2025 KOnnect

Mining Root Cause Analysis for Strategic Risk Transformation

SPEAKER

Katie McKinley, MHA, CPPS

Senior Clinical Risk Services Manager | UNT Health Clinical Practice Group

CONNECTING RISKS THAT MATTER

2025 KOnnect

University of North Texas Health Science Center

UNT Health Clinical Practice Group &
SaferCare Texas

CONNECTING RISKS THAT MATTER

UNT Health Clinical Practice Group

- Academic Clinical Practice
  - 11 Primary Care & Specialty Clinics + partnership with UNT clinics
  - Resident/Fellow Continuity Clinic in partnership with Medical City (HCA)
  - Multidisciplinary practice model with student rotations
  - Annual Encounters: **90k w/ 24k+ unique patients**
  - Team: **60+ providers & 130+ clinical team members**
- Riskonnect Go-Live: **August 1, 2022**
  - 1650+ events reported

SaferCare Texas

- First Ambulatory Care Patient Safety Organization (PSO) in Texas
  - Legal protection for Patient Safety Work Product (PSWP)
  - Consultation for Patient Safety Activities
  - Riskonnect Access
    - **Go-Live – October 11, 2023**
  - Various training offerings
    - Crisis Prevention Institute (CPI) & QPR Gatekeeper Trainers
    - Stop the Bleed & Friday Night at the ER
    - MOPS (Medical Office Patient Safety) Survey
    - Just Culture/High Reliability Organization/TeamStepps

2025 KOnnect

You Have A Choice

Will you go down the rabbit hole?

CONNECTING RISKS THAT MATTER

Which Would You Choose?

RED PILL

- Acknowledge there is room for improved safety
- Deny the accepted
- Set sights on more than what is required or regulated
- Move toward change

BLUE PILL

- Assume care is safe
- Accept status quo
- Satisfied with meeting the benchmark

2025 KOnnect

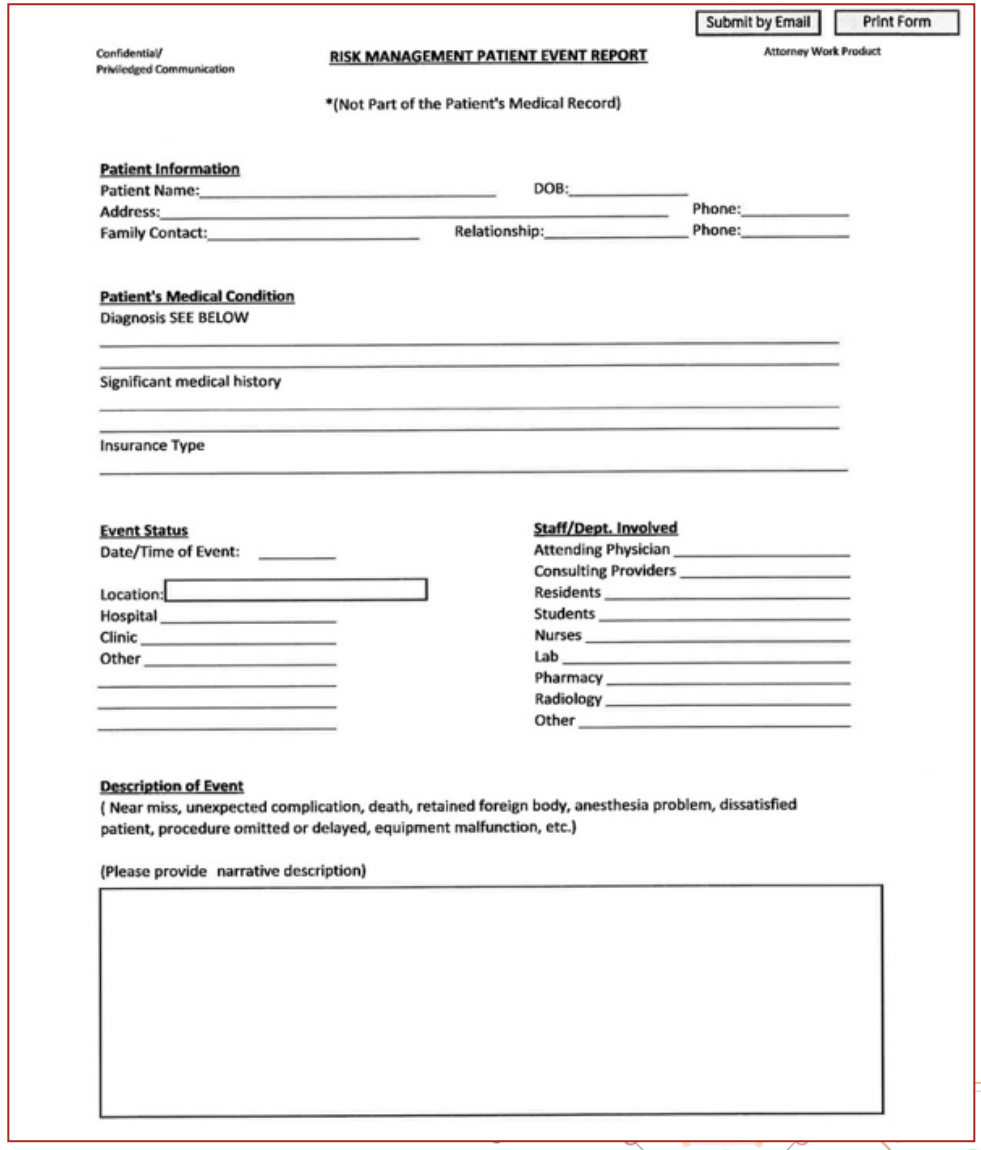
Our Red Pill Journey

Let the mining begin

CONNECTING RISKS THAT MATTER

Antiquated to Transformative

- Inherited PDF form
- Riskonnect Journey (3 years)
  - Buy-in to launch
- Integrated Reports
  - Clinic and Practice Level
- Deep Dives
  - RCA & Trend Analysis
- Strategic Integration



Submit by Email | Print Form

Confidential/ Privileged Communication

RISK MANAGEMENT PATIENT EVENT REPORT

Attorney Work Product

*(Not Part of the Patient's Medical Record)

Patient Information
Patient Name:_____ DOB:_____
Address:_____ Phone:_____
Family Contact:_____ Relationship:_____ Phone:_____

Patient's Medical Condition
Diagnosis SEE BELOW
_____
_____
Significant medical history
_____
_____
Insurance Type
_____

Event Status
Date/Time of Event: _____
Location:
Hospital _____
Clinic _____
Other _____
_____
_____
_____

Staff/Dept. Involved
Attending Physician _____
Consulting Providers _____
Residents _____
Students _____
Nurses _____
Lab _____
Pharmacy _____
Radiology _____
Other _____

Description of Event
(Near miss, unexpected complication, death, retained foreign body, anesthesia problem, dissatisfied patient, procedure omitted or delayed, equipment malfunction, etc.)

(Please provide narrative description)

Chipping Away at Dynamite

Basic Event Investigation

- Day-to-day events
- Varying impact/severity
- Clinic Level Impact
- **Goal: 30 days or less**

Root Cause Analysis

- Severity Driven
- Lower threshold in ambulatory care
- Clinic or Practice level impact based on situation
- **Goal: 45 days**

Trend Analysis

- Multiple events
- Practice level impact
- **Months/Years**

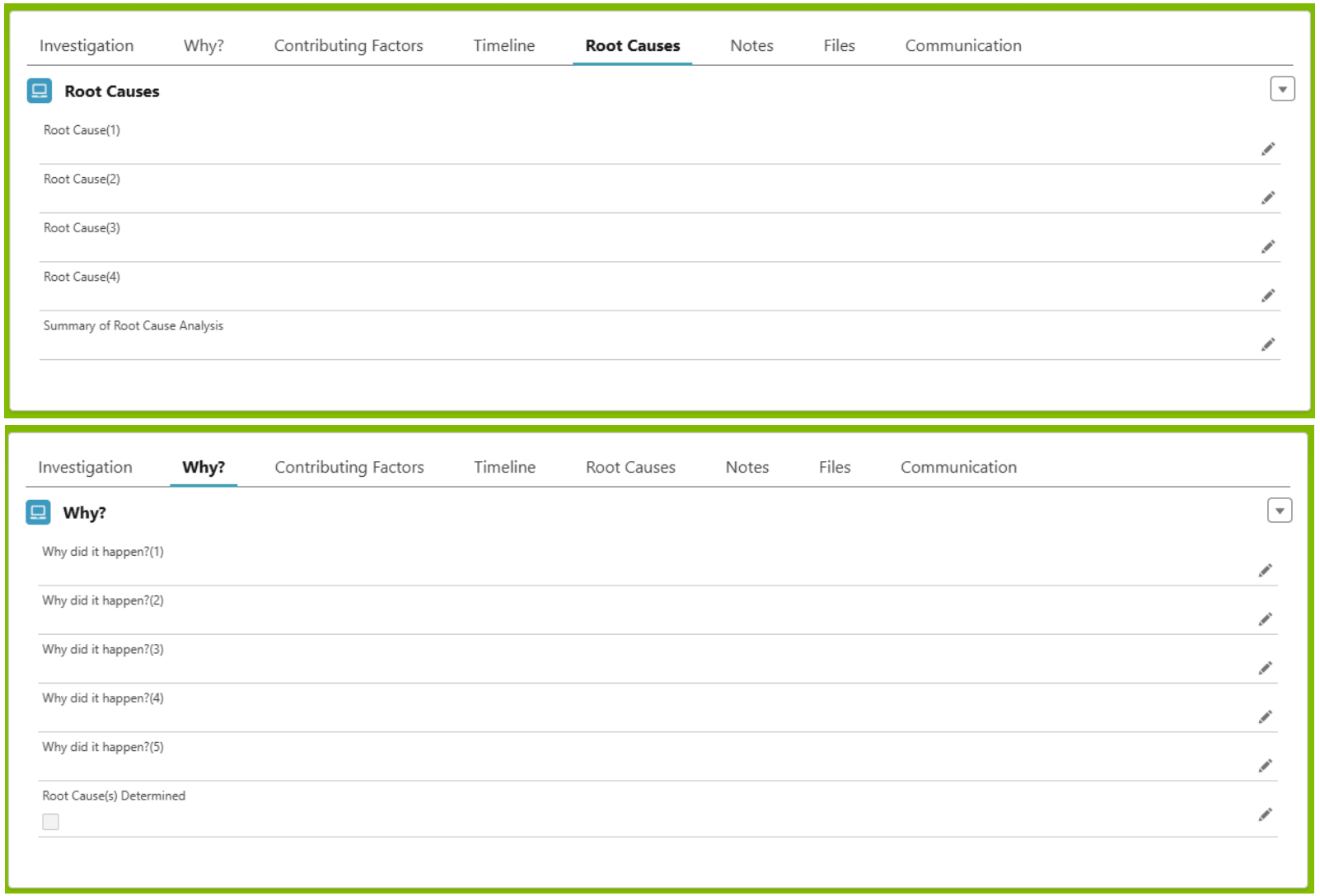
Basic Event Investigation

- Led by clinic-level leaders
  - Clinic Operations and Nursing Managers, Clinical Medical Directors
  - Administration (Operations, EMR, Billing, etc.)
- Risk Management support
  - Monitoring for action, severity, trends, and closure
- Building blocks for RCA and Trend Analysis

Root Cause Analysis

- Serious Safety Event (SSE) Criteria
  - Standard (death, severe harm, or permanent harm)
  - Indicative of a serious process gap
  - Ambulatory Special Circumstances
    - Medication/Vaccination administered to the wrong patient
      - Including near misses
    - Events related to Cardiology testing in the Nuclear Cardiology clinic
    - Medical emergencies due to in-office treatment, regardless of severity

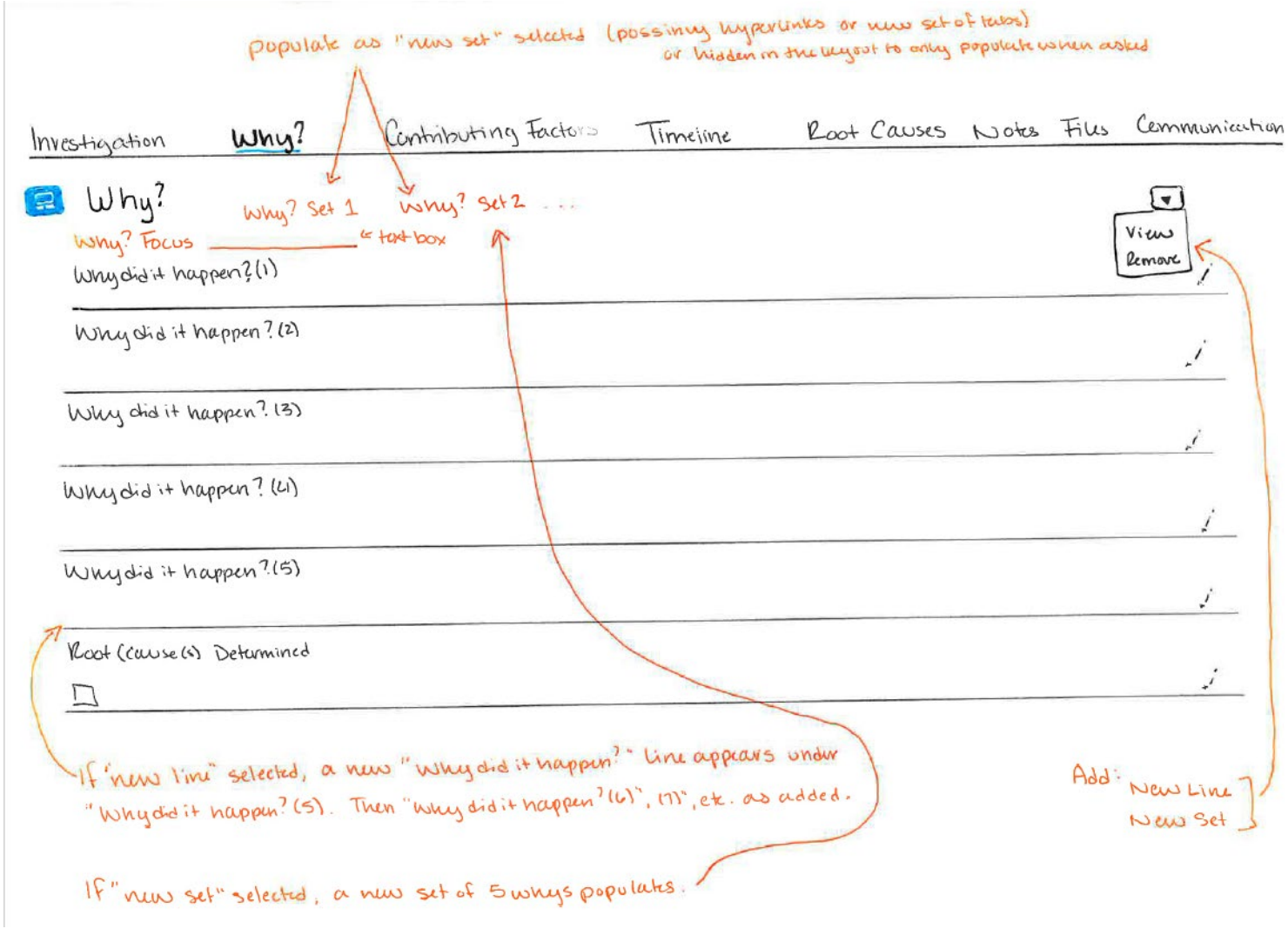
Root Cause Analysis



Limited to **4 Root Causes** and **5 Whys**

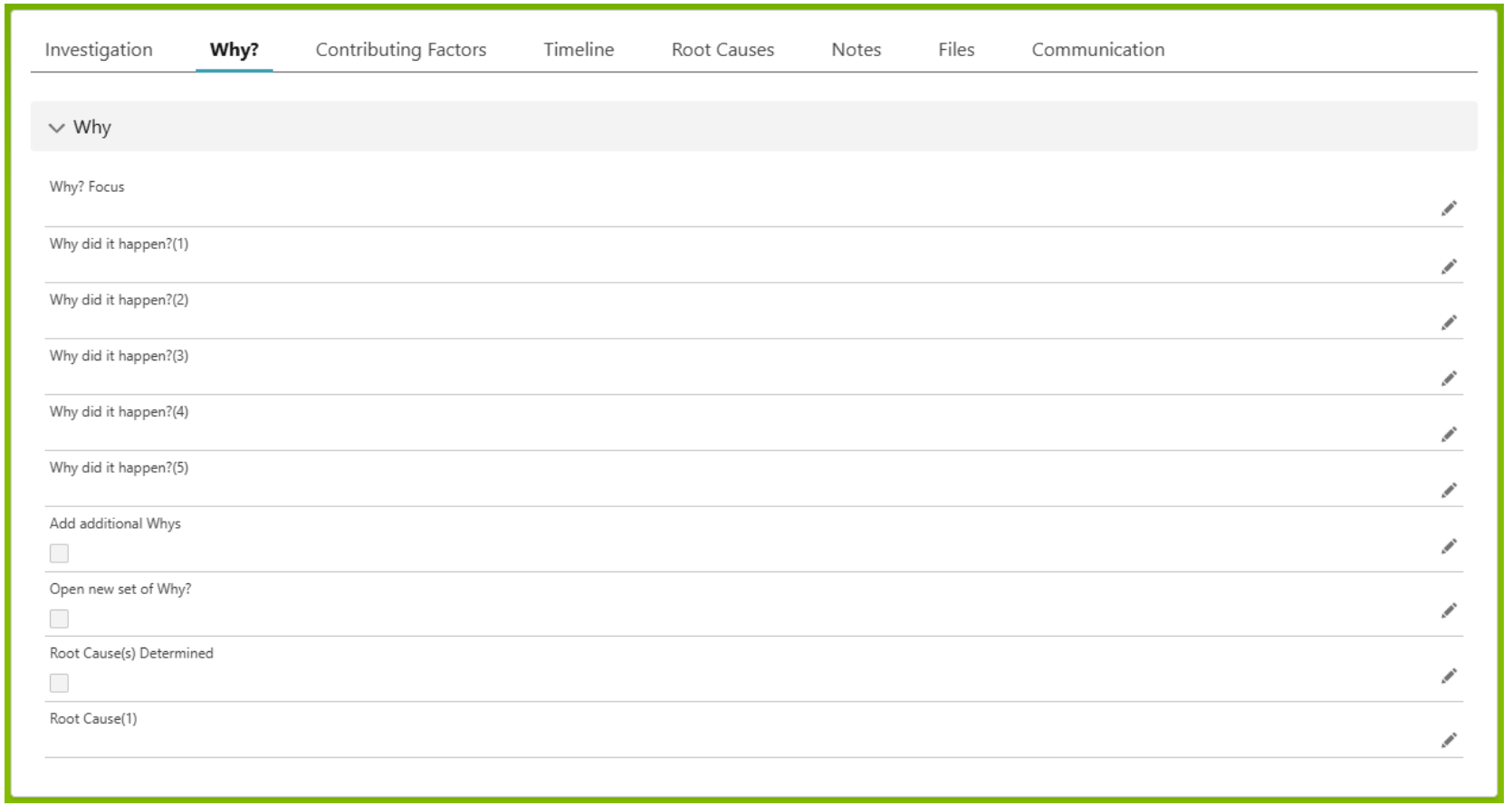
How do we expand functionality to fit our needs?

Root Cause Analysis



- Design for our needs
- Collaborate with Success Services

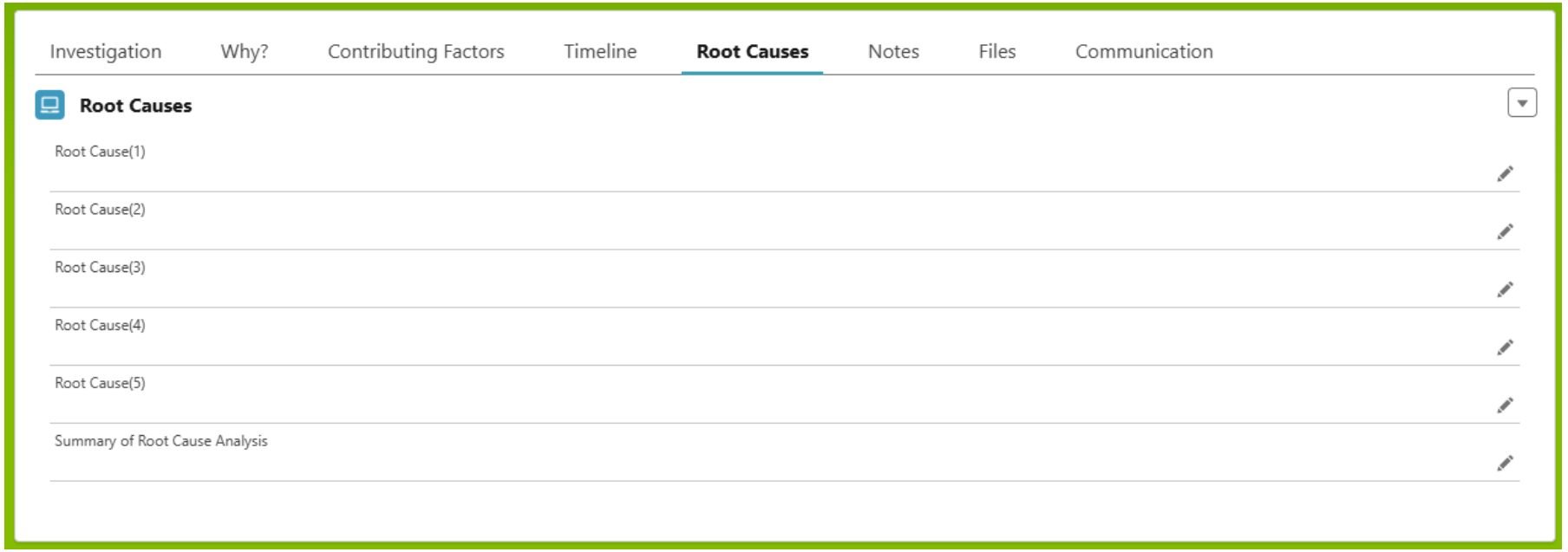
Root Cause Analysis



Results

Expanded “Why” functionality

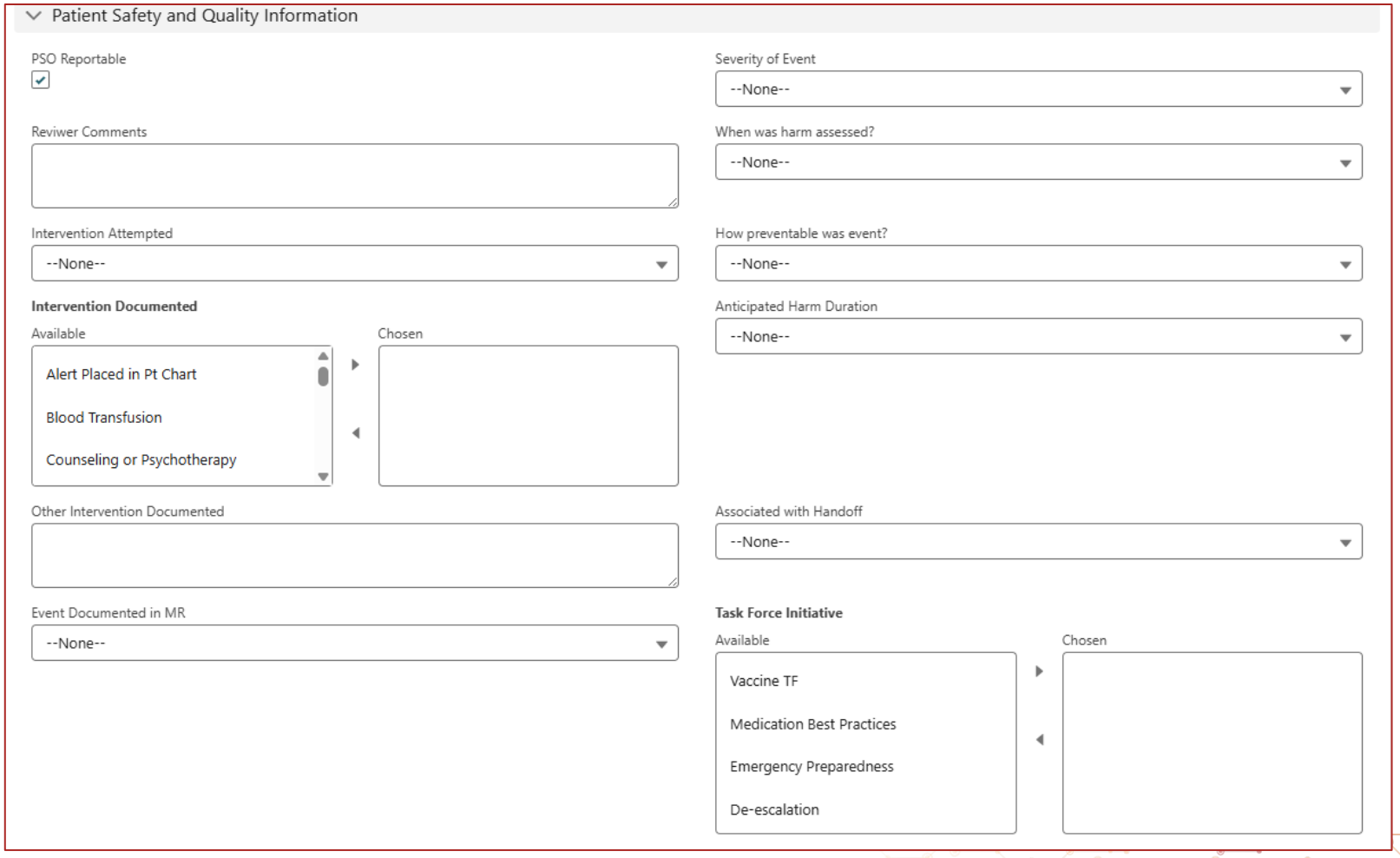
Root Cause Analysis



Results
Additional
Root Cause

Trend Analysis

- Task Force Initiative
- Query the Field
- Standard Report
- External Brainstorming



2025 KOnnect

Strategic Risk Transformation

Skill Download

CONNECTING RISKS THAT MATTER

What Skill Do We Need?

- Driven by investigation, RCA, and Trend Analysis
  - Not required to wait for claim-based financial impact
- Is there a common theme?
  - It may not be the main focus of an event
- Is it clinic or practice level impact?
- Consider the Risk Matrix
- Impact internally and externally

Building the Team

- Leveraging Riskonnect data
  - Data is part of the team
  - Pairing quantitative with qualitative
- Stakeholders
- Frontline
- Experts and novices
- Roles and responsibilities
- Outline expectations

Team Download

- “How” is equally important as “what”
- Advocate with stakeholders
- Find your champions
- Make safety a required part of your strategic plan
- Track the data
- Embrace PDSA Cycles

Currently Downloading…

- Trend Analysis Riskonnect integration
  - Related lists
  - Expand functionality – brainstorm stage
- UNT Health Safety Initiatives
- Cost savings
  - Operational efficiencies
  - Service recovery
  - Reduction in turnover

2025 KOnnect

Questions?

CONNECTING RISKS THAT MATTER

THE
MATRIX

Thank You!

CONNECTING RISKS THAT MATTER

2025 KOnnect

Connect with me.

Katie McKinley, MHA, CPPS

e: Kaitlyn.McKinley@unthealth.edu

t: 817-735-2162

w: https://www.unthsc.edu/patient-care/

in/kaitlyn-mckinley-mha-cpps-945a87143

2025 KOnnect