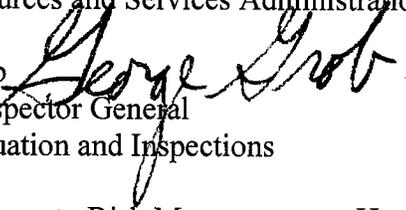




FEB 17 2005

**TO:** Dennis P. Williams, Ph.D.  
Deputy Administrator  
Health Resources and Services Administration

**FROM:** George Grob   
Assistant Inspector General  
for Evaluation and Inspections

**SUBJECT:** OIG Final Report: Risk Management at Health Centers (OEI-01-03-00050)

Attached is a final inspection report providing perspectives of community health center officials regarding risk management practices and the challenges health centers experience in conducting them.

Broadly defined, risk management includes any activity, process, or policy to reduce liability exposure. From both a patient safety and a financial perspective, it is vital that health centers conduct risk management activities aimed at preventing harm to patients and reducing medical malpractice claims. In fiscal year 2003, a total of 240 medical malpractice claims (seeking \$1.4 billion in damages) were brought against health centers that are covered under the Federal Tort Claims Act. The Health Resources and Services Administration (HRSA) paid \$22.7 million for 65 claims against these health centers.

To learn more about risk management at health centers, we identified 16 risk management practices and surveyed health center grantees to learn about their experiences with them and to obtain their assessment and advice about them. Respondents selected credentialing, quality improvement, comprehensive medical records, and clear communication with patients as the most important risk management activities. They identified training, patient tracking, and peer review as the most difficult to do and indicated that inadequate financial resources, staffing, and training are the key challenges to conducting risk management.

We are providing this information solely for your use in addressing these challenges. HRSA's positive response to the report reflects its commitment to improving risk management for health centers. If you have any questions about this report, please do not hesitate to call me or one of your staff may contact Elise Stein, Director, Public Health and Human Services Branch, at (202) 619-2686 or through e-mail [[Elise.Stein@oig.hhs.gov](mailto:Elise.Stein@oig.hhs.gov)]. To facilitate identification, please refer to report number OEI-01-03-00050 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**RISK MANAGEMENT AT  
HEALTH CENTERS**



Inspector General

February 2005  
OEI-01-03-00050

# *Office of Inspector General*

<http://oig.hhs.gov>

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## E X E C U T I V E S U M M A R Y

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### OBJECTIVE

To obtain health center grantees' perspectives regarding the relative importance of certain risk management practices and to identify any challenges or promising approaches regarding those practices.

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### BACKGROUND

The Health Resources and Services Administration (HRSA) awards grants to health centers to improve the health status of underserved populations. In fiscal year (FY) 2003, HRSA received \$1.5 billion to fund 890 health center grants. These health centers served 12.4 million patients. In FY 2002, the President began a 5-year initiative to expand the health center program. This initiative is expected to add 1,200 new health center delivery sites and to increase the number of patients served in these sites to 16 million.

Broadly defined, risk management includes any activity, process, or policy to reduce liability exposure. From both a patient safety and a financial perspective, it is vital that health centers conduct risk management activities aimed at preventing harm to patients and reducing medical malpractice claims. Health centers treat a wide variety of conditions, including diabetes, asthma, hypertension, and cardiovascular diseases, which makes it imperative for health centers to ensure that their patients receive the highest level of care. Many health centers also provide obstetric care, a high-risk area.

From a financial perspective, HRSA has a particular interest in deemed health centers. Deemed health centers, which make up the majority of health centers, are those covered under the Federal Tort Claims Act for the purposes of medical malpractice. Therefore, they do not have to purchase private malpractice insurance. This results in savings for the health centers. HRSA is financially responsible for any payments or settlements arising from claims against these centers. In FY 2003, 240 medical malpractice claims were brought against deemed health centers, seeking \$1.4 billion in damages.

Through document reviews and interviews, we identified 16 risk management practices that health centers are likely to conduct. These 16 practices included maintaining comprehensive medical records, credentialing, and conducting peer review. We surveyed a random sample of 248 health center grantees to learn about their experiences and to obtain their assessment and advice. We received a 71 percent

response rate. To ensure that our results covered a broad spectrum of health centers, we stratified the sample by the number of patients served at health centers. However, the data in this report are not weighted and, therefore, we cannot make any statistical projections to the entire population of health centers. All data are self-reported and are not verified. The survey was anonymous with the intent to reduce bias in our survey results.

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## SURVEY RESULTS

**Health center respondents selected credentialing, quality improvement, comprehensive medical records, and clear communication with patients as the most important risk management activities.** We asked health centers to select the three most important risk management practices for reducing medical malpractice claims and ensuring patient safety. The risk management practice cited most often was credentialing (51 percent of respondents cited it as one of the three). The second practice cited most often was quality improvement (42 percent), the third was comprehensive medical records (41 percent), and the fourth was clear communication with patients (38 percent).

On a separate survey question, respondents indicated that all 16 risk management practices were important. Respondents varied little in their assessment of how important each practice was. Between 92 and 100 percent of respondents indicated that each practice was either very or somewhat important.

**Respondents selected training, patient tracking, and peer review as the three most difficult risk management practices to conduct.** We asked health centers to select the three most difficult risk management practices to conduct. Forty-eight percent responded that regular staff training was one of the three most difficult risk management activities to implement. Forty-two percent selected patient tracking mechanisms, and 32 percent selected peer review.

**Inadequate financial resources, staffing, and training were seen as key challenges to conducting risk management.** Eighty-four percent of respondents cited lack of financial resources for risk management as a major or moderate challenge, 83 percent cited lack of a dedicated full-time equivalent staff person for risk management, and 64 percent cited lack of training.

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## RESPONDENT COMMENTS

Twenty-five percent of respondents offered their suggestions about promising or innovative approaches for risk management and 39 percent of respondents offered recommendations to HRSA. In the report we include highlights from these responses, as they may be useful to HRSA.

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## OPPORTUNITIES FOR IMPROVEMENT

The fundamental challenge that respondents experienced in conducting risk management was the lack of financial resources. This has implications for training, staffing, and other risk management activities. HRSA may want to ensure that all health centers are adequately investing in risk management. In particular, HRSA may want to determine the amount of savings deemed health centers realize from being deemed and ensure that they are reinvesting some portion of their savings into risk management.

In addition, HRSA may want to consider developing a comprehensive, ongoing training agenda on risk management for health centers. HRSA may also want to explore creative, inexpensive ways to assist health centers, such as disseminating best practices or a newsletter, developing tool kits that contain sample policies and procedures, and encouraging health centers to participate in regional networks for sharing information and resources about risk management.

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## AGENCY COMMENTS

HRSA responded positively to the report and its comments reflect its commitment to improving risk management for health centers. It has established a new goal that by 2010, 100 percent of health centers will participate in risk management training. HRSA plans to achieve this goal by holding risk management workshops and by developing a comprehensive training agenda. For HRSA's complete response, see Appendix C attached to the main body of the report.

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## OBJECTIVE

To obtain health center grantees' perspectives regarding the relative importance of certain risk management practices and to identify any challenges or promising approaches regarding those practices.

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## BACKGROUND

The Health Resources and Services Administration (HRSA), within the Department of Health and Human Services, awards grants to a variety of health centers, including community health centers, migrant health centers, and public housing primary care centers.<sup>1</sup> Each of these health centers addresses the needs of a specific population and is designed to increase access to primary health care services and to improve the health status of underserved populations.

In fiscal year (FY) 2003, HRSA received \$1.5 billion to support 890 health center grants. These funds supported general operating expenses and patient services. The health centers encompassed about 3,600 health care delivery sites and served 12.4 million people. They employed about 7,800 physicians and dentists and 70,000 other health care practitioners and administrative staff. Also in FY 2003, health centers received an estimated \$2.1 billion from Medicaid and an estimated \$327 million from Medicare.

### **The Importance of Risk Management**

Broadly defined, risk management includes any activity, process, or policy to reduce liability exposure. This involves all aspects of a health center's infrastructure and services, including financial matters, facility maintenance, fire safety, compliance with applicable laws and regulations, and clinical care. However, for the purposes of this report, we limit the meaning of risk management to activities aimed at reducing medical malpractice claims and ensuring patient safety (protecting patients from harm).

Health centers conduct a wide array of activities to reduce medical malpractice claims, such as credentialing and privileging health care practitioners, using clinical protocols, and maintaining medical records. These activities are critical for several reasons, which we elaborate on in this section.

***Ensuring patient safety.*** Health centers treat a wide variety of conditions, including diabetes, asthma, hypertension, and

cardiovascular diseases, which makes it imperative for health centers to ensure that patients receive the appropriate level of care. Many health centers also provide obstetric care, a high-risk area, which further underscores the importance of risk management.

Medical malpractice claims demonstrate the significance of potential problems that can occur in health centers. Medical malpractice claims filed in 2003 cover a broad range of conditions and severity. Examples of some more serious claims included the following allegations: failure to diagnose asthma, improper prescription of diabetes medication, failure to treat elevated blood pressure, and failure to diagnose and treat congestive heart failure and myocardial infarction. In addition, there were claims related to obstetric care, which included the following allegations: failure to remove gauze during delivery; negligent prenatal care, labor, and delivery; and failure to diagnose and treat an ectopic pregnancy. Although these claims have not yet been finally resolved or determined to have merit, they illustrate the nature of some of the more serious potential problems.

**Costs associated with medical malpractice claims.** To cover financial losses due to medical malpractice claims, health centers can either obtain coverage at no cost to the health center under the Federal Tort Claims Act or purchase medical malpractice insurance from a private company.<sup>2</sup>

Health centers that elect to be covered under the Federal Tort Claims Act are referred to as deemed health centers.<sup>3</sup> Eligible health centers include migrant health centers, community health centers, health care for the homeless grantees, school-based health centers, and health services for public housing residents grantees. In FY 2003, 680 health centers were deemed (about 80 percent). The primary reason health centers choose this option is the savings they realize by not having to purchase private medical malpractice insurance.<sup>4</sup>

HRSA is financially responsible for any payments or losses arising from medical malpractice claims against deemed health centers. Since deeming began in 1992, 345 health centers have incurred claims against them. Of these, 40 percent had 1 claim, 18 percent had 2 claims, and the remainder had 3 or more claims.

In FY 2003, 240 medical malpractice claims were brought against deemed health centers, seeking \$1.4 billion in damages. There is a considerable difference in the amount claimants seek and the actual amount HRSA pays out. Historically, the median amount demanded by

claimants was \$1.5 million, whereas the median amount paid out by HRSA was \$125,000. In FY 2003, HRSA paid \$22.7 million for 65 claims against these health centers. (These paid claims were not necessarily filed in FY 2003.)

HRSA covers claim payments out of its Health Center Tort Claims Fund. HRSA has raised concerns about the financial viability of this fund as the health center program expands. HRSA's FY 2003 budget justification stated:

... FTCA [Federal Tort Claims Act] payments for settled claims are expected to increase as a result of increases in the number of covered health centers, health center physicians, and patients, as well as, the overall upward trend in judgments and settlements being experienced in the medical malpractice marketplace. In addition, a number of insurance companies are dropping malpractice coverage because of substantial losses in providing malpractice insurance.

In FY 2004, HRSA received \$45 million in appropriations for this fund.<sup>5</sup> The President's budget for FY 2005 requests \$45 million.

In the cases in which a health center opts to purchase private insurance, the insurer is financially responsible for any payments or losses arising from medical malpractice claims against the center. To reduce liability, the private insurer typically provides the health center with a risk management assessment, training, and technical assistance. Nondeemed health centers may choose to purchase private insurance because they can afford the premiums and want to benefit from the risk management services provided by the private insurer.

**Expansion of the program.** In FY 2003, health centers served 12.4 million patients. This number is expected to increase as the program expands, thereby exposing HRSA to greater liability. In FY 2002, the President began a 5-year initiative to expand the health center program. This initiative is expected to add 1,200 new health center delivery sites and to increase the number of patients served in all sites to 16 million. The President's FY 2005 budget requests the third year of funding for this initiative, seeking \$1.8 billion for the health center program. With these funds it is expected that by the end of FY 2005 the total number of health center delivery sites will be 3,800.

**Past program vulnerabilities.** A 1997 U.S. Government Accountability Office report raised concerns about the risk management services that

HRSA intended to provide health centers at that time.<sup>6</sup> Specifically, it found that HRSA was providing limited risk management services to deemed health centers. At the time this report was issued, the Federal Tort Claims Act option for health centers had only been in place for a few years. Health centers and HRSA both had little experience with deeming. Since that time HRSA has taken steps to provide health centers with additional risk management services. Still, it is timely to reexamine these issues given that 7 years have passed.

### **Health Center Requirements for Risk Management**

HRSA's regulations and policies require all health centers to conduct certain risk management activities. These activities include implementing a quality assurance program, performing credentialing and privileging for certain health care providers, and developing risk management policies and procedures, among others. (See the primer on page 7 for a list of risk management activities HRSA requires.)

In addition to these requirements, deemed health centers must adhere to two additional requirements. First, the statute requires deemed health centers to cooperate with the Department of Justice in providing information related to medical malpractice claims.<sup>7</sup>

Second, HRSA's policy requires a portion of the savings deemed health centers realize to be reinvested in risk management. The policy specifically states that HRSA ". . . expects as health centers begin to realize savings in malpractice insurance costs due to coverage under the Federal Tort Claims Act, centers will reinvest some of the savings to target malpractice risk reduction."<sup>8</sup> However, the same policy may cause some confusion about this requirement, because it also states that the savings can be used for *any* activity within the scope of the grant. Specifically, it states:

For example, these funds may be used to increase the number of users, increase the range of services provided . . . or to implement administrative improvements (including clinical compensation, clinical quality improvement/risk management activities).

HRSA monitors risk management at all health centers in two key ways: grant applications and onsite reviews. The grant application and, when applicable, the deeming application provide information about relevant aspects of a health center's risk management program. The grant application also requires health centers to describe their quality assurance and risk management practices. The deeming application

## I N T R O D U C T I O N

requires health centers to certify that they have certain risk management practices in place, such as credentialing and privileging.

In terms of onsite reviews, HRSA previously relied on its Primary Care Effectiveness Reviews, which were onsite performance reviews that health centers received about once every 5 years. These reviews included specific questions examining centers' risk management practices. However, HRSA no longer performs these reviews.

HRSA has developed a new performance assessment protocol for all its grantees, including health centers. This new protocol is currently being implemented and will likely include performance measures related to risk management.

Health centers that are accredited by the Joint Commission on Accreditation of Healthcare Organizations (referred to throughout the report as the Joint Commission) must adhere to its standards for ambulatory health care programs, which include numerous requirements relevant to risk management.<sup>9</sup> For example, these standards require credentialing and privileging of providers and internal monitoring of adverse events, among others. In 1997, HRSA began an initiative to encourage health centers to seek accreditation. As of 2003, 290 health centers (about 33 percent) had received accreditation from the Joint Commission.

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## METHODOLOGY

This inspection is based on a document review, stakeholder interviews, and a survey of health center grantees. All the data presented in this report are self-reported and are not verified. To reduce bias in the responses, we administered the survey anonymously. For a detailed description of our methodology, see Appendix A.

To improve our understanding of risk management we reviewed documents and interviewed various stakeholders (e.g., the National Association of Community Health Centers, primary care associations, and selected health centers). Based on these sources, we identified 16 risk management practices that health centers are likely to conduct (some of which are required). See the primer on page 7 for a complete list and description of these 16 practices, including which are required. We used these 16 risk management practices as the basis for our survey questions.

## I N T R O D U C T I O N

We surveyed a random sample of 248 health center grantees out of 835 grantees in FY 2002. To ensure that our results covered a broad spectrum of health centers, we stratified the sample by the number of patients served. The sample included deemed and nondeemed and accredited and nonaccredited health centers. We received 175 replies to our survey, for a response rate of 71 percent. Eighty-eight percent of respondents to the survey were deemed. Because not all respondents answered every question, the actual number of respondents varies by question. Therefore, throughout the report we provide percentages based on the actual number of respondents for each question.

### **Data limitations**

Because the survey was anonymous and we obtained only self-reported estimates about the number of patients served in FY 2002, we were unable to determine which stratum each respondent fell into. As a result, we could not weight the data, nor could we calculate confidence intervals. Therefore, we cannot make statistical projections to the entire population of health centers based on the survey data. The data presented in the report are simple frequencies of the responses. We did not independently verify any statements health center grantees made on the survey. Finally, we are unable to conduct a nonrespondent analysis because the survey was anonymous. Therefore, we cannot estimate the level of bias among respondents. These limitations apply to all data analysis and comparisons presented in the report.

### **Standards**

We conducted this inspection in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency.



## P R I M E R O N R I S K M A N A G E M E N T

We identified 16 risk management practices that health centers are likely to conduct to reduce medical malpractice claims and ensure patient safety. We identified these practices based on interviews with health centers, Federal officials, and other key stakeholders; a review of relevant statutes, regulations, and policies; and a review of pertinent literature regarding risk management in health care settings. Ten of these 16 risk management practices are explicitly required either by statute or by HRSA regulation or policy (as designated by an asterisk). The Joint Commission requires all 16 of these practices.

**Active quality improvement program\*:** Internal efforts to improve the quality of care. These efforts may include reviewing clinical outcome data and conducting long-term projects aimed at improving clinical care, among others.

**Appropriate use of clinical protocols\*:** Established guidelines for providing clinical care that health care practitioners use. These guidelines may be developed by professional organizations or by the health center's clinical staff.

**Clear communication with patients\*:** Patients have a voice in determining their care and receiving information about their care in a way that they can comprehend. This includes providing translation services when necessary.

**Clear communication with providers:** Health care providers receive clear communication from the health center's leadership about their roles and responsibilities and they communicate clearly with one another.

**Comprehensive patient medical records\*:** These records document the care provided to the patient at the health center. They can be either paper or electronic.

**Credentialing of health care professionals\*:** The process of verifying that health care providers meet all required educational and licensing requirements. The health center or a third party may conduct this activity.

**Documentation of informed consent:** Patients are adequately informed about risks and benefits of their treatment.

**Formal patient grievance mechanism\*:** A system to collect, analyze, and address complaints received from patients and/or staff.

**Internal incident reporting system:** A system to collect and analyze information on adverse events that occur within the health center resulting from inappropriate care.

**Ongoing peer review of patient cases:** The review of medical records or patient cases by health care professionals, either within the health center or as outside consultants, to ensure that appropriate care was provided.

**Onsite assessment of risks and risk management practices:** A process to assess the potential risks of the health center and the health center's activities to reduce its risks. This assessment can be done by the health center or by outside consultants.

**Patient tracking system:** A formal system, either electronic or paper, to ensure that key patient information, such as test results, missed appointments, and care at different health care institutions, is not overlooked.

**Privileging of health care professionals\*:** The process of verifying, on a routine basis, that practitioners have the appropriate clinical competencies and the ability to perform clinical procedures effectively.

**Regular patient satisfaction survey\*:** A survey to assess patient satisfaction with the level of service and clinical care that they received.

**Regular staff training on risk management\*:** Staff receive either onsite or offsite training on topics related to risk management.

**Up-to-date policies and procedures on risk management\*:** Written documents that explicitly describe a health center's operations and processes related to risk management.

► SURVEY RESULTS

**While health center respondents indicated that all 16 risk management practices were important, they selected credentialing, quality improvement, comprehensive medical records, and clear communication with patients as the most important**

We asked respondents to select the three risk management practices they considered to be the most important for reducing medical malpractice claims and ensuring patient safety. The range of responses among the 16 practices varied from 3 to 51 percent. (See Table 1.)

| <b>Table 1. The Level of Importance of Risk Management Practices According to Respondents</b> |   |  |
|---|---|--|
| <b>Risk Management Practice</b>   | <b>Percentage of Respondents Who Selected the Practice as One of the Three Most Important</b> | <b>Percentage of Respondents Who Indicated the Practice Was Very or Somewhat Important</b> |
| Credentialing of Health Care Professionals*   | 51  | 98   |
| Active Quality Improvement Program*   | 42  | 99   |
| Comprehensive Patient Medical Records*  | 41  | 100  |
| Clear Communication With Patients*  | 38  | 99   |
| Patient Tracking System   | 20  | 97   |
| Ongoing Peer Review of Patient Cases  | 16  | 94   |
| Internal Incident Reporting System  | 15  | 98   |
| Appropriate Use of Clinical Protocols*  | 14  | 96   |
| Regular Staff Training on Risk Management*  | 14  | 96   |
| Privileging of Health Care Professionals*   | 11  | 95   |
| Onsite Assessment of Risks and Risk Management Practices                                      | 7   | 92   |
| Documentation of Informed Consent   | 6   | 97   |
| Formal Patient Grievance Mechanism*   | 6   | 97   |
| Regular Patient Satisfaction Survey*  | 5   | 96   |
| Clear Communication With Providers  | 4   | 99   |
| Up-To-Date Policies/Procedures on Risk Management*  | 3   | 97   |

\*Indicates risk management practices explicitly required by statute or HRSA regulation or policy.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

**Credentialing.** Credentialing is the process of verifying that a health care practitioner meets all required educational and licensing requirements; it is a requirement for all health centers.<sup>10</sup> The health center or a third party may conduct this activity. Respondents cited credentialing most often (51 percent) as one of the three most important risk management activities.

The level of importance respondents attributed to credentialing may reflect the recent attention HRSA has given to this area. In 2001 and 2002, HRSA issued policy information notices emphasizing the importance of credentialing and its expectations for health centers. HRSA expects health centers to review and verify their practitioners' qualifications, including professional credentials, references, and claims history.<sup>11</sup>

Respondents commented that credentialing is the foundation for risk management. It is essential that health centers have qualified staff to ensure safe and appropriate treatment of their patients. One respondent summed it up by writing “. . . the care you give can only be as good as the providers you hire. . . .” Respondents also commented that credentialing is important from a liability perspective, as it documents that health centers carry out due diligence when hiring health care providers.

**Quality improvement programs.** Quality improvement programs, which are required by HRSA, include internal efforts to improve the quality of the clinical care, such as analyzing clinical outcome data. Respondents cited quality improvement programs second most often (42 percent) as one of the three most important risk management activities.

Respondents commented that quality improvement activities allowed them to identify areas needing improvement, thereby helping them to prevent future problems. Respondents also commented that they conduct many of their risk management practices as part of their quality improvement program. These programs serve as a way to integrate numerous risk management activities into one comprehensive program. Finally, respondents mentioned that quality improvement programs are important because they provide an objective means of measuring and monitoring their performance over time.

**Comprehensive patient medical records.** Medical records document the care provided to the patient at the health center, and HRSA requires them for all health centers. The records can be either paper or electronic. Respondents rated maintaining comprehensive patient

medical records third (41 percent) among the three most important risk management practices.

Respondents cited several reasons they consider medical records to be important. First, when a malpractice claim is filed, medical records serve as a key piece of evidence in determining whether appropriate care was provided. Respondents indicated that malpractice claims can often be quickly dismissed if medical records demonstrate that appropriate care was provided. One respondent wrote “. . . if it isn’t documented, it didn’t occur.” Second, respondents pointed out that medical records play an important role in preventing errors, because they serve as a complete record of the patient’s care and assist the health care provider in making decisions about appropriate next steps. Medical records are especially important if multiple providers are working with a patient. Finally, respondents commented that medical records can also be a rich source of information for quality improvement programs and peer review efforts.

**Clear communication with patients.** Clear communication with patients, which is also required by HRSA, involves making sure patients have a voice in determining their care and providing them with information about their care in a way they comprehend. This includes providing translation services when necessary. Thirty-eight percent of respondents cited clear communication with patients as one of the three most important risk management practices.

Respondents cited several reasons why clear communication with patients is critical. One common theme among respondents was the opinion that, when patients understand their diagnosis and treatment, they are more likely to be compliant with their treatment regimen. Another common theme mentioned by several respondents was that patients who understand their treatment and are active participants are less likely to sue when something goes wrong.

**All 16 practices.** We asked respondents to give their opinion on the level of importance of each of the 16 risk management practices. Respondents varied little in their assessments. Between 92 and 100 percent of respondents assessed each practice as either very or somewhat important. (See Table 1 on page 9.)

Several respondents identified other important risk management practices in addition to the 16 we identified. These included obtaining accreditation by the Joint Commission, monitoring medication usage, implementing appropriate procedures for infection control, assessing

S U R V E Y R E S U L T S

performance of clinical staff, and documenting telephone calls with patients.

**Respondents selected training, patient tracking, and peer review as the three most difficult risk management practices to conduct**

We asked respondents to select the three risk management practices they considered to be the most difficult to implement. (See Table 2.)

| <b>Table 2. Health Center Respondents' Self-Assessment of Their Performance for Risk Management Practices</b> |  |  |
|---|--|--|
| <b>Risk Management Practice</b>   | <b>Percentage of Respondents Who Selected the Practice as One of the Three Most Difficult to Conduct</b> | <b>Percentage of Respondents Who Indicated They Were Doing an Excellent or Good Job at Conducting the Practice</b> |
| Regular Staff Training on Risk Management*  | 48   | 54   |
| Patient Tracking System   | 42   | 66   |
| Ongoing Peer Review of Patient Cases  | 32   | 70   |
| Onsite Assessment of Risks and Risk Management Practices  | 30   | 58   |
| Active Quality Improvement Programs*  | 26   | 87   |
| Up-to-Date Policies/Procedures on Risk Management*  | 21   | 70   |
| Comprehensive Patient Medical Records*  | 17   | 90   |
| Appropriate Use of Clinical Protocols*  | 14   | 82   |
| Credentialing of Health Care Professionals*   | 11   | 95   |
| Internal Incident Reporting Systems   | 10   | 84   |
| Clear Communication With Patients   | 8  | 93   |
| Privileging of Health Care Professionals*   | 7  | 86   |
| Clear Communication With Providers*   | 4  | 90   |
| Formal Patient Grievance Mechanism*   | 3  | 88   |
| Regular Patient Satisfaction Survey*  | 3  | 82   |
| Documentation of Informed Consent   | 1  | 89   |

\*Indicates risk management practices explicitly required by statute or HRSA regulation or policy.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

**Training.** Training, which is required by HRSA, can be provided either onsite or offsite and can address a wide array of topics related to risk management. Respondents cited regular staff training most often (48 percent) as one of the three most difficult risk management activities to conduct.

Among the reasons respondents cited were the lack of staff, money, and training materials. Training is often deferred to a later date, since providing care is perceived to be more important and staff time is limited.

**Patient tracking.** Patient tracking, which is not required by HRSA, is a formal system, either electronic or paper-based, used to ensure that key patient information is not overlooked. Key information includes test results, missed appointments, and care at different health care institutions. Respondents ranked patient tracking second (42 percent) among the three most difficult activities to conduct.

Respondents commonly cited the lack of information technology as a reason this activity is difficult to conduct. Respondents also commented that even if they had the appropriate information technology, it would require time, which respondents reported is often in short supply, to input data and monitor the system. Finally, respondents commented that some patients are homeless and/or transient, making followup difficult under any circumstances.

**Peer review.** Peer review, also not required by HRSA, involves the review of medical records or patient cases by health care professionals, who are either within the health center or outside consultants, to ensure that appropriate care was provided. Respondents ranked peer review third (32 percent) among the three most difficult activities to conduct.

Respondents commented again that time and resources were an issue that made peer review difficult. Several respondents mentioned that the staff view patient care as a higher priority and may be unwilling to spend time conducting peer review. In addition, several respondents mentioned that with a small staff, practitioners are often uncomfortable reviewing one another. In fact, some respondents indicated that they have only two to three staff per site.

**All 16 practices.** While 90 percent of respondents thought that, overall, they were doing an excellent or good job at conducting risk

management, the portion of respondents who felt they were doing either an excellent or good job for each of the 16 practices ranged from a low of 54 percent to a high of 95 percent. (See Table 2 on page 12.)

For additional survey data on these assessments by the size of the respondents, see Table 10 in Appendix B.<sup>12</sup>

**Health center respondents indicated that inadequate financial resources, staffing, and training are key challenges to conducting risk management**

Respondents experienced several challenges that prevented them from doing all that they would like in terms of risk management. In fact,

40 percent of respondents indicated that there are risk management practices that they would like to conduct, but are currently unable to. These respondents mentioned additional training, onsite reviews, peer review, and patient tracking as activities they would like to conduct.<sup>13</sup>

To better understand these challenges, we provided respondents with a list of potential challenges and asked them to indicate to what extent each hindered their ability to conduct effective risk management.

For additional survey data on these challenges by the size of respondents, see Table 11 in Appendix B.

**Financial resources.** Eighty-four percent of respondents selected lack of financial resources as a major or moderate challenge. Financial resources have consequences for staffing, training, and information technology, all of which affect a health center’s ability to conduct risk management.

Financial resources are a concern even for deemed respondents. Deemed health centers are covered under the Federal Tort Claims Act for the purposes of medical malpractice claims; therefore, they do not have to purchase comprehensive private malpractice insurance. This results in savings for the health center. Eighty-eight percent of respondents to the survey were deemed. Of those deemed respondents, 83 percent reported that the lack of financial resources was a major or moderate challenge. Eighty-six percent of nondeemed respondents reported that the lack of financial resources was a major or moderate challenge.

Still, 73 percent of deemed respondents indicated that being deemed had to a great or moderate extent improved their ability to conduct risk

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management. This may be in part due to the savings from not having to purchase private malpractice insurance. Deemed respondents reported saving \$228,000 per year on average, with individual respondents saving between \$7,500 and \$2 million.

However, only 47 percent of deemed respondents reported that they were using these savings, in whole or in part, for risk management practices. Of those using these savings for risk management, common activities included hiring additional staff, conducting more staff training, implementing a quality improvement program, seeking accreditation, and hiring outside consultants.

Twenty-two percent of deemed respondents indicated that they were not using these savings for risk management and 31 percent were unsure how they were using these savings. HRSA's policy is unclear on how much of these savings should be used for risk management; HRSA's Policy Information Notice 1999-08 states:

[HRSA] expects as health centers begin to realize savings in malpractice insurance costs due to coverage under the FTCA [Federal Tort Claims Act], centers will reinvest some of the savings to target malpractice risk reduction.

This same policy states that health centers may use these savings for activities within the scope of the grant:

For example, these funds may be used to increase the number of users, increase the range of services provided . . . or to implement administrative improvements (including clinical compensation, clinical quality improvement/risk management activities).

It is important to point out that it is difficult for health centers, especially those that have been deemed for several years, to know how much they are actually saving per year. HRSA does not require health centers to track their savings. In fact, it would be difficult for them to do so, because it would require health centers to have an understanding of their local insurance markets so they could estimate the current cost of malpractice insurance. Health centers do provide HRSA with their annual budgets; however, not all risk management activities are easily accounted for in terms of financial expenditures, such as clear communication with patients and maintaining up-to-date policies and procedures.

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**Staffing.** Eighty-three percent reported that a lack of dedicated full-time equivalent staff for risk management was a major or moderate challenge. Only 19 percent of respondents reported that they have a dedicated staff position, either full- or part-time, for risk management.

Instead, most respondents reported that they rely on their executive directors, compliance officers, physicians, and nurses to play key roles in risk management for the health center. However, these individuals are also busy managing other responsibilities and may have difficulty finding the time or obtaining the necessary expertise for risk management activities. This is especially the case for clinical staff: 82 percent of respondents indicated that the lack of clinical staff time was a major or moderate challenge to conducting risk management.

**Training.** Sixty-four percent of respondents indicated that training was a major or moderate challenge. Lack of training can affect the level of expertise among staff for risk management and, in fact, 64 percent responded that the lack of expertise among staff was a major or moderate challenge.

Notwithstanding these challenges, 69 percent of respondents indicated that their staff received training on risk management in FY 2003. Fifty-three percent responded that their staff received training no less than once every few months, and 33 percent said their staff received training once a year.

Respondents indicated that they received training from a variety of sources. Fifty-eight percent received training from their own staff, 25 percent from State primary care associations, 30 percent from the National Association of Community Health Centers, and 27 percent from private insurance companies.

HRSA also provides training to health centers. However, only 13 percent of respondents reported that they received training from HRSA (including both regional and/or central office), even though HRSA provides several resources. (See Table 3 on page 17 for a complete list of HRSA's resources.) Respondents varied in how satisfied they were with the risk management resources HRSA provides. They appeared to be the most satisfied with HRSA policy information notices, the Federal Tort Claims Act helpline, and accreditation from the Joint Commission. (See Table 3 on page 17.)

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Notably, respondents reported that they had no experience with many HRSA resources. However, some of these resources were available only on a limited basis. Nevertheless, nearly 45 percent reported that they had no experience with the publication “Risk Management,” published

| <b>Table 3. Health Center Respondents' Satisfaction with Risk Management Assistance from HRSA</b>  |   |  |
|--|---|--|
| <b>HRSA Resources</b>  | <b>Percentage of Respondents Who Indicated They Were Completely or Somewhat Satisfied</b> | <b>Percentage of Respondents Who Indicated No Experience With the Resource</b> |
| HRSA's policy information notice on credentialing and privileging (Policy Information Notice 2002-22)  | 79  | 6  |
| Federal Tort Claims Act helpline (1-866-FTCA HELP)   | 78  | 28   |
| HRSA's program expectation (Policy Information Notice 1998-23)   | 74  | 7  |
| Accreditation by the Joint Commission on Accreditation of Healthcare organizations supported by HRSA   | 74  | 49   |
| HRSA's online resources (i.e., Web site)   | 63  | 23   |
| National Association of Community Health Centers' malpractice risk management consultation line (1-888-800-3772), funded by HRSA   | 59  | 36   |
| Risk management recommendations provided by a review of Federal Tort Claims Act medical malpractice claims by HRSA's Division of Clinical Quality (formerly the Center for Risk Management)* | 58  | 46   |
| Federal Tort Claims Act claims-related site visits initiated by HRSA's Division of Clinical Quality (formerly the Center for Risk Management)*   | 50  | 71   |
| HRSA's distribution of the publication, "Risk Management," printed by the Department of Legal Medicine, Armed Forces Institute of Pathology  | 48  | 45   |
| Referral to appropriate risk management resources by HRSA project officer  | 46  | 49   |
| Incident reporting system (i.e., Doctor Quality)*  | 39  | 51   |

Note: The percentage of respondents who indicated that they were completely or somewhat satisfied is out of those respondents who indicated they had experience with the resource. The percentage of respondents who indicated they had no experience with the resource is out of the total number of survey respondents.

\*Indicates that this service is available only on a limited basis.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

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by the Armed Forces Institute of Pathology and distributed to all health centers by HRSA. Thirty-six percent of respondents indicated no experience with the risk management telephone consultation line, which is also available to all health centers. (See Table 3 on the previous page.)

Even with these resources, 87 percent of respondents indicated that they would like to receive more training. Topics for additional training included documentation, incident reporting, and patient records. Respondents also called for general or overall help in developing a risk management program. Several respondents were looking for a better understanding of the basics of a risk management program and how to implement such a program in their health center.

## Health center respondents identified promising approaches to conducting risk management

Twenty-five percent of respondents offered their suggestions about promising approaches. Below are some highlights.

### Onsite Assessments

- Proactively doing self-assessments of some departments and processes.
- We do our own periodic environment of care “walk throughs” using the same tool as our State licensing auditors and the Joint Commission use. This keeps us on our toes.
- We started emergency room site visits by the key management during night duty hours. Assessment of medical practices, billing procedures, medical supply, security of the building and equipment, patient satisfaction, and adherence with the organizational policies and procedures is performed during each visit.
- Daily emergency medical audit report.
- Monthly risk assessment walk throughs are conducted by our safety committee and are designed to integrate needs for many risk-surveillance areas: infection control, emergency medication use, quality control log compliance, facility and the Office of Occupational Safety and Health Administration hazards, and others. These findings are tracked through a larger performance improvement committee responsible for initiating followup activities where improvements or risk reduction is needed.
- We have implemented monthly safety audits at all sites—both clinical and nonclinical. Different staff members conduct the audit each month and report back to quality review management department.
- We requested from the general liability insurance company a loss control assessment. It was performed during 2003. Recommendations were properly addressed. A followup visit and risk management conference was scheduled for March 2004.

**Quality Improvement Programs**

- Part of a Health Center Network, Council of Community clinics, that facilitates/coordinates/supports coordinated quality improvement programs.
- The rate of medication errors has [been] reduced due to having an additional pharmacist on board. The double checking of dispensing drugs has greatly reduced high volume area and enhanced quality control of dispensing the wrong medication to our patients.
- We are a large prenatal provider and we do 100 percent chart review on all prenatal charts at 28 weeks to ensure a GTT [glucose tolerance test] has been run and results documented. Lack of GTT and diagnosing gestational diabetes can lead to complications, which we want to avoid by making sure we do this test.
- Yearly review by life cycle and risk groups of preventive care guidelines and health maintenance issues promotes identification of problem areas and medical plan to address the problem.

**Incident Reporting**

- We have an active medical safety committee where we review all adverse drug events and potential adverse drug events. These are computerized in an incident reporting system.
- Incident reports are summarized on a multi-year basis for trends and improvements.
- New incident report form is easy to use—requires mostly checking specific categories—categories are based on meta-analysis of incident reports filed over last several years.

**Patient Satisfaction**

- Our satisfaction survey includes children K-5 grades. Along with the satisfaction survey, we also survey parents, teachers, administrator, staff at the school and we use a standard health behavior survey in children 4-5 (grades) to evaluate effectiveness of health prevention activities.
- Patients who transfer medical records are mailed a survey to determine the reason for leaving our practice. The survey results are rewarded [reviewed] by the board of directors,

administrative staff, and provider and support staff.  
Corrective action is implemented when appropriate.

- Direct line for patients with complaints to the chief executive officer who actively responds to such complaints. Believe this has defused potential problems at the early stage.
- The center utilizes a public board forum where the public gets to meet the board of directors and directors of services at least 2 times per year. This unique forum allows the community at large, and the patients to come and listen to the board speak about the changes and challenges in the provision of care. The patients and the community-at-large also get the opportunity to voice their opinions on the care received, services they need, and satisfaction in general.

**Training**

- Risk management topic at every monthly administration staff meeting.
- Annual in-service training with staff, annual education day with all employees to go over Office of Occupational Safety and Health Administration safety and required in-services.
- Conducting weekly case conferences with clinicians from medicine, mental health, and social work to review patients with non-adherence issues and/or behavior problems that pose a potential liability risk to the organization and how to deal with those patients moving forward.

**Medical Records**

- Electronic medical record with drug interaction warnings, reminder modules, and other decision support tools.
- We are currently developing and implementing an electronic medical record program. This will enhance and facilitate quality improvement and other monitoring capabilities as well as improve client assessment and care by use of required fields for key/critical assessment, accreditation, preventive care, and documentation requirements.

**Peer Review**

- Use of former medical director (now retired) to conduct peer review.

- Have set up a system of peer review whereby providers exchange pertinent sections of medical record by mail (because of great distance between our 7 clinics). The process ends with the audit tool returned to the credentialing department and recorded for each individual.

**Health center respondents offered recommendations to HRSA regarding risk management**

Thirty-nine percent of respondents offered recommendations to HRSA. Below are some highlights.

**Training and Technical Assistance**

- Seminars so that health center staff can network with HRSA staff.
- Try to utilize technology to offer training on risk management (video conferencing, satellite broadcasts).
- Get the information out on available resources.
- Most risk management information is hospital/inpatient based. Would be nice to have HRSA provide information related to health centers' risk management issues on a regular basis.
- Work more closely with the National Association of Community Health Centers on this. The National Association of Community Health Centers provides great training, in general.
- Develop training that dedicates time to develop/review risk management policies and procedures, or gives a clear step-by-step approach.

**Policies and Guidance**

- Make the Policy Information Notices more user friendly.
- Quick reference handouts for staff updates.
- Seek out best practices and disseminate.
- Sample policies.
- Incorporate a strong risk management program into the requirements for section 330 funding and performance review calculations.
- Specialized risk management for mental health, dental, and obstetrics/gynecology.

**Federal Tort Claims Act**

- More feedback from HRSA after a FTCA [Federal Tort Claims Act] case is filed concerning progress, outcome, and suggestions for improvements.
- Should provide numbers of the most cases of malpractice suits filed and trends.
- Cover any remaining gaps in FTCA [Federal Tort Claims Act] coverage such as volunteers, consultants, and sexual harassment.

**Medical Records**

- Invest in electronic medical records.

**Incident Reporting**

- Develop a nonpunitive culture on local, State, and Federal level for a reporting system. This would help to identify and quantify possible medical errors or sentinel events in a health center.

**Peer Review**

- For rural/sparse areas establish a network that encourages peer review.

**On-Site Assessment**

- Onsite assessment of the center's risks (physical and nonphysical risks, nonclinical and clinical).



Respondents indicated that they experience several challenges in conducting risk management. Given the importance of risk management from both a patient safety and a financial perspective, it would be helpful for HRSA to explore these challenges in greater depth to ensure that all health centers are, in fact, able to implement and maintain effective and comprehensive risk management programs.

The fundamental challenge according to respondents is the lack of financial resources. This has implications for training, staffing, and other risk management activities. Even deemed respondents reported that financing was an issue. Yet, almost a third of deemed respondents did not know if they had reinvested their savings in risk management and 22 percent indicated that they did not reinvest it in risk management. Although HRSA's policy is unclear as to its expectations for reinvesting in risk management, it is reasonable to expect deemed health centers to spend some portion of their savings on risk management. Toward that end, HRSA may want to ensure that all health centers are investing adequately in risk management. For deemed health centers in particular, HRSA may want to determine the amount of savings these health centers realize from being deemed and ensure that they are reinvesting some portion of these savings into risk management.

In addition, respondents indicated that the lack of training was a challenge that affected their ability to conduct risk management. Although HRSA has provided opportunities for training, it is clear that health centers want more. HRSA may want to develop a comprehensive, ongoing training agenda for health centers on risk management.

Finally, HRSA may also want to explore creative, inexpensive ways to assist health centers. These could include disseminating best practices or a newsletter; developing tool kits that contain sample policies and procedures; developing Web-based training; and encouraging health centers to take advantage of existing HRSA-funded networks, such as the Healthy Disease Collaborative and the Integrated Service Delivery Initiative, as a vehicle to share resources and information on risk management.

In accomplishing all these goals, we encourage HRSA to work with its partners, such as the State Primary Care Associations and other regional and national associations with an interest in health centers.

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## AGENCY COMMENTS

HRSA responded positively to the report and its comments reflect its commitment to improving risk management for health centers. For HRSA's complete response to the report, see the following section.

HRSA has established a new goal that, by 2010, 100 percent of health centers will participate in risk management training. HRSA indicated that it has several initiatives planned or underway to meet this goal.

HRSA is planning a risk management workshop at the Annual National Association of Community Health Centers Policy and Issues Forum in March 2005. This workshop will feature discussions of risk management practices, existing risk management resources, and the costs associated with conducting risk management. At this workshop, HRSA will provide health centers with estimates on the potential savings from participating in the FTCA deeming process. HRSA also intends to encourage health centers to reinvest those savings in risk management. It is exploring additional opportunities to conduct similar workshops on risk management.

HRSA is in the process of developing a comprehensive risk management training agenda for health centers. This training agenda will address: (1) HRSA's expectations for risk management, (2) mechanisms in which HRSA can assist health centers to obtain continuing medical and professional education, and (3) cost estimates of establishing continuing education. HRSA plans to have a comprehensive risk management agenda in place by June 2005.

▶ A G E N C Y C O M M E N T S



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Resources and Services  
Administration

Rockville MD 20857

JAN 21 2005

TO: George Grob  
Assistant Inspector General  
For Evaluation and Inspections

FROM: Administrator

SUBJECT: Office of Inspector General Final Report: "Risk Management at Health Centers" OEI-01-03-00050

Thank you for the opportunity to provide comments to the above subject final report. Attached please find our response.

Questions may be referred to Gail Lipton in HRSA's Office of Federal Assistance Management at (301) 443-6509.

  
Betty James Duke

Attachment

**Health Resources and Services Administration's Comments on the Office of  
Inspector General's Final Report: "Risk Management at Health Centers"  
OEI-01-03-00050**

The Health Resources and Services Administration (HRSA) has reviewed the final inspection report entitled "Risk Management at Health Centers" and agrees that there are opportunities for improvement in risk management practices in HRSA-supported health centers. HRSA appreciates the opportunity to comment on the report. As this evaluation occurred concurrently with HRSA's implementation of a new organizational structure and strategic planning aimed at improving risk management, the results of this report are timely and have the potential to impact our future risk management operational planning.

The development of the new Division of Clinical Quality (DCQ) within HRSA's Bureau of Primary Health Care (BPHC) enhances HRSA's ability to support the provision of high quality clinical care within the national system of federally-supported health centers. The division accomplishes this primarily through encouraging health center participation in structured risk management programs, external accreditation, and the Health Disparities Collaboratives (a quality improvement initiative based on the evidence-based model of care developed by the Sandy McColl Institute for Healthcare Innovation). A BPHC/DCQ goal is that by 2010, 100 percent of health centers will participate in structured risk management activities as a strategic element for improving health care quality. The actions HRSA has taken and/or plans to take in response to each opportunity for improvement are outlined below.

**Opportunity for Improvement #1: HRSA may want to ensure that all health centers are adequately investing in risk management. For deemed health centers in particular, HRSA may want to determine the amount of savings they realize from being deemed and ensure that they are reinvesting some portion of their savings into risk management.**

Health centers must be knowledgeable about available risk management resources in order to make practical investment choices, regardless of deeming status or malpractice history. HRSA currently disseminates information about risk management resources through State Primary Care Associations (PCAs), the National Association of Community Health Centers (NACHC), the HRSA/BPHC Web site, and the health center listserv. HRSA provides grants to PCAs who then provide training and technical assistance activities to BPHC-supported programs. Through a cooperative agreement with NACHC, health centers receive specific training in implementing and improving risk management programs. The HRSA/BPHC Web site provides health centers with access to risk management guidance, and the health center listserv provides a forum for health centers' discussion and sharing of risk management information.

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The Agency is also working to develop new ways to disseminate information to health centers. HRSA/BPHC is planning a risk management workshop at the 30<sup>th</sup> Annual NACHC Policy and Issues Forum in March of 2005. This workshop will provide participants with relevant background information on risk management concepts and principles and existing risk management resources and associated costs. The results of this report will be incorporated into workshop presentations. Moreover, HRSA will share estimates of the amount of monies health centers save as a consequence of participating in the Health Center Federal Tort Claims Act (FTCA) Medical Malpractice Insurance Program and thus obviating their need to purchase private medical malpractice insurance coverage (otherwise known as FTCA deeming). Through this workshop, HRSA intends to strongly encourage health centers to reinvest their savings in risk management activities and provide them with guidance in identifying readily available risk management resources. Other organizations such as the National Health Care for the Homeless (HCH) Council (including their HCH Clinicians' Network), the National Center for Farmworker Health, and the Migrant Clinicians Network have mechanisms to communicate with clinicians on a regular basis via newsletters and listservs, and all support training sessions and conferences through which they can address risk management issues. BPHC/DCQ is exploring the possibility of conducting risk management workshops at the National Farmworkers Conference in May 2005 and the National HCH Conference in June 2005.

HRSA/BPHC will continue to ensure that risk management processes are in place through the FTCA deeming process. Per section 224 (h)(1) of the Public Health Service Act, a deemed health center must have implemented appropriate policies and procedures to reduce the risk of malpractice and the risk of lawsuits arising out of any health or health-related functions performed by the entity. HRSA/BPHC will also continue to collaborate with HRSA's Office of Performance Review to incorporate risk management performance measures in health centers' performance reviews.

**Opportunity for Improvement #2: HRSA may want to consider developing a comprehensive, ongoing training agenda for health centers on risk management. HRSA may also want to explore creative inexpensive ways to assist health centers, such as disseminating best practices or a newsletter, developing tool kits that contain sample policies and procedures, and encouraging health centers to participate in regional networks for sharing information and resources about risk management.**

HRSA/BPHC agrees that a comprehensive risk management training agenda would be helpful to health centers, and thus began its development of a comprehensive risk management plan in the spring of 2004. HRSA plans to first obtain a broad assessment of the resources and processes used by private medical malpractice companies and others in the health care industry to disseminate and reinforce risk management/quality assurance (RM/QA) concepts and practices in health care organizations.

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HRSA will use this information to model RM/QA strategic and operational plans to include: (1) RM/QA expectations for federally-supported health centers; (2) mechanisms by which HRSA/BPHC can facilitate health center staff participation in structured RM/QA continuing medical/professional education (CME/CPE) activities (e.g., Web-based resources for CME/CPE programs); and (3) an estimation of the human and financial resources required by HRSA/BPHC, health centers and/or our partners (e.g., NACHC, PCAs) to develop risk management continuing education for health centers. HRSA is currently in negotiations with a contractor with nationally-recognized expertise in this field and plans to obtain a comprehensive training agenda for health centers on risk management by June of 2005.

In addition, HRSA will continue to provide health centers with access to risk management services that it has developed and/or funded. These services are provided either directly by HRSA at no cost (e.g., Health Center Program Expectation Policy Information Notice (PIN), Credentialing PIN, FTCA Helpline, on-site technical assistance visits), or through cooperative agreements and/or contracts with NACHC and PCAs.

## Methodology

### Document Review

We obtained and reviewed relevant documents associated with risk management and health centers, such as laws, regulations, policies, guidance documents, and training materials. These documents included:

- Federally Supported Health Center Assistance Acts of 1992 and 1995
- 42 C.F.R. Subpart C-Grants for Operating Community Health Centers
- HRSA's Policy Information Notices (1998-23, 1999-08, 2002-22, 2002-24, 2002-32)
- Joint Commission's Comprehensive Accreditation Manual for Ambulatory Care
- HRSA's Federal Tort Claims Act Clinician's Handbook
- HRSA's Deeming and Re-Deeming Application Forms
- HRSA's Primary Care Effectiveness Review Protocol (March 2000)
- Resources provided to health centers during HRSA-sponsored training on risk management by the National Association of Health

### Stakeholder Interviews

We interviewed experts within and outside of HRSA to learn about risk management and to identify potential key risk management practices to use on the survey. Persons interviewed included:

- HRSA officials
- Representatives from the National Association of Community Health Centers
- Representatives from several State Primary Care Associations
- Representatives from the Association of Healthcare Risk Managers
- Representatives from the Joint Commission

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- Representatives from the Management Assistance Corporation, a HRSA contractor that provides clinical risk assessment for health centers
- Representatives from private malpractice insurance companies that offer malpractice insurance and risk management services for health care facilities, including Princeton Risk Protection, Inc.

**Survey of Health Centers**

We surveyed a stratified random sample of 248 health center grantees out of the 835 grantees that received funding from HRSA in FY 2002. We chose this sample size to ensure a precision of +/- 5 percent at the 95-percent confidence level. However, later methodological limitations prevented us from generalizing to the entire population. (See section on data limitations on page 28.)

We drew the sample from a list provided by HRSA. Prior to pulling the sample, we eliminated 17 health centers from the original 852 in the list provided by HRSA because we lacked information on the number of patients served. (See Table 4.)

We drew a stratified random sample from the 832 remaining health centers. We divided the population into three strata based on the number of patients served in FY 2002. (See Table 4 for the strata.) We defined the strata based on the way the data were distributed. From each of the first two strata, we randomly selected 91 health centers from each of the totals. We included all 86 health centers from the third stratum. This resulted in a total sample of 268 health centers. We eliminated 20 health centers from the 268 because their names, in whole or in part, matched those of health care organizations that are part of ongoing investigations

| <b>Strata by Number of Patients Served in FY 2002</b> | <b>Population of Health Centers</b> | <b>Revised Population of Health Centers</b> | <b>Sample of Health Centers</b> | <b>Centers That Received a Survey</b> | <b>Number of Survey Respondents*</b> |
|---|-------------------------------------|---|---------------------------------|---------------------------------------|--------------------------------------|
| < 5,000 patients                                      | 226                                 | 226   | 91                              | 89                                    | 55                                   |
| 5,000 - 30,000 patients                               | 523                                 | 523   | 91                              | 83                                    | 60                                   |
| > 30,000 patients                                     | 86                                  | 86  | 86                              | 76                                    | 50                                   |
| Unknown   | 17                                  | 0   | 0                               | 0                                     | 10                                   |
| <del>100 Teachers</del>                               | <del>000</del>                      |   |                                 |                                       |                                      |
| <b>Overall Total</b>                                  | <b>852</b>                          | <b>835</b>                                  | <b>268</b>                      | <b>248</b>                            | <b>175</b>                           |

\*The data in this column were self-reported by respondents and not based on actual numbers provided by HRSA.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

conducted by the Office of Investigations within the Office of Inspector General. This resulted in a final sample size of 248.

The survey contained 43 questions regarding the importance of the 16 specific risk management practices, a self-assessment of how centers were doing on each of these practices, and challenges to implementing these practices. We identified these 16 risk management practices and potential challenges from our document review, which included applicable HRSA policies and regulations and risk management standards and training materials from other private organizations and Federal agencies. We also identified these practices and challenges from interviews with key stakeholders.

We pretested the survey with two health centers. We addressed the survey to the health centers' executive directors as identified by HRSA. In the cover letter we asked the executive directors to complete the survey.

To encourage a high response rate, we sent an introductory letter to each health center in our sample explaining the purpose of the survey. In the cover letter, we emphasized that the survey was anonymous. (The survey was anonymous with the intent to reduce bias in our survey results.) In our introductory letter we also included a brief description of the Office of Evaluation and Inspections and a two-page summary of the inspection.

One week later we mailed the first survey. We sent a second survey 1 month later. All health centers received the second survey because we were unable to determine which health centers had already responded due to the anonymity of the respondents. Finally, 1 month later, we followed up with telephone calls to all health centers for which we could readily obtain working telephone numbers.

We received 175 responses to the survey, for a response rate of 71 percent. (See Table 4 on the previous page.) Because not all respondents answered every question, the actual number of respondents varies by question. Therefore, throughout the report we provide percentages based on the actual number of respondents for each question.

We conducted subanalysis by the self-reported number of patients served (i.e., small and medium versus large) and by deemed status (i.e., deemed versus nondeemed) for selected questions.

We provide self-reported, descriptive information on the respondents. (See Tables 5, 6, 7, 8, and 9 on the following pages.)

**Data Limitations.** Because the survey was anonymous and we obtained only self-reported estimates about the number of patients served in FY 2002, we were unable to correctly determine which stratum each respondent fell into. As a result, we could not weight the data, nor could we calculate confidence intervals. Therefore, we cannot make statistical projections to the entire population of health centers based on the survey data. The data presented in the report are simple frequencies of the responses. We did not independently verify any statements health centers made on the survey. Finally, we are unable to conduct a nonrespondent analysis because the survey was anonymous. Therefore, we cannot estimate the level of bias among respondents. These limitations apply to all data analysis and comparisons presented in the report.

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| <b>Table 5. Percentage of Health Center Respondents by Type*</b> |                                  |                             |                                 |
|--|----------------------------------|-----------------------------|---------------------------------|
| <b>Type of Health Center</b>                                     | <b>Percentage of Respondents</b> | <b>Percentage of Sample</b> | <b>Percentage of Population</b> |
| Community Health Center  | 89                               | 89                          | 88                              |
| Migrant Health Center  | 21                               | 19                          | 15                              |
| Health Care for the Homeless                                     | 16                               | 20                          | 18                              |
| School-Based Health Center                                       | 1                                | 1                           | 4                               |
| Public Housing Residents   | 7                                | 12                          | 9                               |

\*Numbers exceed 100% because a health center may be more than one type.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

| <b>Table 6. Percentage of Health Center Respondents by Amount of HRSA Section 330 Funding Received in FY 2002*</b> |                                  |                             |                                 |
|--|----------------------------------|-----------------------------|---------------------------------|
| <b>Amount of Funding in FY 2002</b>  | <b>Percentage of Respondents</b> | <b>Percentage of Sample</b> | <b>Percentage of Population</b> |
| < \$500,000  | 19                               | 25                          | 21                              |
| \$500,000-\$1 million  | 32                               | 25                          | 30                              |
| \$1-\$2 million  | 19                               | 21                          | 29                              |
| > \$2 million  | 30                               | 29                          | 21                              |

\*Numbers do not add up to 100% due to rounding.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

| <b>Table 7. Percentage of Health Center Respondents by Number of Delivery Sites in FY 2002*</b> |                                  |                             |                                 |
|---|----------------------------------|-----------------------------|---------------------------------|
| <b>Number of Delivery Sites</b>   | <b>Percentage of Respondents</b> | <b>Percentage of Sample</b> | <b>Percentage of Population</b> |
| 1   | 22                               | 19                          | 21                              |
| 2-5   | 44                               | 43                          | 47                              |
| > 5   | 35                               | 38                          | 32                              |

\*Numbers do not add up to 100% due to rounding.

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

| <b>Table 8. Percentage of Deemed Health Center Respondents</b> |                                  |                             |                                 |
|--|----------------------------------|-----------------------------|---------------------------------|
| <b>Federal Tort Claims Act Status</b>                          | <b>Percentage of Respondents</b> | <b>Percentage of Sample</b> | <b>Percentage of Population</b> |
| Deemed   | 88                               | 74                          | 73                              |
| Nondeemed  | 12                               | 26                          | 27                              |

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

| <b>Table 9. Percentage of Health Center Respondents Accredited by the Joint Commission</b> |                                  |                             |                                 |
|--|----------------------------------|-----------------------------|---------------------------------|
| <b>Joint Commission Status</b>   | <b>Percentage of Respondents</b> | <b>Percentage of Sample</b> | <b>Percentage of Population</b> |
| Accredited   | 51                               | 34                          | 34                              |
| Nonaccredited  | 49                               | 66                          | 66                              |

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

## Additional Analysis by Size of Respondents

| <b>Table 10. The Level of Importance of Risk Management Practices by the Size of Health Center Respondents*</b> |  |   |
|---|--|---|
| <b>Risk Management Practice</b>   | <b>Percentage of Small and Medium Respondents Who Indicated They Were Doing an Excellent or Good Job at Implementing This Practice</b> | <b>Percentage of Large Respondents Who Indicated They Were Doing an Excellent or Good Job at Implementing This Practice</b> |
| Regular Staff Training on Risk Management   | 50   | 66  |
| Privileging of Health Care Professionals  | 82   | 96  |
| Regular Patient Satisfaction Survey   | 78   | 92  |
| Up-To-Date Policies/Procedures on Risk Management   | 66   | 78  |
| Active Quality Improvement Programs   | 85   | 96  |
| Comprehensive Patient Medical Records   | 86   | 96  |
| Onsite Assessment of Risks and Risk Management Practices  | 56   | 66  |
| Internal Incident Reporting Systems   | 81   | 90  |
| Credentialing of Health Care Professionals  | 94   | 100   |
| Clear Communication With Patients   | 91   | 96  |
| Documentation of Informed Consent   | 88   | 90  |
| Clear Communication With Providers  | 90   | 90  |
| Formal Patient Grievance Mechanism  | 88   | 88  |
| Appropriate Use of Clinical Protocols   | 83   | 78  |
| Ongoing Peer Review of Patient Cases  | 73   | 68  |
| Patient Tracking System   | 69   | 61  |

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

\*We defined the size of a health center based on the number of patients served in FY 2002 as reported by respondents. Small centers reported serving fewer than 5,000 patients, medium centers reported serving between 5,000 and 30,000 patients, and large centers reported serving more than 30,000 patients.

**Table 11. Challenges to Conducting Risk Management by the Size of Health Center Respondents\***

| <b>Challenges to Risk Management</b>                      | <b>Percentage of Small and Medium Respondents Who Indicated it Was a Challenge to a Major or Moderate Extent</b> | <b>Percentage of Large Respondents Who Indicated it Was a Challenge to a Major or Moderate Extent</b> | <b>Percentage of All Respondents Who Indicated it Was a Challenge to a Major or Moderate Extent</b> |
|---|--|---|---|
| Lack of financial resources                               | 86   | 80  | 84  |
| Lack of dedicated full-time equivalent staff              | 85   | 74  | 83  |
| Lack of clinical staff time                               | 86   | 74  | 82  |
| Lack of expertise among staff regarding risk management   | 66   | 60  | 64  |
| Lack of staff training on risk management                 | 68   | 54  | 64  |
| Lack of technical assistance                              | 54   | 40  | 49  |
| Lack of clear requirements from HRSA                      | 49   | 44  | 47  |
| Lack of commitment by the health center's governing board | 13   | 2   | 10  |

Source: Office of Evaluation and Inspections' analysis of survey responses, 2004.

\*We defined the size of a health center based on the number of patients served in FY 2002 as reported by respondents. Small centers reported serving fewer than 5,000 patients, medium centers reported serving between 5,000 and 30,000 patients, and large centers reported serving more than 30,000 patients.

## ► A C K N O W L E D G M E N T S

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► E N D N O T E S

<sup>1</sup> Authorized under section 330 of the Public Health Service Act.

<sup>2</sup> U.S.C. Title 28, Part VI, Chapter 171.

<sup>3</sup> The Federally Supported Health Center Assistance Act of 1992 (P.L. 102-501) provided initial coverage to eligible health centers under the Federal Tort Claims Act (FTCA) for a 3-year period. This provision became permanent under the Federally Supported Health Center Assistance Act of 1995 (P.L. 104-73).

<sup>4</sup> Typically health centers still have to purchase additional medical malpractice insurance to cover certain employees not covered under the FTCA and claims from years not covered under the FTCA. This insurance is referred to as gap or supplemental insurance and generally is less expensive than comprehensive medical malpractice insurance.

<sup>5</sup> Funds that are not spent remain in this fund for the following year.

<sup>6</sup> “Medical Malpractice: Federal Tort Claims Act Coverage Could Reduce Health Centers’ Costs,” Government Accountability Office, April 1997 (GAO/HEHS-97-57).

<sup>7</sup> Federally Supported Health Centers Assistance Act of 1992 and 1995 (P.L. 102-501).

<sup>8</sup> “Credentialing and Privileging of Health Care Practitioners,” Policy Information Notice 2001-16, HRSA, July 17, 2001; and “Clarification of Bureau’s of Primary Health Care Credentialing and Privileging Policy Outlined in Policy Information Notices 2001-16,” Policy Information Notice 2002-22, HRSA, July 10, 2002.

<sup>9</sup> “Comprehensive Accreditation Manual for Ambulatory Care,” Joint Commission on Accreditation of Healthcare Organizations, Draft 2004-2005.

<sup>10</sup> Federally Supported Health Centers Assistance Act of 1992 and 1995 (P.L. 102-501).

<sup>11</sup> “Credentialing and Privileging of Health Care Practitioners,” Policy Information Notice 2001-16, HRSA, July 17, 2001; and “Clarification of Bureau’s of Primary Health Care Credentialing and Privileging Policy Outlined in Policy Information Notices 2001-16,” Policy Information Notice 2002-22, HRSA, July 10, 2002.

<sup>12</sup> We defined these categories based on the number of patients served in FY 2002. Small centers reported serving fewer than 5,000 patients, medium centers reported serving between 5,000 and 30,000 patients, and large centers reported serving more than 30,000 patients.

<sup>13</sup> HRSA policies require health centers to provide training; however, the policies do not specify how much training is required. HRSA does not require onsite review, peer review, or patient tracking.