Origination:	*09/2018*
Effective:	*11/2019*
Last Approved:	*11/2019*
Last Revised:	*09/2018*
Next Review:	*11/2020*
Owner:	*Bernard Hooper: Compliance Officer*
Policy Area:	*Compliance*
References:	

Risk Management Policy

POLICY

It is the policy of Detroit Wayne Integrated Health Network (DWIHN) to have in place a Risk Management Policy (Policy) which is reviewed and approved annually.

PURPOSE

The Policy is designed to support the mission and vision of DWIHN as it pertains to four categories of risk: safety, reputation, finance, legal/regulatory.

APPLICATION

This policy applies to DWIHN Board, Staff, Volunteers, Interns, Contractual individuals, Visitors, Project Consultants and DWIHN Provider Network as applicable.

KEYWORDS

1. Adverse event or incident
2. Claims management
3. Failure mode and effects analysis
4. Loss control/loss reduction
5. Loss prevention
6. Near miss
7. Behavioral Health Patient Safety Goals
8. Potentially compensable event (PCE)
9. Risk analysis
10. Risk assessment
11. Risk avoidance
12. Risk control
13. Risk financing
14. Risk identification

15. Risk management
16. Risk Management Information System (RMIS)
17. Risk retention
18. Risk transfer
19. Root-cause analysis
20. Sentinel event
21. Trigger methodology
22. Unsafe and/or hazardous condition

STANDARDS

1. **GUIDING PRINCIPLES**
    a. The Policy is an overarching, conceptual framework that guides the development of a formal, written Risk Management Plan (Plan) and related policies and procedures.
    b. It is DWIHN's philosophy that risk management is everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential. The Plan will be implemented through the coordination of multiple organizational functions and the activities of multiple departments.
    c. DWIHN supports the establishment of a just culture where potential risks are readily and pro-actively identified, rather than blame and punishment. Individuals must still comply with risk management practices.
    d. The Policy drives the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Policy provide the foundation for developing the Plan, key policies and procedures for day-to-day risk management activities, including, but not limited to:
        1. Complaint resolution
        2. Claims management
        3. Confidential information
        4. Event investigation, root-cause analysis, and follow-up
        5. Failure mode and effects analysis
        6. Fiscal Matters
        7. Information Technology
        8. Physical Plant
        9. Provider and staff education, competency validation, and credentialing requirements
        10. Quality Performance Monitoring
        11. Reporting and management of adverse events and near misses
        12. Trend analysis of events
    e. The risk management process adopted by DWIHN is based on the Australian/New Zealand Risk Management Standard (Australian/New Zealand 4360:2004). This standard is an internationally

recognized risk management standard which provides a framework for the risk management process. The five steps are:

1. Establish the context of risks
2. Identify the risks
3. Analyze/Assess risks
4. Treat risks
5. Monitor and review risks

f. This five-step process is outlined in Figure 1.1 below.

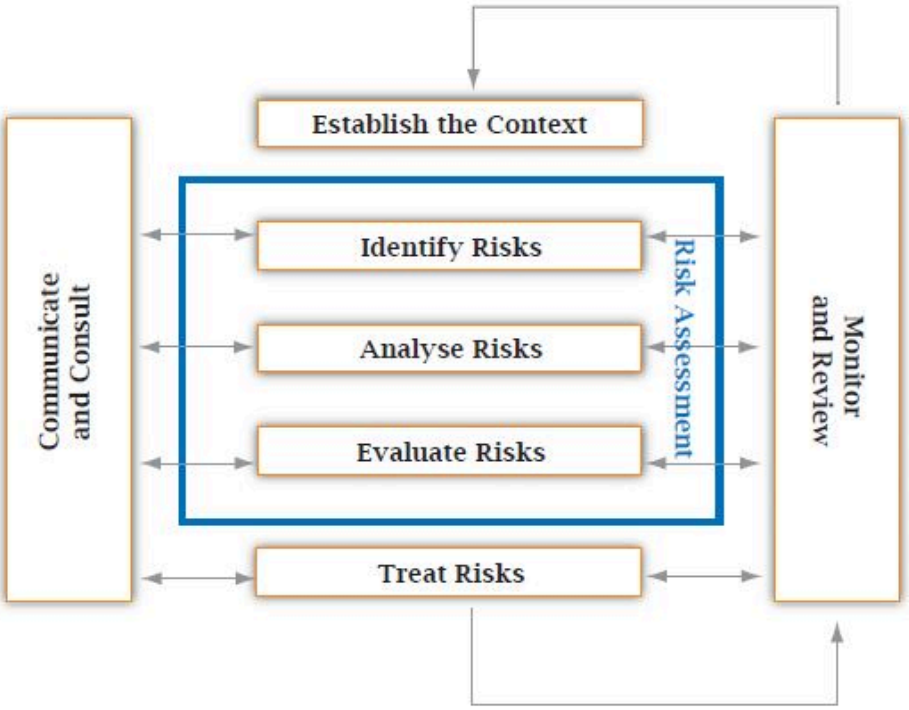

Figure 1.1: The Risk Management Process, (AS/NZ 4360:2004)

2. **EXECUTIVE LEADERSHIP**
   a. The success of the DWIHN Policy and Plan requires top-level commitment and support. The executive leadership and management teams are responsible for implementing performance improvement and risk management strategies.
3. The Policy requires the development of a Plan. The Plan will outline the DWIHN Risk Management goals and objectives.
4. **SCOPE AND FUNCTIONS OF THE PLAN**
   a. **Functional Interfaces**
      1. Business Continuity
      2. Claims Management

3. Corporate/Regulatory Compliance
4. Credentialing and Impaneling
5. Disaster Preparation and Management
6. Employee wellness
7. Event/incident/accident reporting and investigation
8. Evidence-based/Best Practices
9. Fiscal Matters
10. Fraud, Waste, and Abuse
11. Human Resources
12. Infection control
13. Information technology
14. Legal and contractual
15. Marketing/advertising/public relations
16. Member Experience
17. Member/population health
18. Patient and family education/Prevention services
19. Peers / Certified Peer Support Specialists / Peer Recovery Coaches
20. Performance Monitoring
21. Pharmaceuticals/Medication management
22. Physical Plant
23. Product/materials management
24. Quality improvement
25. Safety and security
26. Social service programs
27. Workforce competency
28. Volunteers/Interns

b. **Risk Management Functions**

1. Risk identification is the first stage of the entire risk management process. Identifying, understanding and prioritizing risks, enables informed decision making about policies and service delivery systems.
2. Risk management functional responsibilities include, but are not limited to:
    i. Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event-reporting policies and procedures.
    ii. Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events (e.g., preventive screening,

medication use processes). Proactive risk assessment can include the use of failure mode and effects analysis, system analysis, and other tools.

iii. Overseeing the organizational Risk Management Information System (RMIS) for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program.
This system may utilize and include, but is not limited to, the following:

a. Committee reports and minutes
b. Criteria-based outcome studies
c. Event, incident, or near miss reports
d. Medical record reviews
e. Monitoring systems based on objective criteria
f. Administrative and civil actions
g. Recipient Rights, Appeals, and Grievance complaints
h. Physician and other health professionals' input
i. Results of root-cause analysis of high-risk processes
j. Root-cause analyses of sentinel events

iv. Analyzing data collected on adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and workforce; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events. Root-cause analysis and systems analysis can be used to identify causes and contributing factors in the occurrence of such events.

v. Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.

vi. Facilitating and ensuring the implementation of safety initiatives such as improved tracking systems for preventive screenings, medication safety systems, and falls prevention programs.

vii. Monitor to ensure plans of correction are successfully implemented.

viii. Facilitating and ensuring provider and workforce participation in educational programs on safety and risk management.

ix. Pro-actively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, providers, visitors, workforce, and volunteers.

x. Reducing the probability of events that may result in losses to the physical plant and equipment (e.g., equipment maintenance, fire prevention).

xi. Preventing and minimizing the risk of liability to the organization, and protecting the financial, human, and other tangible and intangible assets of the organization.

xii. Decreasing the likelihood of claims and lawsuits by developing a member and family/ systems communication and education plan. This includes communicating and disclosing errors and events that occur in the course of member care with a plan to manage any

adverse effects or complications.

xiii. Decreasing the likelihood of lawsuits through effective claims management, and investigating and assisting in claim resolution to minimize financial exposure.

xiv. Reporting claims to MDHHS and ICOs in accordance with the requirements of the contract.

xv. Supporting quality assessment and improvement programs throughout the organization.

xvi. Implementing programs that fulfill regulatory, legal, and accreditation requirements.

xvii. Establishing an ongoing risk management committee composed of representatives from key clinical and administrative departments and services.

xviii. Monitoring the effectiveness and performance of risk management actions. Performance monitoring data may include but is not limited to:

a. Claims and claim trends

b. Culture of safety surveys

c. Event trending data

d. Ongoing risk assessment information

e. Member/enrollee and/or family's perceptions of how well the organization meets their needs and expectations

f. Quality performance data

g. Best Practices data

xix. Developing and monitoring for continuity of member care at transitions.

xx. Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and workforce members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments.

5. **ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION**

a. The CEO is responsible for ensuring the Plan is administered through the Quality, Finance and Legal departments ("Designee(s)"). The Designees interface with administration, staff, providers, and other professionals and have the authority to cross operational lines in order to meet the goals of the Plan. The Designees or alternate as designated by the CEO, co-chair the activities of the Risk Management Committee (Committee). The Committee meets regularly and includes representatives from key departments. The composition of the Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines and to optimize the use of key findings from risk management activities in making recommendations concerning overall safety, reputation, finances, and legal/regulatory matters.

b. The Designees are responsible for overseeing day-to-day monitoring of patient safety and risk management activities and for investigating and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy and/or contract. The Designees serve as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The Designees oversee the reporting of events to external organizations, per regulations and contracts, and

communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

6. **CONFIDENTIALITY**
    a. Any and all documents and records that are part of the risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections can include, but are not limited to, attorney - client privilege, attorney work product, and peer review protections.
    b. Medical providers may be able to apply the federal privilege and confidentiality protections granted by the Patient Safety and Quality Improvement Act of 2005 to its patient safety events, data, and reports — referred to in the law as patient safety work product — by creating a patient safety evaluation system, through which the organization collects patient safety work product with the intent of providing it to one or more patient safety organizations for analysis and feedback. Care must be taken to ensure that any patient safety evaluation system is developed within the context of the provider's state laws for legal privilege and peer review as well as the new federal law.

QUALITY ASSURANCE/IMPROVEMENT

1. The Committee reviews risk management activities regularly. The Designees and Committee members report activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries and trends) regularly to the Quality Improvement Steering Committee (QISC), the governing board, and State and Federal Agencies as applicable. The reports are intended to identify the efforts made to reduce risks and the success of these activities and communicates outstanding issues that need input and/or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and workforce education, and risk management activities. Performance improvement goals are developed to remain consistent with the stated risk management goals and objectives.
2. DWIHN Providers must develop and implement a risk management plan.

COMPLIANCE WITH ALL APPLICABLE LAWS

DWIHN workforce, contractors, and subcontractors are bound by all applicable local, state and federal laws, rules, regulations and policies, all federal waiver requirements, state and county contractual requirements, policies, and administrative directives, as amended.

LEGAL AUTHORITY

1. MDHHS Medicaid Managed Specialty Supports and Services Concurrent 1915(b)/(c) Waiver Program(s), the Healthy Michigan Program and Substance Use Disorder Community Grant Programs Agreement
2. MDHHS Community Mental Health Service Program Agreement
3. Integrated Care Organization Agreements (MI HealthLink)
4. Medicaid Health Plan Agreement
5. Michigan Department of Corrections SUD Agreement
6. Patient Safety and Quality Improvement Act of 2005

RELATED POLICIES

1. DWIHN QAPIP Plan
2. All policies relevant to items in Standard (4) "Scope and Functions of the Plan"

RELATED DEPARTMENTS

1. All Departments

CLINICAL POLICY

No

INTERNAL/EXTERNAL POLICY

External

Attachments:

Approval Signatures

Approver	Date
Dana Lasenby: Chief Clinical Officer	11/2019