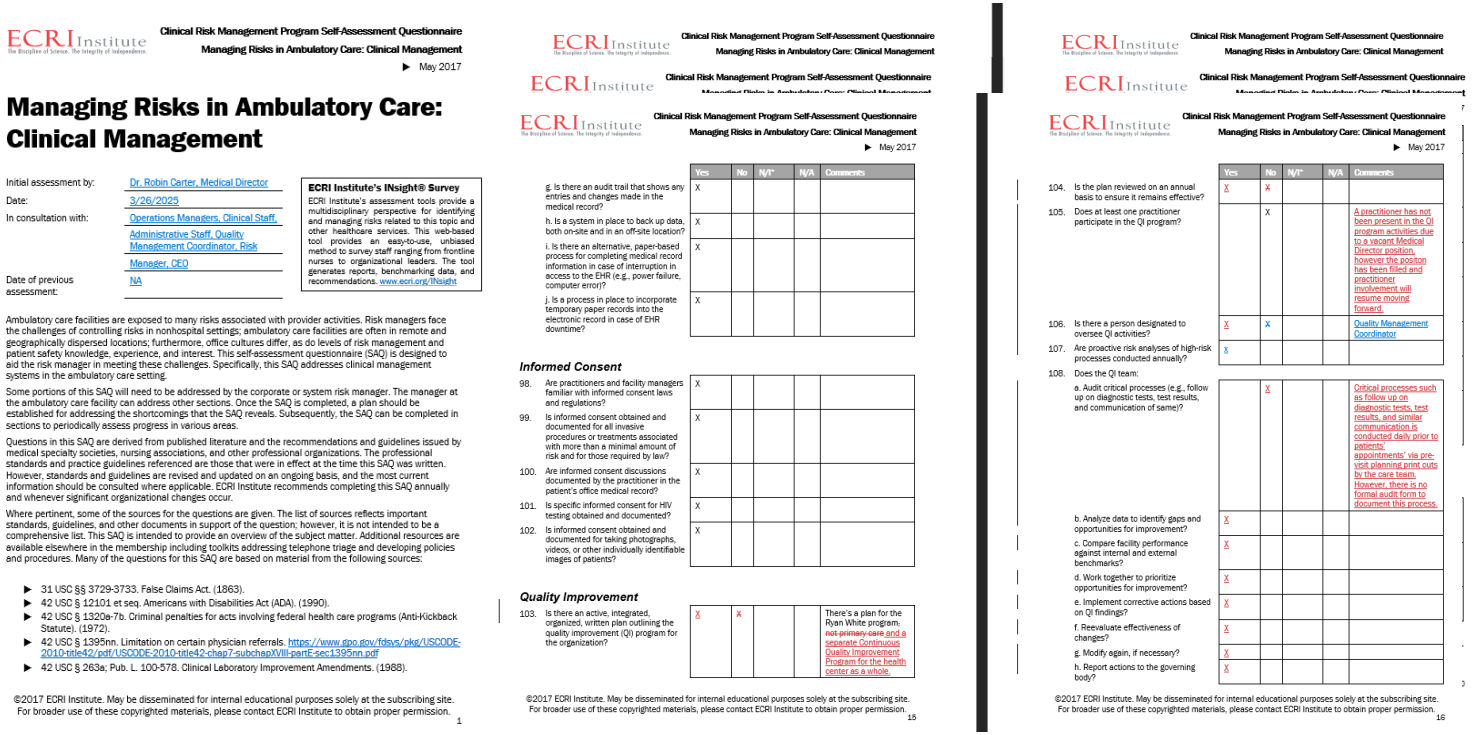
2025 Q1 Quarterly Risk Management Assessment

2025 Q1 Quarterly Risk Assessment

- FTCA requires one risk assessment to be completed each quarter.
- The one required risk assessment for Q1 is complete, making the requirement at 100% compliance through Q1.
- The tool used for the Q1 Risk Assessment is called the ECRI Managing Risks in Ambulatory Care: Clinical Management Tool
  - 140 Criteria Audited
  - 126/140 compliant (90%)
  - Action Plan to correct other 14 criteria done and under way.



ECRI Institute — Clinical Risk Management Program Self-Assessment Questionnaire
Managing Risks in Ambulatory Care: Clinical Management
May 2017

Managing Risks in Ambulatory Care: Clinical Management

Initial assessment by: Dr. Robin Carter, Medical Director
Date: 3/26/2025
In consultation with: Operations Managers, Clinical Staff, Administrative Staff, Quality Management Coordinator, Risk Manager, CEO
Date of previous assessment: NA

ECRI Institute's INsight® Survey
ECRI Institute's assessment tools provide a multidisciplinary perspective for identifying and managing risks related to this topic and other healthcare services. This web-based tool provides an easy-to-use, unbiased method to survey staff ranging from frontline nurses to organizational leaders. The tool generates reports, benchmarking data, and recommendations. www.ecri.org/INsight

Ambulatory care facilities are exposed to many risks associated with provider activities. Risk managers face the challenges of controlling risks in nonhospital settings; ambulatory care facilities are often in remote and geographically dispersed locations; furthermore, office cultures differ, as do levels of risk management and patient safety knowledge, experience, and interest. This self-assessment questionnaire (SAQ) is designed to aid the risk manager in meeting these challenges. Specifically, this SAQ addresses clinical management systems in the ambulatory care setting.

Some portions of this SAQ will need to be addressed by the corporate or system risk manager. The manager at the ambulatory care facility can address other sections. Once the SAQ is completed, a plan should be established for addressing the shortcomings that the SAQ reveals. Subsequently, the SAQ can be completed in sections to periodically assess progress in various areas.

Questions in this SAQ are derived from published literature and the recommendations and guidelines issued by medical specialty societies, nursing associations, and other professional organizations. The professional standards and practice guidelines referenced are those that were in effect at the time this SAQ was written. However, standards and guidelines are revised and updated on an ongoing basis, and the most current information should be consulted where applicable. ECRI Institute recommends completing this SAQ annually and whenever significant organizational changes occur.

Where pertinent, some of the sources for the questions are given. The list of sources reflects important standards, guidelines, and other documents in support of the question; however, it is not intended to be a comprehensive list. This SAQ is intended to provide an overview of the subject matter. Additional resources are available elsewhere in the membership including toolkits addressing telephone triage and developing policies and procedures. Many of the questions for this SAQ are based on material from the following sources:

- 31 USC §§ 3729-3733. False Claims Act. (1863).
- 42 USC § 12101 et seq. Americans with Disabilities Act (ADA). (1990).
- 42 USC § 1320a-7b. Criminal penalties for acts involving federal health care programs (Anti-Kickback Statute). (1972).
- 42 USC § 1395nn. Limitation on certain physician referrals. https://www.gpo.gov/fdsys/pkg/USCODE-2010-title42/pdf/USCODE-2010-title42-chap7-subchapXVIII-partE-sec1395nn.pdf
- 42 USC § 263a; Pub. L. 100-578. Clinical Laboratory Improvement Amendments. (1988).

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1

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		Yes	No	N/T*	N/A	Comments
g.	Is there an audit trail that shows any entries and changes made in the medical record?	X				
h.	Is a system in place to back up data, both on-site and in an off-site location?	X				
i.	Is there an alternative, paper-based process for completing medical record information in case of interruption in access to the EHR (e.g., power failure, computer error)?	X				
j.	Is a process in place to incorporate temporary paper records into the electronic record in case of EHR downtime?	X				
Informed Consent						
98.	Are practitioners and facility managers familiar with informed consent laws and regulations?	X				
99.	Is informed consent obtained and documented for all invasive procedures or treatments associated with more than a minimal amount of risk and for those required by law?	X				
100.	Are informed consent discussions documented by the practitioner in the patient's office medical record?	X				
101.	Is specific informed consent for HIV testing obtained and documented?	X				
102.	Is informed consent obtained and documented for taking photographs, videos, or other individually identifiable images of patients?	X				
Quality Improvement						
103.	Is there an active, integrated, organized, written plan outlining the quality improvement (QI) program for the organization?	X	X			There's a plan for the Ryan White program, ~~not primary care~~ and a separate Continuous Quality Improvement Program for the health center as a whole.

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15

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		Yes	No	N/T*	N/A	Comments
104.	Is the plan reviewed on an annual basis to ensure it remains effective?	X	X			
105.	Does at least one practitioner participate in the QI program?		X			A practitioner has not been present in the QI program activities due to a vacant Medical Director position, however the position has been filled and practitioner involvement will resume moving forward.
106.	Is there a person designated to oversee QI activities?	X	X			Quality Management Coordinator
107.	Are proactive risk analyses of high-risk processes conducted annually?	X				
108.	Does the QI team:					
	a. Audit critical processes (e.g., follow up on diagnostic tests, test results, and communication of same)?		X			Critical processes such as follow up on diagnostic tests, test results, and similar communication is conducted daily prior to patients' appointments' via pre-visit planning print outs by the care team. However, there is no formal audit form to document this process.
	b. Analyze data to identify gaps and opportunities for improvement?	X				
	c. Compare facility performance against internal and external benchmarks?	X				
	d. Work together to prioritize opportunities for improvement?	X				
	e. Implement corrective actions based on QI findings?	X				
	f. Reevaluate effectiveness of changes?	X				
	g. Modify again, if necessary?	X				
	h. Report actions to the governing body?	X				

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16

Risk Assessments			
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**
RM	# Completed annual high-risk assessments	≥ 2/yr	
RM	# Completed quarterly assessments	Min 1/qtr	1
RM	% Open action plans	≤75%	100%

2025 Q1 Quarterly Risk Assessment Findings

2025 Q1 Risk Assessment Findings and Action Plan for the ECRI Managing Risks in Ambulatory Care: Clinical Management Tool

Findings/areas of highest risk identified:

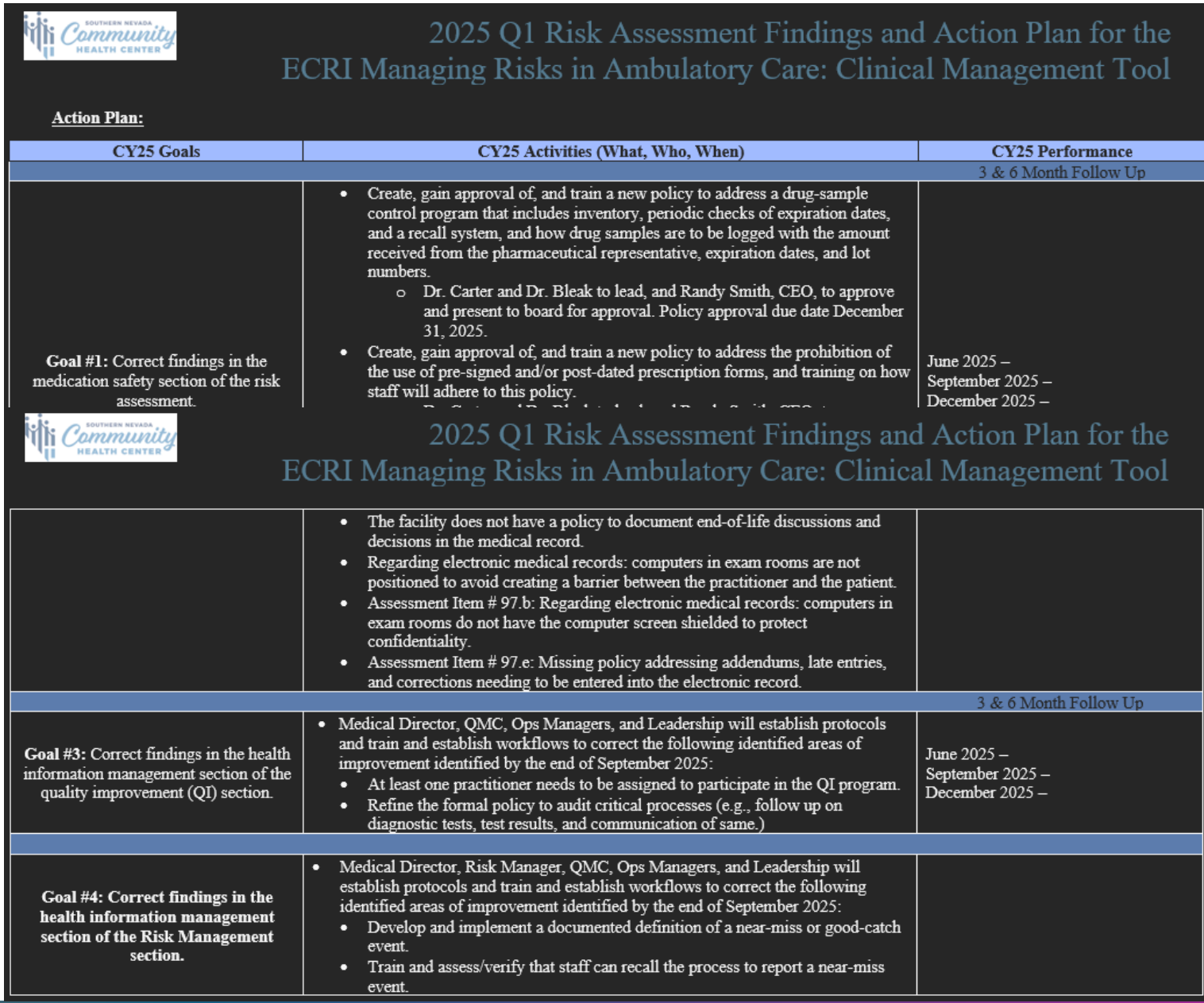
A. Medication Safety
   1. **Noncompliant –**
      i. Assessment Item # 47& 49: As of 3/27/2025, there is not a policy for:
         1. A drug-sample control program that includes inventory, periodic checks of expiration dates, and a recall system, and
         2. Samples logged with the amount received from the pharmaceutical representative, expiration dates, and lot numbers.
      ii. Assessment Item # 55& 56: As of 3/27/2025, there is no policy for:
         1. The prohibition of the use of pre-signed and/or post-dated prescription forms, and
         2. Training on how staff will adhere to this policy.
      iii. Assessment Item # 58: As of 3/27/2025, there is not a policy that requires:
         1. A "read back" of the complete order by the person taking verbal or telephone medication orders to confirm that they are correct.

B. Health Information Management
   1. Noncompliant –
      i. Assessment Item # 85.i: Documentation of treatment or procedures performed in the facility does not include patient condition at discharge.
      ii. Assessment Item # 86: The facility does not have a standardized set of abbreviations, acronyms, and symbols for use throughout the facility.
      iii. Assessment Item # 87: The facility does not have a "do not use" list of abbreviations, acronyms, and symbols.
      iv. Assessment Item # 88: The facility does not have a policy to document end-of-life discussions and decisions in the medical record.
      v. Assessment Item # 97.a: Regarding electronic medical records: computers in exam rooms are not positioned to avoid creating a barrier between the practitioner and the patient.
      vi. Assessment Item # 97.b: Regarding electronic medical records: computers in exam rooms do not have the computer screen shielded to protect confidentiality.
      vii. Assessment Item # 97.e: Missing policy addressing addendums, late entries, and corrections needing to be entered into the electronic record.

C. Quality Improvement
   1. **Noncompliant**
      i. **Assessment # 105: At least one practitioner is not participating in the QI program.**
      ii. Assessment # 108.a.: Although here is not a defined formal policy to audit critical processes (e.g., follow up on diagnostic tests, test results, and communication of same.)

D. Risk Management
   1. **Noncompliant**
      i. Assessment Item # 130: There is not a documented definition of a near-miss or good-catch event.
      ii. Assessment Item # 131: Staff are not able to recall the process to report a near-miss event.

2025 Q1 Quarterly Risk Assessment Action Plan



2025 Q1 Risk Assessment Findings and Action Plan for the ECRI Managing Risks in Ambulatory Care: Clinical Management Tool

Action Plan:

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Goal #1: Correct findings in the medication safety section of the risk assessment.	• Create, gain approval of, and train a new policy to address a drug-sample control program that includes inventory, periodic checks of expiration dates, and a recall system, and how drug samples are to be logged with the amount received from the pharmaceutical representative, expiration dates, and lot numbers. o Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025. • Create, gain approval of, and train a new policy to address the prohibition of the use of pre-signed and/or post-dated prescription forms, and training on how staff will adhere to this policy.	June 2025 – September 2025 – December 2025 –

2025 Q1 Risk Assessment Findings and Action Plan for the ECRI Managing Risks in Ambulatory Care: Clinical Management Tool

	• The facility does not have a policy to document end-of-life discussions and decisions in the medical record. • Regarding electronic medical records: computers in exam rooms are not positioned to avoid creating a barrier between the practitioner and the patient. • Assessment Item # 97.b: Regarding electronic medical records: computers in exam rooms do not have the computer screen shielded to protect confidentiality. • Assessment Item # 97.e: Missing policy addressing addendums, late entries, and corrections needing to be entered into the electronic record.	
		3 & 6 Month Follow Up
Goal #3: Correct findings in the health information management section of the quality improvement (QI) section.	• Medical Director, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: • At least one practitioner needs to be assigned to participate in the QI program. • Refine the formal policy to audit critical processes (e.g., follow up on diagnostic tests, test results, and communication of same.)	June 2025 – September 2025 – December 2025 –
Goal #4: Correct findings in the health information management section of the Risk Management section.	• Medical Director, Risk Manager, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: • Develop and implement a documented definition of a near-miss or good-catch event. • Train and assess/verify that staff can recall the process to report a near-miss event.	


Questions?