LakeCounty
Health Department and
Community Health Center

Title: 2024 Annual Risk Management Report to the Lake County Health Department and Community Health Center Governing Council

Report Period: January 1, 2024 to December 31, 2024

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Introduction

The purpose of this report is to provide an account of Lake County Health Department and Community Health Center's (LCHD/CHC) annual performance related to the clinical risk management plan and to evaluate the effectiveness of risk management activities aimed at mitigating risks and responding to identified areas of high risk. Topics presented include quarterly risk assessments, adverse event reporting, risk management training, risk and patient safety activities, and claims management. Each topic area includes a combination of the following:

- An introduction to explain the relevance of the topic.
- A data summary to highlight performance relative to established goals
- A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis to identify additional factors related to performance.
- Follow-up actions to note activities aimed at maintaining or improving performance throughout the year.
- A conclusion to summarize findings at year-end
- Proposed future activities to respond to identified areas of high organizational risk.

Quarterly Risk Assessments

Introduction

The Health Center Program Compliance Manual requires quarterly risk assessments focused on patient safety. A risk assessment is a structured process used to identify potential hazards within the organization's operations, departments, and services. Collecting data on practices, policies, and safety cultures in various areas generates information that can be used to proactively target patient safety activities and prioritize risk prevention and reduction strategies.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
# Quarterly risk assessments	The health center conducts one focused risk assessment quarterly. Risk assessments are focused on patient safety and agreed upon by the Director of Healthcare Operations in conjunction with the Risk Manager, and Clinical Risk and Patient Safety (CRPS) Committee. Topics are chosen based on identified opportunities within the health system. Opportunities are identified through clinical audits, review of the incident reporting system (Healthcare SafetyZone portal (HCSZ)), and discussion with leadership.

% Open action items related to quarterly risk assessments	Quarterly risk assessments have an Intervention Strategies and Action Planning section. Action items are detailed within the risk assessment and a get well date is identified for applicable action items. Action plans contain meaningful risk reduction strategies to improve overall patient safety and are meant to be implemented in a timely manner. All action items are monitored by the CRPS Committee for further discussion and intervention as needed. The CRPS Committee has not set a threshold for open action items past their initial get well date as quarterly risk assessments were implemented in 2024. The Committee will continue to monitor open action items and work towards identifying a threshold in 2025.

Data Summary

See the dashboard below for a status of the health center's performance related to completed risk management activities including quarterly risk assessments and action items identified during the action planning process.

Person Responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Annual Total
Risk Manager	# Completed quarterly risk assessments	4/yr			Contract Lab	ED Referrals	2
Risk Manager	% Open action items	Not Yet Identified			1		1

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
The Risk Manager developed a new risk assessment tool in 2024 based on feedback given during the 2024 FTCA Deeming process. The new tool meets HRSA requirements and was implemented in Q3 of 2024.	The health center learned during the 2024 FTCA Deeming year that activities submitted as risk assessments did not meet HRSA requirements for documentation of completed risk assessment.	The health center had a transition in its Risk Manager position in 2024. With this transition came an opportunity to restructure the CRPS program aligning with HRSA requirements.	The local and national economic climate and potential loss of funding and staff could affect clinical risk and patient safety.

Follow-up Actions

Q1 [2024]: In lieu of a focused risk assessment; areas of high risk for continuous monitoring were identified and discussed during the Clinical Risk and Patient Safety (CRPS) Committee on 3.16.24. These focus areas included immunizations, contract lab services, ED referrals, BBP exposures/needlesticks, and sterilization. The Committee also noted obstetrics training, medication administration, and medical emergencies as areas of clinical risk.

Q2 [2024]: The Risk Management training plan was reviewed at CRPS Committee on 4.16.24. The Committee agreed that the Postpartum Hemorrhage training selected for staff was appropriate and met HRSA requirements for training.

Q3 [2024]: A focused risk assessment was completed on LCHD/CHC's contract lab vendor. A patient safety risk related to specimen collection, specimen handling and specimen labeling was identified through reviewing HCSZ incident reports, onsite observations, annual staff competency, policy review, and monthly onsite lab audits. Interventions were put in place to address phlebotomist errors, gaps in education, communication, and language barriers. These interventions include a new workflow for reviewing and responding to incidents, an updated specimen handoff log, a new Teams channel for communication among lab staff and care teams, and a dual language reference sheet for verifying patient identification. Online training for phlebotomists is in development and is currently the only open action item identified.

Q4 [2024]: A focused risk assessment on ED referrals was completed. By reviewing incident reports for CY2024, our ED referral workflow, audit tool, policies, and documentation in our electronic health record; it was identified that our current closed loop system was not consistently adhered to. This posed a risk to patient safety including the potential for poor patient outcomes, dissatisfied patients, ineffective communication, and potential medical malpractice lawsuits. The ED referral workflow was updated to clearly define staff responsibilities and a monthly audit and report to leadership were implemented to ensure timely follow-up and documentation. New and existing closed loop strategies to mitigate risks and consistently monitor trends were reinforced with staff during trainings held on 10.21.24 and 12.30.24.

Conclusion

The health center learned during the 2024 deeming application process that previous documented activities did not meet the intent of HRSA's quarterly risk assessment requirement. The health center's 2024 deeming application was initially found to be non-compliant in part due to the quarterly risk assessment criteria not being met. In response, the Risk Manager developed a risk assessment tool based on guidance provided by the application reviewer. The HRSA application reviewer confirmed via email on 10.16.24 that the risk assessment performed in Q3 [2024] on contract lab services provided evidence of compliance and could also be submitted during the 2025 deeming application process.

Proposed Future Activities

Risk assessments will continue to be conducted on a quarterly basis. All risk assessments will be reviewed and monitored by the CRPS committee. The Committee will continue to monitor action items and work towards identifying a threshold for open items past their get well date in 2025.

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Adverse Event Reporting

Introduction

Event reporting is an essential component of the risk management program and is considered part of the performance and quality improvement process. Each provider, employee, or volunteer is responsible for reporting all adverse events, including sentinel events, incidents, and near misses at the time they are discovered to his or her immediate supervisor and/or the Risk Manager. The Risk Manager, in conjunction with applicable leadership and staff, is responsible for conducting follow-up investigations. The investigation process is a form of self-critical analysis to determine the cause of the incident, analyze the current process, and make improvements.

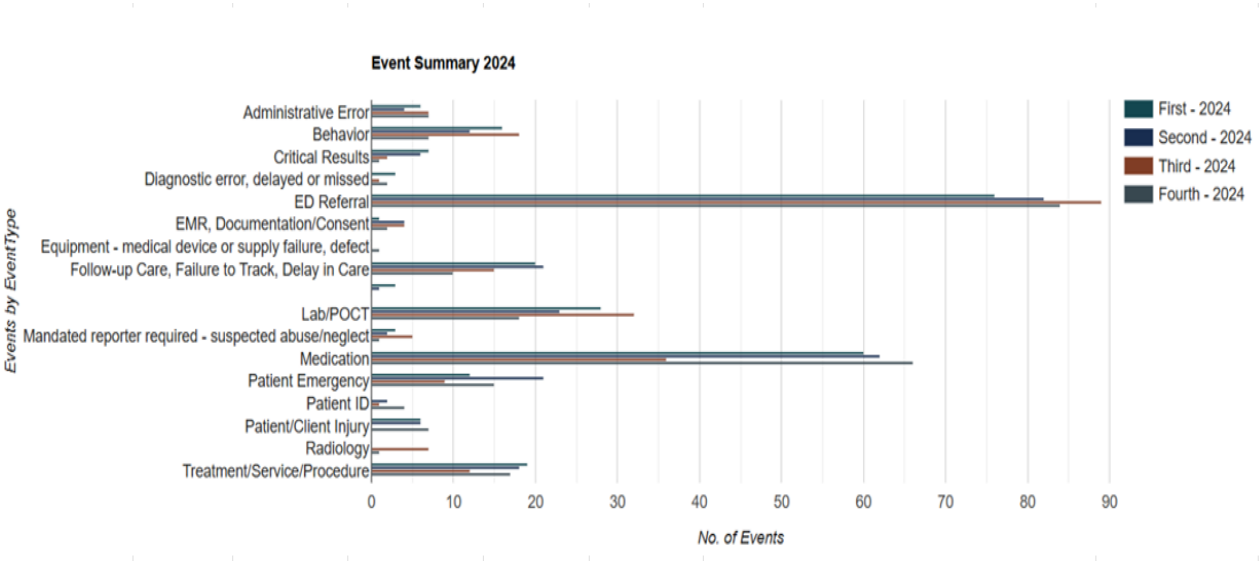
Risk Activity Focus Area/ Measure	Summary Description of Assessment/Methodology/Indicators
#Adverse Event (Incident)	An adverse event or incident is a patient safety event that reached the patient, whether or not the patient was harmed. The health center monitors the number of events reported per quarter. Low volumes of reports may indicate barriers to reporting, such as fear of personal blame for events. The goal is to report all events so no minimum, nor maximum threshold is set.
#Near Miss	A near miss is an unplanned event that by chance did not result in injury, illness or fatality but has the potential to do so in the future if left unaddressed. The health center monitors the number of near misses reported per quarter. Near misses are viewed as opportunities for learning and developing preventive strategies and actions. No minimum nor maximum threshold is set.
#Unsafe Condition	An unsafe condition is a circumstance that increases the probability of a patient safety event occurring such as a potentially hazardous condition, circumstance, or event that has the capacity to cause injury, accident, or healthcare error. The health center monitors the number of unsafe events per quarter. Reporting unsafe conditions can prevent an event from occurring. No minimum nor maximum threshold is set.
#Serious Reportable Event/Sentinel Event	Serious reportable events (SREs) are serious, largely preventable, and harmful clinical events. The National Quality Forum has defined a set of SREs by event type. SREs may also be known as “never events”. A sentinel event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches the patient and results in death, permanent harm, or severe

	temporary harm. Sentinel events may also be known as “serious events” Both serious reportable and sentinel event types are serious and result in severe harm to the patient, warranting thorough investigation. The health center monitors the number of serious reportable/sentinel events reported per quarter. No minimum nor maximum threshold is set.
#RCAs Completed per Quarter	Root-cause analysis (RCA) is a process for identifying the reasons why variation in performance and or policy occurred. The RCA focuses on systems and processes by investigating, reviewing, and developing an action plan to improve and or prevent further harm or injury within LCHD/CHC programs, or determine after review and analysis that no opportunities for improvement exist. The Joint Commission tool, Framework For Root Cause Analysis And Corrective Actions* is used for conducting RCAs. The health center monitors the number of RCAs conducted per quarter. No minimum threshold is set.

Data Summary

See below for a breakdown of events and event types /reported during each quarter of CY2024.

Person Responsible	Measure/Ket Performance Indicator	Threshold/Goal	Q1	Q2	Q3	Q4	Annual Total
Health Center Staff	# Adverse events	Total #/qtr	205	229	192	203	829
Health Center Staff	# Near miss	Total #/qtr	39	24	36	33	132
Health Center Staff	# Unsafe conditions	Total #/qtr	16	12	9	7	44
Health Center Staff	# Serious reportable events/Sentinel events	Total #/qtr	0	0	0	0	0
Risk Manager	# RCAs completed	Total #/qtr	0	0	0	0	0



SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
A total of 1005 events were entered in CY2024 showcasing staff commitment to reporting adverse events, near misses and unsafe conditions. A culture of safety survey was conducted in 2024.	New staff and leadership receive training on our event reporting system. However, there have been some reports from new staff and leadership that they would like more detailed training. Ongoing training for existing staff has not been consistently conducted.	An opportunity exists to create more detailed training for staff using our online training management system, Relias. This training could be assigned to staff electronically and tracked for completion.	The health center is transitioning to a new enterprise resource planning (ERP) system that may affect our current workflow for reporting events. This change could impact timely reporting and follow-up of events.

Follow-up Actions

Q3 [2024]: The LCHD Immunizations Coordinator presented data to the CRPS Committee regarding an increase in medication events. Most of these events were documentation errors that occurred after vaccine administration and while documenting the site and route in the EHR.

To address these errors site leadership was asked to have staff enter an event report and to reeducate staff on how to correctly document in the EHR before the event could be closed. Periodic updates will be given at CRPS Committee.

A quarterly risk assessment was completed to address Lab/POCT events and can be referenced in the quarterly risk assessment section of this report.

Q4 [2024]: Culture of safety survey results and action planning were shared with staff at various meetings. Messaging included an emphasis on leadership and agency commitment to culture of safety as well as event reporting and follow-up.

A quarterly risk assessment was completed to address ED referrals and can be referenced in the quarterly risk assessment section of this report.

Conclusion

Adverse event reporting has been stable during CY2024. Staff and leadership are engaged in event reporting and follow up. Timely follow up and documentation have improved on lab and ED referral events after sharing quarterly risk assessment findings as well as culture of safety presentations with staff.

Proposed Future Activities

In addition to culture of safety action planning and event reporting trainings for new staff, an online event reporting training course will be developed and assigned to all staff.

Risk Management Training

Introduction

The Health Center Program Compliance Manual requires risk management training for all staff members and documentation that all appropriate staff complete training at least annually. Risk management education and training are critical for clinical and non clinical staff to improve safety and mitigate risk related to patient care. The areas of highest risk within the health center were determined to be Obstetrics and Dental. Staff within these areas complete specific risk management training within the context of their associated risks.

The Risk Manager in conjunction with the Clinical Education and Training Manager, Associate Director, Healthcare Operations, and Director, Healthcare Operations, are responsible for developing and implementing the health center's annual risk management training plan.

Training topics are selected based on HRSA regulatory requirements and according to the areas of highest risk, as well as available data and information collected during risk management activities.

Risk Activity Focus Area/Measure	Summary Description Assessment/Methodology/Indicators
# Risk management education required by HRSA	The health center provides mandatory training to all health center staff on the following topics: Health Insurance Portability and Accountability Act (HIPAA), medical record confidentiality requirements, basic infection prevention and control issues, event reporting, and culture of safety. This training is mandated upon hire and annually. Training is provided electronically through Relias, our training management system.
# Other risk management education	The health center mandates other selected risk management training as part of the annual risk management training plan on the following topics: health equity, using data to drive continuous quality improvement, sexual harassment and misconduct in healthcare, corporate compliance, identifying and reporting critical incidents (OIG), security awareness training, and cultural sensitivity. This training is mandated either upon hire and/or annually. Training is provided electronically through Relias, our training management system.
# Other specialty services and areas of high risk Clinical specialties: Obstetrics and Dental	The health center identified Obstetrics and Dental as areas of high risk which require several additional trainings outlined here: **Obstetrics:** Diabetes and other chronic conditions in pregnancy and sensitive encounters. All other clinical and non clinical staff are required to take training on postpartum depression. **Dental:** Instrument reprocessing and infection control for sterilization, vistapure water filtration system, and statclave G4 chamber autoclave. This training is in addition to all other training required and is offered annually.

Data Summary

Training completion rates are monitored through the Relias training system. The completion status of risk management training is detailed in our annual FTCA deeming application and not this report.

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
The Relias training system makes it easy to assign and track completed trainings. We can create and modify trainings in this system allowing us the ability to tailor trainings to our specific needs.	We have had challenges with staff completing training in the allotted timeframe.	We learned that more communication with leadership and carving out more time during work helped to increase compliance.	The health center is transitioning to a new enterprise resource planning (ERP) system that may affect our current workflow for assigning and tracking training.

Follow-up Actions

Q4 [2024]: The Risk Manager and Clinical Education and Training Manager met to collaborate on a plan for assigning and tracking required training. The Clinical Education and Training Manager created FQHC training groups in the Relias training system to more easily capture compliance.

Conclusion

The risk management training plan was closely followed, and all applicable staff were assigned the appropriate risk management trainings. Obstetrical trainings were discussed and decided upon based on the level of care provided by LCHD/CHC Obstetrical staff.

Proposed Future Activities

We will continue to communicate with leadership regarding training compliance and encourage supervisors to give staff time to complete trainings during their workday. The risk management training plan will be reviewed annually and submitted to Governing Council for approval.

Risk and Patient Safety Activities

Introduction

The objective of the health center's clinical risk and patient safety management program is to continuously improve patient safety and minimize and/or prevent the occurrence of errors, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.

The Clinical Risk and Patient Safety Committee has chosen several focus areas including immunizations, contract lab services, ED referrals, BBP exposures/needlesticks, and sterilization. These focus areas have been identified based on their clinical risk and have been assigned an action plan with patient safety activities that are monitored by the committee on a periodic basis,

and some have been the focus of quarterly risk assessments. These focus areas are highlighted below:

- **Immunizations**
  - **Risk Area:** Documentation Errors (wrong site/wrong route) documented in NextGen have increased. The Immunizations Coordinator and the Immunizations team are working diligently to decrease the occurrence of these errors through reeducation and are tracking events using HCSZ.
  - **Action Plan:** (July 2024) The Immunizations Coordinator presented recent data on errors and intervention to the CRPS Committee. The Immunizations team is following up with site leadership for these errors and the respective Nurse Manager is providing education for respective staff. Nurse Managers are closing the loop by documenting training before the event is closed.
  - **Update:** (October 2024) Errors are decreasing, Q2 there were 52 incidents reported/Q3 there were 24 Incidents reported (54% decrease). We must work to close incidents as many remain open. We are evaluating needing assistance from the immunizations team to follow up on incidents.

- **Contract Lab Services**
  - **Risk Area:** There was a gap in training and lab workflow identified. Recent incidents involving mislabeled specimens, specimens not sent, two patient identifiers not used, and incorrect tubes for STI/State labs.
  - **Action Plan:** (July 2024) Continuing to monitor monthly at LabCorp leadership meeting. Specimen drop off log created, retraining from STI on specific labs and State lab draws, quick reference sheet created in English/Spanish for phlebotomists, weekly schedule sent on Thursday every week to confirm coverage.
  - **Update:** (October 2024) Q3 Focused Risk Assessment.

- **ED Referrals**
  - **Risk Area:** Clearly documented follow up in HCSZ demonstrating the closed loop system currently in place has been identified as an opportunity as it appears there is inconsistent documentation.
  - **Action Plan:** (April 2024) The Director of Provider Operations presented the ED referral workflow at the All Staff meeting 4.15.24. The Safety Coordinator will review HCSZ access to ensure proper escalation of reports to applicable staff for follow up.

- **BBP Exposures/Needlesticks**
  - **Risk Area:** BBP Exposure protocol needs a review and update as a recent incident highlighted a need to address a standardized post exposure follow-up process.
  - **Action Plan:** (April 2024) The Safety Coordinator completed a thorough investigation post exposure to identify trends and ensure the follow up process is adhered to. Clinical training and Education conducted post exposure/sharps safety training after each exposure. Updated post exposure protocol and BBP exposure Policy.

- **Sterilization**
  - **Risk Area:** LEEP procedures pose a high clinical risk for infection. Single use disposable speculums are no longer available of the size required to perform LEEPS. Due to the high risk of infection due to sterilizing multiuse speculums, and the low number of LEEPS currently performed Physical Health leadership will explore options for uninsured patients.
  - **Action Plan:** (April 2024) All uninsured patients requiring a LEEP procedure will be scheduled through the North Shore program or at a facility of the patient's choosing. We will continue to investigate alternative options for patients as well as alternative single use disposable speculums.

Conclusion

Risk and patient safety activities described in the focus areas above will continue to be monitored by the CRPS Committee for progress on current action plans and to propose future patient safety activities. The committee will continue to monitor event reports, clinical audits, leadership concerns and trends to make decisions about future high risk focus areas.

Claims Management

Introduction

The health center's process for addressing any potential or actual health or health-related claims includes notification of the Lake County Risk Management Department, the LCHD/CHC Compliance Officer, Director of Healthcare Operations, Risk Manager, and the Board of Health. The Lake County Risk Management Department holds the primary responsibility for notification and coordination of information with, the United States Department of Health and Human Services (HHS). The health center, in turn, works with the County Risk Management Department in securing any necessary documentation and additional information required to address the claim.

Claims Management Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
# Claims Submitted to HHS	The health center immediately sends court complaints or notices of intent to the HHS Office of the General Counsel. The health center monitors the number of claims sent per quarter. No minimum nor maximum threshold is set.
# Claims settled or closed	The health center monitors the number of claims settled or closed per quarter. No minimum nor maximum threshold is set.
# Claims open	The health center monitors the number of claims opened per quarter. No minimum nor maximum threshold is set.

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Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Person Responsible	Measure, Key Performance Indicator	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Annual Total
Compliance Officer	# Claims submitted to HHS	0	0	0	1	1
Compliance Officer	# Claims settled or closed	0	0	0	0	0
Compliance Officer	# Claims Open	0	0	0	1	1

Report Submission

The 2024 Annual Risk Management Report to the Lake County Health Department and Community Health Center Governing Council is respectfully submitted to demonstrate the ongoing risk management program to reduce the risk of adverse outcomes and provide safe, efficient, and effective care and services.