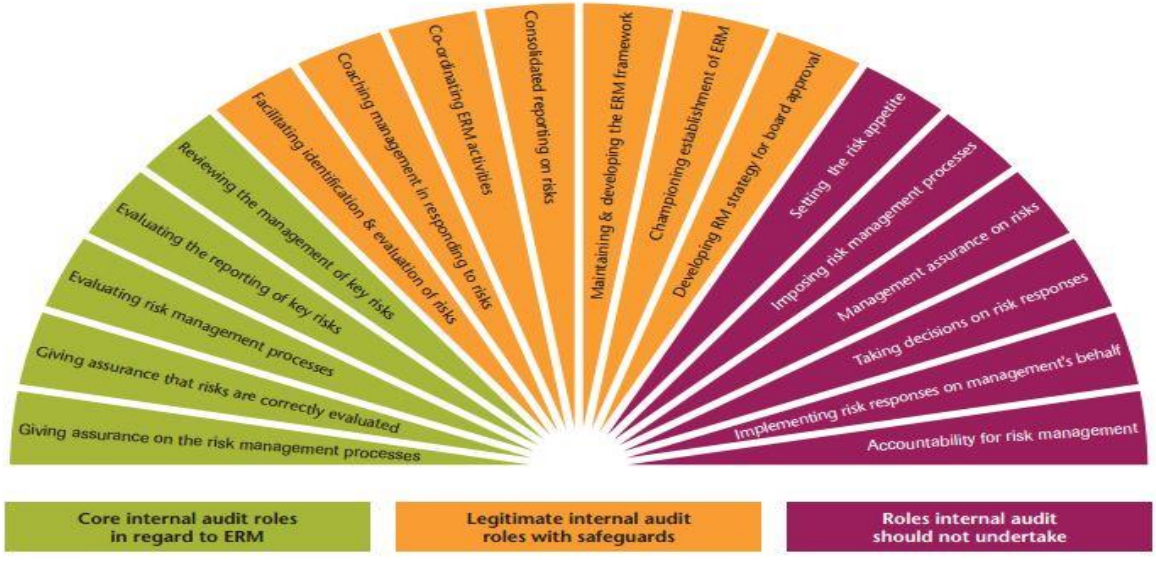
ENTERPRISE RISK MANAGEMENT (ERM)

Other Key Components of ERM:

- ❑ Risk Assessment
  - ❑ Probability or Likelihood
  - ❑ Severity or Impact
- ❑ Inherent versus Residual Risk
- ❑ Risk Appetite & Risk Tolerance
- ❑ Risk Response / Risk Action Plan:
  - ❑ Optimize Opportunities
  - ❑ Eliminate, Mitigate, Transfer, or Accept Challenges

Risk Matrix graphic source: www.smartsheet.com

The role of internal audit in Enterprise-wide Risk Management



ERM graphic source: www.iia.org.uk

Patient Safety & Quality

LEAPFROG HOSPITAL SAFETY GRADE

Per LEAPFROG (https://www.hospitalsafetygrade.org/what-is-patient-safety_m):

What is the difference between patient safety and quality?

Patient safety is an important element of an effective, efficient and quality - oriented health care system:

- **Safety** has to do with lack of harm.
  Quality has to do with efficient, effective, purposeful care: right job at the right time.
- **Safety** focuses on avoiding bad events.
  Quality focuses on doing things well.
- **Safety** makes it less likely that mistakes happen.
  Quality raises the ceiling so the overall care experience is a better one.

Leapfrog graphic source: www.leapfroggroup.org

PATIENT SAFETY

Hippocratic Oath: "First do no harm"

According to LEAPFROG:

- **"When we talk about patient safety, we're really talking about how hospitals and other health care organizations protect their patients from errors, injuries, accidents, and infections."**
- **"As many as 440,000 people die every year… from preventable errors in hospitals."**
- **If the goal of healthcare is to do no harm, then patient safety and quality healthcare practices require attention!**

Do No Harm graphic source: floxiehope.com

PATIENT SAFETY

Patient Safety Risks:

- ❑ **Clinician Egos**
- ❑ **Clinician Fatigue (overworked doctors, nurses, etc.) A big risk currently for the COVID front line!)**
- ❑ **Diagnostic Errors / Alarm Fatigue**
- ❑ **Discharge Errors, Lack of Follow-up, etc.**
- ❑ **Hospital Safety Issues / Acquired Conditions (e.g., Bed Sores, falls, etc.)**
- ❑ **Medication Errors, Lapses, Theft, etc.**
- ❑ **Medical Device / Reprocessing / Sterilization / Cybersecurity Issues**
- ❑ **Electronic Health Record Errors (systemic design errors, data entry errors, etc.)**
- ❑ **Unidentified / Undocumented / Ignored Allergy Alerts**
- ❑ **Super Bugs (COVID)**
- ❑ **Untrained or improperly trained clinician and staff**

"The patient in the next bed is highly infectious. Thank God for these curtains."

Check out the ECRI Institute at www.ecri.org for more on patient safety issues and risks.

Curtain graphic source: www.pinterest.com

PATIENT SAFETY

Patient Safety Controls:

- ➢ **Policy, procedure, protocol & related accountability, measure and follow-up**
- ➢ **Root-cause analysis processes**
- ➢ **Required education & training**
- ➢ **Safety issue reporting processes**
- ➢ **Non-retaliation policy**
- ➢ **Patient Surveys & Hospital Safety Climate Surveys**
- ➢ **Patient Monitoring Processes / Adverse Event Measures**
- ➢ **Pharmacy Verification of Medication Orders**
- ➢ **Patient Discharge:** medication reconciliation, patient-centered hospital discharge education, and post discharge continuity checks

Survey graphic source: www.cfhi-fcass.ca

QUALITY

Per health.gov, "Keeping patients safe in health care settings is fundamental to achieving high-quality health care for all Americans."

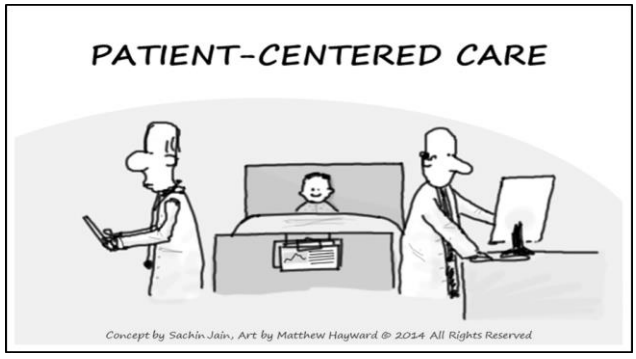
Clinician Quality

Device Quality

Medication Quality

Process Quality

Quality Indicators



Patient graphic source: healthcarethejournal.org

QUALITY

AHRQ Agency for Healthcare Research and Quality

Per the DHHS Agency for Healthcare Research and Quality, there are Six Domains of Healthcare Quality:

- **Safe**: Avoiding harm to patients from the care that is intended to help them.
- **Effective**: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
- **Patient-centered**: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- **Timely**: Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- **Efficient**: Avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable**: Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

For more details see: https://www.ahrq.gov/talkingquality/measures/six-domains.html

QUALITY

Quality Risks - The overall quality risk is harm to patients, which can result from:

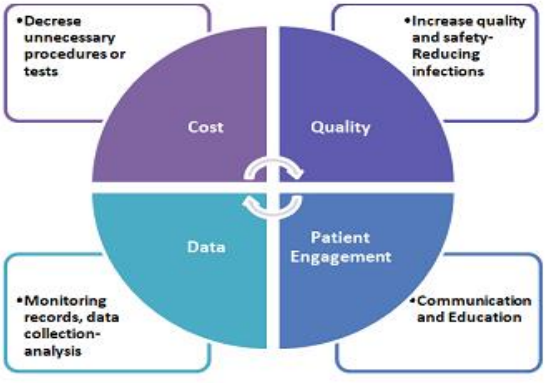
- ❑ Patient Safety Risks as noted previously
- ❑ No formal quality management / oversight
- ❑ Bad morale
- ❑ Failure to hold individuals accountable
- ❑ Poor labeling of materials, meds and patients
- ❑ Inter-discipline communication breakdown
- ❑ Lack of or insufficient training and education

Quality graphic source: quotesgram.com

QUALITY

Quality Controls:

- ➢ Board Quality Committee
- ➢ Utilization Review
- ➢ Root-Cause Analysis Processes
- ➢ Required Education & Training
- ➢ Checklists, forms, etc.



Utilization Management and Review

- ➢ Quality Indicators Tracking & Follow-up
- ➢ For more Healthcare Quality insights, check out the Agency for Healthcare Research and Quality at www.ahrq.gov

Utilization graphic source: study.com

WRAP-UP

- **The goal of the CHIAP is to help healthcare internal audit professionals organize, document and convey to others their related healthcare internal audit expertise.**
- **While expertise in each area of healthcare should be pursued, the CHIAP is focused on having a strong understanding of all key areas of healthcare.**
- **Your focus: understand the purpose of each of the areas discussed and the related healthcare specific nuances.**
- **Prep your mind and body for the exam.**
- **Prepare, don't despair!**
  You can earn the CHIAP designation!

QUESTIONS

If your question was not addressed during the webinar, please submit your questions to AHIA as follows:

- **AHIA ListServ / AHIA Connected Community**
- **EMAIL: info@ahia.org or certification@ahia.org**
- **PHONE: 888-ASK-AHIA**