Mission Statement: Foothills Community Health Care is a comprehensive and compassionate medical home that offers affordable, high-quality primary and preventive care for individuals and families.

Foothills Community Health Care, Inc.
Board of Directors Meeting
Agenda for June 13, 2019

Presenter	Business Issue	Action Required
Amy Anderson	• Call to Order • Establishment of Quorum • Mission Statement • May 4, 2019 Board Minutes	None Establish None Board Approval
Ellie Taylor	• Quality Assurance Committee • Quality Improvement Program 2019 • Policy CO03 – EHR Use and Documentation • Eliminate Policy CO02, CO08 and CO11	None Board Approval Board Approval Board Approval
Wayne Helms	• Personnel Committee • Policy HR045 – Risk Management	None Board Approval
Manju Lakra	• CMO Report • Risk Management Report	None None
Mary Arnette	• FCHC Audit Update	None
Mark Rajkowski	• CEO Report • Board Website Presentation	None None
Amy Anderson	• Adjournment	Board Approval

Next board meetings: July 11, 2019

Minutes of the Board of Directors' Meeting
Foothills Community Health Care, Inc.
May 4, 2019

The meeting was called to order by Amy Anderson, Board Chair.

Board members present: Leah Sanders, Amy Anderson, Keith Moody, Kyle Hicks, Ellie Taylor Wayne Helms, Peter Sparks, Kendra Johnson & Janet Marsh

Board members not present: Cindy Trimmier-Lee

Summary of Agenda:

Business Issue	Action Required	Action Taken/ Notes
Amy Anderson		
• Call to Order	None	None
• Establishment of Quorum	Establish quorum	Quorum established
• Mission Statement	None	None
• April 4, 2019 Board Minutes	Board Approval	Approved
Wayne Helms		
• Personnel/Nominating Committee Minutes	None	None
Janet Marsh		
• Marketing Committee Minutes	None	None
Manju Lakra		
• CMO Report	None	None
Mary Arnette		
• March 2019 Financials	Board Approval	Approved
• Audit Proposal	Board Approval	Approved
Mark Rajkowski		
• CEO Report	None	None
• Semi Annual Workforce Report	None	None
Amy Anderson		
• Adjournment	Board Approval	Approved

Prior to the Board of Directors Meeting, the Board and staff had their Strategic Planning Retreat facilitated by Lathran J. Woodard of the South Carolina Primary Health Care Association. The meeting began at 9:00AM – 2:30PM. The current strategic plan was reviewed and suggestions for modifications were made. Ms. Woodard will send us her ideas and changes when complete.

Narrative Account: The Board of Directors of Foothills Community Health Care met on Thursday, May 4, 2019 for their monthly meeting. The meeting was called to order at 3:00 p.m. by Board Chair, Amy Anderson. With nine (9) board members present, quorum was established. Amy began the meeting by reading FCHC's Mission Statement.

The minutes from the Board Meeting on April 4, 2019 were emailed to each board member prior to the meeting for their review.

- **Ellie Taylor made a motion to approve April 4th Board minutes. Keith Moody seconded the motion and the motion carried.**

Wayne Helms, Personnel Committee

- The Personnel Committee met on Monday, April 8, 2019.
- Mark presented an overview of current employee's performance and discussed on-going improvement plans.
- Mark discussed pending grant applications and the number of employees that would potentially be hired to fill new positions.
- FCHC dress code policy was discussed when concerns were raised regarding "casual Friday". Mark and his team will present ideas at the next Personnel Committee meeting for options to change the dress code.

Janet Marsh, Marketing Committee

- The Marketing Committee met on April 15, 2019.
- The Committee reviewed the New Patient Growth chart and 385 new patients were seen in the first quarter.
- The top responses to "How did you hear about us" was from friends or family, online search, marketing materials and billboard.
- Foothills purchased a new tent to use for events and all was pleased with the design.
- Anthony is working with Kelly Shaw, behavioral health counselor in Easley, to find ways to increase patients.
- The Marketing Budget and events were reviewed for the first quarter. Also, plans for the up-coming quarter were reviewed.

Manju Lakra, CMO Report

- Dr. Lakra presented the top 10 diagnosis with a chart showing percentage to patient visits.
- Mental Health Disorder did not change, upper respiratory came down, asthma visits increased slightly, and back pain and diabetes came down.
- There were 889 visits in April 2019.

Mary Arnette, CFO

- The Finance Committee met on April 25, 2019 to discuss and review the March 2019 Financials in detail.
- The March 2019 Financial board packet included:
    - Financial Highlights
    - Financial Snapshot
    - Profit and Loss Budget vs. Actual
    - Balance Sheet
    - Statement of Cash Flow
    - Aging by Financial Class, Group and Summary
- Profit and Loss Statement
    - Total operating Income for the month was $196,498; $5635 less than budget
    - Total expenses were $215,699.
    - Other non-operating income was $260.
    - March had a loss of ($18,941).
    - Fiscal year-to-date Profit is $8,959.

- Balance Sheet
  - Cash on Hand - $724,691
  - Total Assets - $1,841,521
  - Accounts Payable - $51,584
  - Total Liabilities - $544,438
  - Total Equity - $1,297,083
  - Total Liabilities and Equity - $1,841,521
  - Net cash increase for the Period - $67,853 (Statement of Cash Flow)
- The financial statements were discussed as well as the expenses that primarily created the loss for the month.
- The items that created the loss are the following, but not limited to:
  - Laptops for new staff
  - Chronic care management services
  - Post card advertisement cost
  - Some conference expenses
- Mary Arnette presented the 2019 Medicare PPS Rate and requested a rate increase as follows:

National FQHC Rate:	$169.77
SC Geographical Factor:	0.959
Encounter Base Rate	$ 162.81
Preventative Encounter Rate:	$ 218.16

- **The Finance Committee made the motion to approve the March 2019 Financials. Wayne Helms seconded the motion and the motion carried.**
- **The Finance Committee made the motion to approve the Medicare PPS rate increase for 2019. Kendra Johnson seconded the motion and the motion carried.**
- Mary Arnette presented the Petway Mills & Pearson audit proposal for the 2019 fiscal year end for the financial audit, single audit and form 990 preparation for the total of $10,100.
- The proposal was discussed and considered to be a very good rate for the services.
- It was also discussed that the lead auditor from PM&P was changed last year to give a fresh perspective on the audit.
- **The Finance Committee made the motion to accept/approve the proposal for the PM&P audits and form 990 in the amount of $10,100. Keith Moody seconded the motion and the motion carried.**

Mark Rajkowski, CEO Report

- Mark presented a chart showing unduplicated patients, encounters, payor mix and new patients.
- Medicare had the largest percentage of payments with 35% and next was Blue Cross Blue Shield at 23%.
- Unduplicated patients for 2019 YTD are 1447.
- The NAP (New Access Point) grant application for Anderson was submitted on time.
- The Oral Health Expansion Grant is a one-time funding for a minimum of $300,000 and is due May 21, 2019.
- Estimated cost for mobile dental unit is between $300,00 - $425,000.
- **Wayne Helms made the motion to approve for Mark Rajkowski to pursue the Oral Health Expansion Grant. Janet Marsh seconded the motion and the motion carried.**
- The SUD non-competitive grant for $145,000 is due May 13, 2019: Exploring options of Medication Assisted Treatment and Telemedicine with Medical University of South Carolina.
- **Janet Marsh made the motion to approve for Mark Rajkowski to pursue the SUD Non-Competitive Grant for $145,000. Wayne Helms seconded the motion and the motion carried.**

- Staff has investigated EMR systems: Aprima, Athena, eClinical works, EPIC and Success EHS.
- FCHC's recommendation is to switch to Aprima with Board approval to sign new contracts.
- **Wayne Helms made the motion to approve Mark Rajkowski to sign contracts to switch to Aprima EMR. Ellie Taylor seconded the motion and the motion carried.**
- On April 19, 2019 FCHC received HRSA approval on capital construction portion of the SUD grant for Easley to use $175,000 for renovation.
- On April 25, 2019 both Easley and Clemson were awarded PCMH certification.
- On April 27, 2019, Dr. Thompson was named Doctor of the Year by Palmetto Medical, Dental and Pharmaceutical 123rd annual meeting/convention.
- On May 21, 2019 FCHC will have a full staff training on Sexual abuse and Human Trafficking.
- Changing hours of operation has been discussed and will need board approval.
- Following are the hours for approval:
    - Easley hours will remain 8AM – 5:00PM – Monday through Friday
    - Clemson hours will be 8:00AM – 5:00PM- Monday, Wednesday, Thursday & Friday. Tuesday hours will be 8:00AM – 7:00PM with two (2) providers.
- **Janet Marsh made the motion to approve the request to change Clemson hours of operation. Peter Sparks seconded the motion and the motion carried.**
- The semi-annual workforce report was presented with two (2) terminations for the report period of 8.5%. Total number of employees averaged 24.
- **Leah Sanders made a motion to adjourn the meeting. Wayne Helms seconded the motion and the motion carried.**

Exhibits/Handouts/Emails

1. Agenda for May 4, 2019
2. Personnel & Nominating Committee Minutes
3. Marketing Committee Minutes
4. Top 10 Diagnosis Chart
5. March 2019 Financials & Committee Meeting Minutes
6. Audit Proposal from Petway, Mills & Pearson, PA
7. Unduplicated Patients, Encounters, Payor Mix & New Patient Chart
8. CEO Report
9. Semi Annual Workforce Report (YTD Turnover Comparison)
10. Board Committee List, 2019
11. Certificate of Recognition on PCMH

APPROVALS:

1. April 4, 2019 Board Minutes
2. March 2019 Financials
3. Medicare PPS rate increase
4. Audit proposal and form 990 for Petway, Mills & Pearson
5. Oral Health Expansion Grant
6. SUD Non-Competitive Grant
7. To sign Aprima Contracts
8. Change of Hours of Operation
9. Adjournment

All meetings will take place in the Corporate Board Room, 1011 Tiger Blvd, Suite 250, Clemson, SC. **The next board meeting is July 11, 2019.**

_____ June 10, 2019

Recorded by Melody L. Young Date

_____ _____

Approved by Board of Directors Date

Foothills Community Health Care, Inc.
Quality Assurance Committee

Members: Ellie Taylor: Chair, Kendra Johnson, Kyle Hicks, Dr. Manju Lakra, Mark Rajkowski
Present: Ellie Taylor: Chair, Kendra Johnson, Dr. Manju Lakra, Mark Rajkowski
Absent: Kyle Hicks

Date: Monday, May 20, 2019 **Time: and Location 5:30 p.m.- 6:55 p.m. Corporate Office**

Topic/Agenda Item	Discussion/Conclusion	Action/Recommendation	Evaluation/Responsible Person
Policy Reviews & NEW QI Plan	**Discussed new Quality Improvement Program 2019 and potential policies (COO8, COO2, COO11) to eliminate since they are covered in the new QI Program. COO3 (EHR Use and Documentation) reviewed and approved.**	Ellie made motion to approve new QI Program 2019 and policy COO3 EHR Use & Documentation but eliminate policies COO2 Clinical Supervision, COO8 Use of Clinical Protocols, and CO11 Peer Review that are covered in new QI Program document. Kendra seconded. Will present at 6/13/19 BOD meeting.	Ellie Taylor
UDS Quality Measures	**New APRIMA EMR will improve input of precise measurements of data. UDS and HEDIS goals can be set, tracked and recorded that they have been met. FCHC can receive HEDIS incentives if goals reached each year.**	Install new EMR this fall.	Mark Rajkowski Manju Lakra
Risk Management Update and Reporting Schedule Incident Reports	**No patient complaints to review this period. No Incident reports.**		

Foothills Community Health Care, Inc.
Quality Assurance Committee

Topic/Agenda Item	Discussion/Conclusion	Action/Recommendation	Evaluation/Responsible Person
Patient Packets: Admission and Annual Update	**Working on streamlining patient packet. New EMR will have the ability to have electronic signing form for HIPPA, Consent to Treat and health information exchange.**	New Electronic Health Record (EHR) will register data and request updates when needed.	Mark Rajkowski
Current Quality Management Plan Review including credentialing reviews	**New management plan has been approved (see above). Credentialing will be reviewed by BOD QA as needed.**	None	Mark Rajkowski
NEW Patient Satisfaction Survey **Data Collection and Current Feedback**	**Reviewed new form and changes were recommended. Data will be presented at future QA meetings.**	Begin implementation one week per month at each site.	Mark Rajkowski Practice Managers at each site
Meeting Adjourned	**Adjourned at 6:55 p.m.**	Minutes for this meeting to be shared at BOD on 6/13/19.	Ellie Taylor

FOOTHILLS
COMMUNITY HEALTH CARE

Foothills Community Healthcare

Quality Improvement Program

2019

Reviewed and Approved by the Board of Directors
XX/XX/XXXX

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Statement of Approval

FOOTHILLS COMMUNITY HEALTH CARE
QUALITY IMPROVEMENT PROGRAM

Program Approval - FY 2019

This document signifies that the Quality Improvement Program for Foothills Community Health Care has been reviewed and approved by its Board of Directors as part of the overall annual grant application review process.

Approval Date: _____

Chief Medical Officer: _____
Manju Lakra, MD

President/CEO: _____
Mark Rajkowski

Board Chair: _____
Amy Anderson

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Mission, Goals, Objectives and Scope

I. Mission

The mission of Foothills Community Health Care Quality Improvement (QI) Program is to monitor and maximize the health of our patients and enhance the patient experience in our centers.

II. Goals

The goals of Foothills Community Healthcare's QI Program are to:

1. Provide a structure and a system to report, achieve and maintain the highest quality standards for our patients utilizing a quality assurance process for continuous improvement of clinical indicators and system procedures
2. Assess the extent to which health services are consistent with the most recently accepted guidelines and recognized standards of care for primary care and preventive health care; and
3. Develop strategies for ensuring that such services are compatible with the guiding principles for improvement in the access to primary care and preventive services

III. Objectives

The objectives of the QI Program are to:

1. Maintain the overall structure and system in place to monitor and review quality indicators
2. Describe the QI Committee structure, purpose, and procedures
3. Identify the core areas of monitoring, both clinical and systematic, based on population data and patient satisfaction surveys.
4. Present standards of care and both monitoring and reporting procedures for key chronic disease states
5. Ensure utilization of current policies and procedures regarding data collection

IV. Scope

The scope of the QI Program is comprehensive and includes all clinical and administrative departments and activities that have a direct or indirect influence on the quality, safety, and outcome of care delivered to all FCHC patients. This scope includes primary care, family planning, and mental health services. All services and sites will be approved by Bureau Primary Health Care (BPHC) to ensure compatibility with scope and provider coverage under Federal Tort Claims Act (FTCA) guidelines. For services provided to FCHC patients through written agreement (specialists, hospital services, etc.), FCHC will perform all necessary "due diligence" before signing the agreement. Through this mechanism, FCHC will ensure that patients receive quality care in these external settings.

Organizational Structure

I. Board of Directors

The Board of Directors (BOD) is ultimately accountable for the quality of care provided at FCHC. The BOD holds the Chief Executive Officer responsible for the efficient and effective functioning of the QI Program. Taking an active fiduciary role in the continual improvement of quality and safety, the BOD reviews and approves the QI Program, receives and acts upon reports from the Chair of the QI Committee, and ensures the availability of resources and systems to support all QI activities.

II. QI Committee

The QI Committee will oversee the comprehensive QI Program, which will be developed with the input from all personnel and will be implemented by all staff, once approved by the Board of Directors. The committee also addresses organization-level issues that relate to quality and patient safety. The QI Committee reports its activities and findings to the Board of Directors Quality Assurance Committee.

III. Chief Medical Officer

The Chief Medical Officer is the Chair of the QI Committee, has overall operational responsibility for the QI Program and is also responsible for the provider performance assessment and improvement component of the QI Program. This position reports to the Chief Executive Officer. The Chief Medical Officer (CMO) is also responsible for presenting QI issues and reports from the QI Committee and for recommending provider credentialing and re-credentialing to the Board. The CMO approves all privileging for providers. These recommendations address both the requirements for credentialing and the specific application of those requirements in ongoing practice.

QI Committee

I. Structure and Schedule

FCHC recognizes the vital role of leadership in the QI Program and the need for broad-based representation of all types of departments and all types of positions in the organization. Therefore, the QI Committee is made up of permanent members from the departments of medical services, nursing, administration, finance and behavior health services. Rotating members include representatives of most, if not all sites, specialties and key job categories and positions. The QI Committee will meet monthly or as needed and will be made up of the permanent and rotating members.

Permanent Members:

- Chief Medical Officer (Chair)
- Quality Improvement (RN)
- Lead Clinical Support (LPN/RN)
- Practice Manager
- Behavior Health Provider
- Chief Executive Officer
- Revenue Cycle Manager

The Chief Medical Officer is Chair of the Quality Improvement Committee and Quality Improvement RN serves as Vice-Chair of the QI Committee. The Chair of the QI Committee will report to the Board of Directors Quality Assurance Committee on a bi-monthly basis regarding QI activities.

II. Agenda

The agenda of the QI committee is determined by standing regular monthly reports, periodic reports, and presentations in the various areas that the QI committee oversees.

III. Minutes

Minutes of each QI Committee meeting will be kept accurately, following generally accepted standards. Minutes will be based on the agenda and stored electronically by permission and password protection so that access is limited to only the Chair and Vice-Chair of the QI Committee.

IV. Annual Review

The QI Committee will review the QI Program on an annual basis and make suggestions for changes or updates to the full QI Committee. The QI Committee will then present the revised plan to the Board of Directors for approval.

V. Methodology for Improvement

The Plan Do Study Act (PDSA) process is the standard methodology for improvement within the organization, whether implemented by the QI Committee, a patient care team, or an individual. Once an issue or problem is identified through either specific incidents or routine monitoring, the QI Committee will implement the PDSA process to examine the problems and develop a process or workflow for resolution.

The solution will be implemented with regular reporting on outcomes to determine if the result was successful or not. If successful, that new solution may become the basis of a new procedure or workflow. If not successful, the QI Committee will revisit the solution or consider alternative solutions and start the process over again. These steps will be repeated as needed until the specific issue or problem has been resolved.

VI. Content

The Quality Improvement Program will address quality assurance/program improvement content regarding the following major functional areas and essential aspects of care:

- Clinical Primary Care
- Patient and Staff Education
- Continuity of Care
- Patient Satisfaction
- Case Management
- Medical Record/Information Systems

Data Collection Plan

Goal: The goal of interpreting and utilizing comparative data is to develop baselines of organizational performance and using internal and external benchmarks, to evaluate and measure the organization's effectiveness, as well as to identify priorities for performance improvement.

Performance Measures: The organization will select performance measures that encompass the crucial aspects of care provided by the program. The organization will conduct a regular review of data for performance measures from a variety of sources. Goals for specific measurements will be based on the original documentation source, e.g., UDS report, grants, CMS requirements. Data sources may include but will not be limited to:

- Clinical measures utilizing UDS data, and based on established guidelines and standards of care:
    - Required HRSA Performance
        - Diabetes Mellitus
        - Hypertension
        - Cardiovascular Disease
        - Cancer Screening
        - Prenatal Health
        - Low Birth Weight
        - Childhood/Immunizations
        - Behavioral Health
        - Oral Health
        - Weight assessment and counseling for children and adolescents
        - Adult weight screening and follow-up
        - Tobacco use assessment and cessation counseling
        - Asthma and pharmacologic treatment for asthma
        - HIV linkage to care
        - Migrant Health
- Patient satisfaction survey results
- Demographic data, visit frequency, and missed appointment data
- Other local and regional collaborative quality initiatives

Patient Satisfaction

Goal: To ensure that our patient's needs and desires are met in a professional manner.

Method:

1. Patient Satisfaction Surveys are prepared by the Quality Improvement Committee to be utilized as scheduled by the Committee.
2. Patients will be surveyed at least yearly and in a random fashion.
3. Every office and every provider will be surveyed.
4. Results will be tallied by the organization as a whole, and by individual center.
5. Results will be presented to the Quality Improvement Committee for recommendations.
6. A summary of results and the recommendations from the Quality Improvement Committee will be presented to the Quality Assurance Committee of the Board of Directors and presented by the committee at the next board meeting.
7. Results will be used to guide changes that may be needed in policy, procedure or workflow to enhance patient satisfaction.

Peer Review

Goal: To ensure providers of all type are adhering to established and agreed upon medical practice guidelines, both in clinical practice and in documentation.

Method:

1. Peer Review Surveys will be conducted twice per year for every employed provider.
2. Providers will be reviewing similar provider types and specialties as much as is possible and will be appointed by the CMO. See Attached Form in Appendix A.
3. Locum tenens providers and providers not regularly scheduled will be exempt.
4. Ten charts will be reviewed for each provider.
5. The Chief Medical Officer will review the results .
6. Outstanding issues will be noted and the CMO will discuss with the individual providers.
7. A summary of results will be presented to the Quality Improvement Committee for recommendations.
8. The summary of results and the recommendations from the Quality Improvement Committee will be presented to the board by the Chief Medical Officer.
9. Results will be used to guide changes that may be needed in policy, procedure, workflow or training to enhance provider performance satisfaction.

Immunizations

Purpose: To reduce morbidity and mortality from diseases that are preventable by immunizations, namely: diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, H. influenza, influenza, varicella, pneumococcal pneumonia, and hepatitis. Influenza infection and pneumococcal pneumonia are also significant public health problems for adults in our service area. Over 80% of the excess deaths from pneumonia and influenza in the United States occur in persons 65 years or older, and a majority of these patients are not adequately immunized. Additionally, two-thirds of all cases of tetanus each year occur in people over the age of 50. Thus, vaccination against influenza, pneumococcal pneumonia and tetanus are a vital part of primary prevention for our adult patients, as well.

Goal: To provide or document adequate immunization for all pediatric, adolescent and adult patients of Foothills Community Health Care, Inc., according to the recommended schedule published by the CDC.

Method:

1. Provide on-site the following vaccines: DTaP, Hib, Hep A, Hep B, HPV, influenza, IPV, l\1MR, rotavirus, Td, Tdap, meningococcal, varicella virus vaccine and pneumococcal vaccine.
2. Administer immunizations by the appropriate schedule as recommended by the CDC for children, adolescents, and adults.
3. Track all patients receiving primary immunizations at FCHC for the intervals determined by their age and immunization status at the time of first FCHC immunization.
4. Document that immunizations are received or offered and refused if the patient is deficient in immunizations.
5. Document the immunization status of all patients who are active users but select to receive their immunizations elsewhere.
6. Verify pediatric patients' immunization status at 12 months, 24 months, and six years old. Those children who are found to be delinquent will have their immunization status rechecked in 6 months.
7. Check adolescent and adult patients' immunization status annually, or at the next visit if more than one year has passed, based on the following:
   Pneumococcal pneumonia vaccine: One time at 65 years or older, or re-vaccination if the first dose was 5 or more years ago, at age <65.
   Influenza vaccine: All ages, yearly before flu season starts.
   Tetanus: Once at 11-12 years, then once every ten years. One vaccination needs to be Tdap.
8. Have in place **a written management** plan to catch up on immunizations, if needed.

Cervical Cancer Screening Protocol

Goal: To reduce the incidence of mortality secondary to undetected or delayed detection of cervical cancer.

Objective: To promote women's gynecological health and reduce the risk of mortality secondary to undetected cervical carcinoma through the implementation of Pap smear screening protocols.

Screening Protocol:

1. Regular Pap tests and gynecological exams recommended for all women starting age 21.
2. Pap tests should be performed at an interval of every three years until age 30.
3. Women age 30 to 65 should have Pap testing in combination with human papillomavirus (HPV) testing every five years.
4. Pap smears may be discontinued after age 65 years if the patient has had adequate prior screening.
5. Women who have had total abdominal hysterectomies, other than for cancer, do not need Pap tests.

Management Protocols: Pap smears will be done per the guidelines above unless otherwise noted.

Follow-up of Pap smears should be as follows:

1. No atypical Cells: routine per screening protocol
2. Benign Cellular Changes: (Infections or Reactive Changes) treat as appropriate and repeat Pap at or before 12 months.
3. Epithelial Cell Abnormalities:
   a. Atypical squamous cells of undetermined significance (ASCUS): Repeat Pap at or before six months:
      i. If same or more severe, refer for a colposcopy within six weeks.
      ii. If normal, repeat every six months for a year, then return to annual Pap if normal.
      iii. If atrophic or suspected inadequate hormones, use estrogen cream or pill (unless contraindicated) and repeat in 3-4 months.
   b. Low-Grade Squamous Intraepithelial Lesion: Referral for a colposcopy in four weeks.
   c. High-Grade Squamous Intraepithelial Lesion: Referral for a colposcopy in two weeks.
   d. Squamous Cell Carcinoma: Referral for colposcopy within two weeks.
   e. Other malignant Lesion: Referral for colposcopy within two weeks.
   f. HPV Effect or clinically apparent condyloma: Repeat in 6 months and follow as if ASCUS.
   g. Record diagnosis on the problem list.

Diabetes Mellitus Protocol

Goal: To reduce unnecessary death and disability from diabetes.

Methods:

Newly Diagnosed Diabetics

1. Should have a complete physical examination and lab work-up to include a urinalysis with microalbumin, BUN, creatinine, glucose, lipid profile, liver enzymes, and electrolytes and EKG if over 40 years of age.
2. Dietary and lifestyle education, including self-management goals, should be given and documented.
3. Follow-ups should be at least at monthly intervals until glucose is stable and should include some type of blood sugar test (fasting blood sugar (FBS), post-prandial blood sugar, or HgAl c).

Established Diabetics

1. Office visits every three months with a blood sugar test. More frequent visits if the patient is symptomatic or abnormalities exist in lab tests. Less frequent acceptable if very stable and very controlled, but no less frequently than every six months.
2. Yearly funduscopic eye exams.
3. Yearly complete diabetic foot exams.
4. Yearly microalbumin and blood lipid level checks.
5. HgAlc every three months; every six months if levels have been controlled and stable.
6. Exercise and diet education, including self-management goals, at least annually.
7. Blood pressure will be tightly controlled, less than 130/80
8. LDL level will be less than 100mg/dL

Hypertension Protocol

Goal: To reduce unnecessary death and disability from uncontrolled high blood pressure.

Methods:

New Hypertensive Patients

1. Blood pressure measurement is taken with a properly calibrated and validated instrument with the patient seated quietly for at least 5 minutes in a chair, with feet on the floor, and arm supported at heart level. At least two measurements should be made. Two readings on separate days of 140/90 or higher constitute a diagnosis of hypertension.
2. Assess risk factors for CAD (family history, DM, cholesterol, smoking, obesity, exercise, alcohol).
3. Document patient education including low salt diet, weight loss, and exercise.
4. If the patient is to be treated with medicines, document that hematocrit, creatinine, cholesterol, urinalysis have been ordered or done within the last year.
5. Ensure that an EKG has been done within the last five years (if over 40 years of age).
6. If diuretics are to be used, document uric acid, potassium and glucose levels checked within the previous year.
7. Reduce blood pressure to less than 130/80 for those with chronic kidney disease or DM, 140/90 for all others, 70% of all patients within three months of the initial visit.
8. If initial diastolic pressure is greater than 100, consider medical therapy at that time.

Chronic Hypertensive Patients:

1. If on medicines and stable (less than 130/80 for those with chronic kidney disease or DM, 140/90 for all others) check blood pressure at least every six months with MD visit.
2. If not on medicines, check blood pressure at least yearly with MD visit.
3. Yearly urinalysis, creatinine, cholesterol (and potassium if on diuretic).
4. EKG every five years (if over 40 years of age).

Asthma

Goal: To reduce unnecessary morbidity and disability from uncontrolled asthma.

Methods:

1. Every asthma patient will be classified with the Classification of Asthma Severity scale.
2. Any patient classified with persistent asthma or uncontrolled will be prescribed the appropriate anti-inflammatory medication to help prevent inflammation and asthma attacks.
3. Patients will be counseled on the use of maintenance medications for persistent control of symptoms vs. use of short-acting rescue medications for acute symptom relief
4. Patients will be encouraged to notice, and further avoid environmental triggers like cigarette smoke and other irritants.
5. Asthma action plan will be completed with instructions on mild, moderate and severe exacerbations.

Classification of Asthma Severity

Classification*	Symptoms	Night symptoms	Lung function
Mild intermittent asthma	Symptoms occurring twice a week or less; No symptoms and normal PEF between exacerbations; Brief exacerbations (lasting a few hours to days) with variable intensity;	Symptoms occurring no more than twice a month;	FEV1/FVC is 80% or more of predicted PEF variability of less than 20%;
Mild persistent asthma	Symptoms occurring more than twice a week; Exacerbations may affect activity;	Symptoms occurring more than twice a month;	FEV1/FVC is 80% or more of predicted PEF variability of 20% to 30%;
Moderate persistent asthma	Daily symptoms; Daily use of inhaled short-acting beta agonist; Exacerbations affect activity; Exacerbations occur more than twice a week and may last for days;	Symptoms occurring more than once a week;	FEV1/FVC is greater than 60% but less than 80% of predicted PEF variability of greater than 30%;
Severe persistent asthma	Continual symptoms; Limited physical activity; Frequent exacerbations;	Frequent symptoms	FEV1/FVC is 60% or less of predicted PEF variability of greater than 30%;

*The initial classification is based on the presence of certain clinical features before treatment. The presence of one of the features of severity is enough to place a patient in that category. A patient should be assigned to the most severe grade in which any feature occurs. The characteristics noted in this classification are general and may overlap because asthma is highly variable. Furthermore, a patient's classification may change over time.

*--Patients at any level of severity can have mild, moderate or severe exacerbations. Some patients with intermittent asthma have severe and life-threatening exacerbations separated by long periods of normal lung function and no symptoms.

Depression

Problem: Depression is a very common and debilitating problem, seen in 5-13% of patient visits to primary care providers.

Goal: To better identify and treat Foothills Community Health Care patients who suffer from clinically significant depression (CSD).

Methods:

1. All patients age 12 years and older will be screened for CSD annually with the either the Patient Health Questionnaire (PHQ) or the Pediatric Symptom Checklist (PSC-17).
2. PHQ screening will start with the PHQ-2, then reflex to the full PHQ-9 if the two answers are not considered clinically negative.
3. Recognize individuals at high risk for depression
    - Chronic insomnia or fatigue;
    - Chronic pain;
    - Multiple or unexplained somatic complaints, "thick charts";
    - Chronic medical illnesses (e.g., diabetes, arthritis);
    - Acute cardiovascular events (myocardial infarction, stroke);
    - Recent psychological or physical trauma;
    - Other psychiatric disorders;
    - Family history of mood disorder.
4. Once depression is diagnosed, therapy can be initiated, whether it consists of psychotherapy, medications, or both.
5. Suicide risk will be assessed regularly throughout the course of treatment, including consultation with family and friends where appropriate. Agitation and suicide risk may increase early in treatment. The following will be used to screen for suicide risk:
    - Ask all depressed patients if they have thoughts of death or suicide, or if they feel hopeless and feel that life is not worth living. Also, ask if they have previously attempted suicide.
    - If the answer is yes, ask about plans for suicide.
        - How much have they thought about suicide?
        - Have they thought about a method?
        - Do they have access to material required for suicide?
        - Have they said goodbyes, written a note or given away things?
        - What specific conditions would precipitate suicide?
        - What is stopping them from suicide?
    - Assess risk factors for suicide:
      Psychosocial - first nations, male, advanced age, single or living alone;
      History - Prior suicide attempt, Family history of suicide, Family history of substance abuse;
      Clinical/Diagnostic - hopelessness, psychosis, medical illness, substance abuse;
    - Consider emergency psychiatric consultation and treatment if:
        - Suicidal thoughts are persistent;
        - The patient has a prior history of a suicide attempt or a current plan;
        - The patient has several risk factors for suicide;
6. Patient will be seen in close follow-up (3-4 weeks) for re-evaluation.
7. Target length to be on antidepressant is 12 months, to minimize possibility of relapse.

PHQ - 2 QUESTION SCREEN

Over the last 2 weeks, have you been bothered by any of the following problems?

Felt Down - Depressed - Or Hopeless	Y ☐	N ☐
Felt Little Interest Or Pleasure In Doing Things	Y ☐	N ☐

Depression Screen Instructions:

Complete the PHQ-2 if positive then complete the PHQ-9 and refer to behavioral health.

PHQ 9 SCREENING	Score
PHQ 9 DEPRESSION SCREENING: Click to Add HEADING to the note Y ☐	
Loss of interest or pleasure in doing things?	☐
Feeling down, depressed or hopeless?	☐
Trouble falling or staying asleep, sleeping too much?	☐
Feeling tired or little energy	☐
Poor appetite or overeating? (specify)	☐
Feeling down, like a failure, like you have let yourself or your family down?	☐
Trouble concentrating on things?	☐
Fidgety, unable to sit still or the opposite, moving or speaking slowly so people notice?	☐
Thoughts that you would be better off dead or hurting your self in any way?	☐
PHQ-9 Depression Scale Score	☐

Over the past 2 weeks, how often have you been bothered by any of the following problems?

NOT AT ALL = 0
SEVERAL DAYS = 1
MOST DAYS = 2
NEARLY EVERYDAY = 3

DEPRESSION & ANXIETY SCREENS & FOLLOW UP

PHQ 2 Score:	Y	M/d/yy ☐
Depression Screening - Phq-9 Score	Y	M/d/yy
Preventive Med Standardized Depression Screening: Negative For Symptoms	Y ☐	
Preventive Med Standardized Depression Screening: Positive For Symptoms	Y ☐	
Patient Education: Mental Health Screening	Y	M/d/yy ☐

Depression Screen Instructions:

Click Y that a depression screen was completed, add the score and enter date screen was completed.

If Negative click Y for negative for sympetoms

If Positive click Y for positive for symptoms.

It is very important to Click Y for Mental Health Care Management: Referral to Mental Helath for Positive Depression Screen and enter a date for any patient that has a positive depression screen (Even if the patient refuses the referral).

PHQ-9

PHQ 9 SCREENING	Score
PHQ 9 DEPRESSION SCREENING: Click to Add HEADING to the note	
Loss of interest or pleasure in doing things?	
Feeling down, depressed or hopeless?	
Trouble falling or staying asleep, sleeping too much?	
Feeling tired or little energy	
Poor appetite or overeating? (specify)	
Feeling down, like a failure, like you have let yourself or your family down?	
Trouble concentrating on things?	
Fidgety, unable to sit still or the opposite, moving or speaking slowly so people notice?	
Thoughts that you would be better off dead or hurting your self in any way?	
PHQ-9 Depression Scale Score	

Symptom Severity

(0) Not difficult at all	
(1) Somewhat difficult	
(2) Very difficult	
(3) Extremely difficult	

Therapy Notes:

Over the past 2 weeks, how often have you been bothered by any of the following problems?

NOT AT ALL = 0
SEVERAL DAYS = 1
MOST DAYS = 2
NEARLY EVERYDAY = 3

New Episode for condition M/d/yy

Mark only if New Episode. A patient should be in remission for at least three months before a clinical determination is made that the patient is experiencing a 'new episode'.

If this is not a new episode of depression, only mark the Psychometric Depression Scale Score with date.

Instructions - How to Score the PHQ-29-S

If the total of the first two questions is 2 or less, that is a negative screen. The patient needs to go no further. Place the total of the two questions in the Total Score box and the test is complete.

If the total of the first two questions is greater than 2, then continue with the questions, adding up the total in the Total Score box.

Major depressive disorder is suggested if:

Of the 9 items, 5 or more are checked as at least 'more than half the days'

Either item a. or b. is positive, that is, at least 'more than half the days'

Other depressive syndrome is suggested if:

Of the 9 items, a., b. or c. is checked as at least 'more than half the days'

Either item a. or b. is positive, that is, at least 'more than half the days'

Also, PHQ-9 scores can be used to plan and monitor treatment. To score the instrument, tally each response by the number value under the answer headings, (not at all=0, several days=l, more than half the days=2, and nearly every day=3). Add the numbers together to total the score on the bottom of the questionnaire. Interpret the score by using the guide listed below.

Guide for Interpreting PH0-9 Scores

Score	Action
0-4	The score suggests the patient may not need depression treatment
5-14	Mild major depressive disorder. Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
15-19	Moderate major depressive disorder. Warrants treatment for depression, using antidepressant, psychotherapy or a combination of treatment.
20 or higher	Severe major depressive disorder. Warrants treatment with antidepressant, with or without psychotherapy; follow frequently.

Functional Health Assessment

The instrument also includes a functional health assessment. This asks the patient how emotional difficulties or problems impact work, things at home, or relationships with other people. Patient responses can be one of four: Not difficult at all, Somewhat difficult, Very difficult, Extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, functional status and number score can be measured to assess patient improvement.

For further information on the PHQ-9:

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *J Gen Intern Med200l; l6:* 606-613.

Cardiovascular Disease

Goal: To decrease morbidity and mortality associated with cardiovascular disease.

Objective: To identify and document cardiac risk factors, and initiate management as necessary to prevent occurrence or recurrence of cardiac disease and injury.

Methods:

1. All adult patients (ages 20-64) should have cardiovascular risk assessment performed within the last four years. The assessment shall include the following:
   - Review of family history (parents and siblings) including that of coronary artery disease.
   - Recommended additional question of any blood relative died suddenly from unexpected disease or had a heart attack before the age of 55.
   - Assess tobacco use
   - Assess for hypertension (BP>140/90 for 2 readings)
   - Assess for elevated lipid levels according to ATP III guidelines: o LDL<100 for CAD or CAD-equivalent
     - o LDL<130 for 2 or more risk factors*
     - o LDL<160 for 1 or less risk factors*

     *Risk factors: smoking, hypertension, HDL<40, FH of significant CAD, men over 45, women over 55

     *Positive risk factor: HDL>=60mg/dL (cancels out one negative)
   - Assess for obesity - BMI>=30 (BMI = 705 x weight in pounds/height in inches squared)

2. Any positive result for tobacco use, hypertension, elevated cholesterol, or obesity should be noted on the problem list.

3. Management plan will be documented for each of the identified risks as follows: Cholesterol not known- advise to test
   Hypercholesterolemia- diet instructions initially and consideration of medical treatment if LDL is not adequately controlled after 3 months on diet
   Obesity- diet and exercise program and instructions
   Hypertension- low salt diet and treatment per hypertension protocol
   Smoking- counseled to stop smoking with or without withdrawal therapy Inactivity- exercise program and instructions
   Family history- review periodically
   Presence of CVD - aspirin therapy - 81mg to 325mg daily, blood pressure control, lipid levels controlled, weight reduction

General Population Disease Prevention

Goal: To reduce morbidity and mortality in the general population by recognizing and identifying potential health risks that may lead to adverse outcomes in cardiovascular and neoplastic processes, not otherwise specified in this manual.

Methods: Items as described in chart below:

A e in years	Identifying factor	Item
45+	Female	Fasting lipid panel in last 5 years
35+	Male	Fasting lipid panel in last 5 years
13+		Documented tobacco use status in last year
All	Tobacco users	Documented advice to quit yearly
19+	BMI>=30 **BMI<=l 8. 5**	Documented counseling on a healthy weight management plan at least yearly
2-18	Regardless of BMI	Documented counseling on nutrition and physical activity at least yearly
50-74	Female	Documented mammography in the last 2 years
50-75		One of the following: Fecal occult blood test (FOBT) within 1year Stool DNA screening test every 3 years Flexible sigmoidoscopy within 10 years plus annual FOBT Colonoscopy within 10 years

Appendix A

Provider Reviewer:	Date :			
MR # Age: Sex:	YES	NO	NA	NI/Comments
General Progress Note				
Chief Complaint identified and c/w HPI/PE/Plan				
Allergies listed/reconciled				
Medications listed and reconciled				
PMH/Surgical Hx/Social Hx listed and/or reviewed				
HPI, ROS, PE c/w working diagnosis				
plan c/w diagnosis				
Labs, diagnostics c/w diagnosis				
Referral appropriate				
Follow up timing appropriate to patient's condition				
Health Maintenance				
Pap up to date				
Mammogram up to date				
Flu shot annually				
Pneumococcal vaccine if appropriate				
Stool for guiac or colonoscopy up to date				
PHQ-9 done annually				
WCC				
Meets criteria for age				
Immunizations up to date				
Diabetes Management				
A1C drawn at appropriate time				
LDL checked and treated				
Patient rxd an ACE or ARB				
Self-management goals addressed				
Hypertension				
Hypertension controlled				
Medication management appropriate				
Lifestyle modification counseling				
Smoking				
Status documented				
Cessation counseling offered for smokers				
BMI				
Weight counseling documented if BMI <19 or >24				
Asthma				
Class identified				
medications appropriate for class				
dental assessment and care recommendations or referral				
Comments				
Reviewed by Chief Medical Officer				

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CLINICAL POLICY

Foothills Community Health Care, Inc. **Policy No: C003**

TITLE: EHR Use and Documentation					APPLICABLE TO: FCHC Staff	
Origination Date					**Supersedes Policy**	
Review Date	10/03/ 2013	08/29/ 2017	6/2019		**Cross Reference**	
Revised Date			6/2019		**Effective Date**	6/2019

STATEMENT / PURPOSE:

To establish the expectation that every provider, clinician, and medical assistant will use the Electronic Health Record (EHR) to access and retrieve patient information, enter data, and respond to clinical decision support interventions in real time and at the point of care.

Point of care - refers to the use of the EHR in close proximity to the patient, such as to support patient positive identification, obtain accurate and complete information for documentation, and appropriately communicates clinical findings to the patient.

Real time - refers to use of the EHR at the time data is captured and used.

The EHR is designed to be used at the point of care to support timely access and retrieval of information, clinical decision-making, and communications with all members of the care process.

1.0 EHR Use and Documentation:

1.1 All providers are expected to use the EHR as the primary means to access and retrieve information, capture data, and to be guided by clinical support.

1.2 In most cases the EHR is used in close proximity to the patient, but in some cases, it is appropriate to use the EHR at a nursing station or other locations away from direct contact with the patient; however, it is expected that such use will occur in real time.

1.3 At FCHC, each user in the care process must be able to access the network.

1.4 All workstations and notebooks are labeled.

1.5 Each user must use a proprietary and secure username and password to log into the EHR system.

1.6 Privilege and access to certain areas of the EHR is dependent upon job description and determination of a "need to know" capability. This is predetermined by

administrative and clinical leadership. Only then will access be given to the EHR for each employee.

1.7 Depending on the level of access, each user is required to enter and accurately document clinical data into the appropriate areas of the clinic visit record.

1.8 There are multiple clinical templates available for documentation according to disease state or level and length of service.

1.9 It is expected that each provider and member of the clinical support staff, will accurately document all subjective and objective findings in real time. Furthermore, it is expected that all levels of diagnostic impression, evaluation and treatment are appropriately documented in the EHR. Other levels of recommendations such as education, referral consultation and changes in medication are also to be documented as usual.

1.10 There is the capability to manually enter lab results or observation data into the EHR. As well, there is the opportunity to directly scan paper documents of results and consultations directly in to the patient EHR.

2.0 Business Rules for the FCHC EHR system:

2.1 The EHR business rules authorize specific users or groups of users to perform specified actions on documents in particular statuses.

2.2 A complete clinical document can be viewed by any authorized user.

2.3 An unsigned clinical document can be edited by the provider.

3.0 Security and Fraud Prevention:

3.1 FCHC has the desire and commitment to conduct business and provide care in an ethical manner. The EHR system has functions and capabilities to prevent or discourage fraudulent activities.

3.2 FCHC specifically prohibits entry of false information into any EHR notation. FCHC expects individual responsibility and accountability for the accuracy and integrity of information and that management will be notified of errors that are discovered.

3.3 FCHC requires that breach of confidentiality or falsification of information and information security will mandate disciplinary action.

3.4 FCHC monitors logging of all activity on the EHR system. The responsibility for auditing of log entries and exceptions is jointly shared by risk management, and clinical and administrative leadership. Areas of auditing and monitoring will include a) abnormal patterns of activity, b) routine documentation monitoring, and c) routine coding monitoring.

3.5 FCHC will comply with HIPAA security rule: mandatory audit trails are to be maintained within the EHR. Internal audit processes and reviews of system activity

will complete for logins and accessing files. Security incidents will be monitored by Quality Improvement/ Assurance and resolved.

3.6 FCHC will annually and at the time of new hire or access to the EHR, provide EHR education to include:

3.6.1 Informing all individuals associated, with the FCHC EHR guidelines.

3.6.2 Explain responsibilities for protecting system access information and creating accuracy of records.

3.6.3 Notify management of problems that are discovered.

3.6.4 Cover proper use, features, and functions of the EHR.

3.6.5 Address methods for preventing erroneous entry of information and prevention of errors.

3.6.6 Review disciplinary action for falsification of EHR information.

3.6.7 Review the FCHC HIPAA policy: noting EHR security is in line with protection and security of health information.

_____

Mark J. Rajkowski
Chief Executive Officer

_____

Manju Lakra, MD
Chief Medical Officer

_____

Amy Anderson
Board Chair

FOOTHILLS
COMMUNITY HEALTH CARE

Patient Satisfaction Survey
June 17, 2019 – June 21, 2019

Where did you go for health care before coming to Foothills Community Health Care?	Emergency Room ☐	Private Doctor ☐	Health Dept. ☐	Other Clinic ☐	Nowhere ☐
What form of transportation did you use today?	Drove Myself ☐	Medical Transportation ☐	Catbus/Public Transportation ☐	Taxi/Friend ☐	Other ☐

Were your treated well by the front desk staff?	☐ YES	☐ NO	☐ N/A
Were you treated well by the Provider?	☐ YES	☐ NO	☐ N/A
Was the appointment time good for you?	☐ YES	☐ NO	☐ N/A
Is the Health Center location easy to get to?	☐ YES	☐ NO	☐ N/A
Were you told what your medicine is for, how to take it, and what to expect?	☐ YES	☐ NO	☐ N/A
Was the need to keep appointments explained?	☐ YES	☐ NO	☐ N/A
Did you make an appointment for your next visit?	☐ YES	☐ NO	☐ N/A
Were your health care needs explained?	☐ YES	☐ NO	☐ N/A
Were you pleased with your care at FCHC?	☐ YES	☐ NO	☐ N/A
Will you recommend our Health Center to others?	☐ YES	☐ NO	☐ N/A
Was the Health Center clean and comfortable?	☐ YES	☐ NO	☐ N/A
If you have phoned the office and left a message, was your call returned within 24 hours?	☐ YES	☐ NO	☐ N/A
If you had a test ordered by FCHC, were you contacted with your results?	☐ YES	☐ NO	☐ N/A

COMMENTS:

FOOTHILLS COMMUNITY HEALTH CARE

Clinical Quality Measures 2018 & YTD 2019					
Measure	HEDIS Goal 2019	HEDIS Actual	2017 UDS Actual	2018 UDS Actual	FCHC Goal 2019
Childhood Immunizations- Children who were up to date on Immunizations by 3rd birthday	21.06%	0%	0%	40%	45%
Cervical Cancer Screen- Female Patients 24-64 with a pap during reporting year (HEDIS 21-64 yrs)	58.48%	24%	15%	29%	31%
Number of children/adolescents 3-17 who had BMI, counseling for nutrition & Physical Activity	48.91%	36%	9%	51%	53%
Adult Weight Screening, Follow Up & BMI Assessment (HEDIS 18-74)	28.79%	45%	42%	54%	56%
Depression Screen & Medication Management (HEDIS >18 yr)	29.07%	69%	22%	61%	65%
Diabetes- Patients 18-75 with HGA1C <=8	33.94%	48.48%	32%	50%	50%
Diabetes- Patients 18-75 with HGA1C >9 or No Test			32%	38%	40%
Tobacco Use Assessment and Cessation Counseling			88%	97%	100%
Asthma- Number of Patients aged 5-40 years who had persistent Asthma and was on appropriate therapy			20%	63%	65%
Coronary Artery Disease- Lipid Therapy- Patients with CAD who were on Lipid Lowering medication			75%	61%	65%
Ischemic Vascular Disease- Aspirin or Antithrombotic Therapy- patients with IVD who were on anti-thrombotic agent			52%	46%	50%
Colorectal Cancer Screen			23%	22%	25%
HIV Linkage to Care			0%	0%	10%
Hypertension- Patients 18-85 with most recent blood pressure < 140/90			46%	42%	45%
Adolescent Well-Care Visit 12-21 yrs	43.06%	27.56%			35%
Breat Cancer Screening 50-74 yrs	58.99%	74.19%			75%

Clinical Quality Measures 2018 & YTD 2019					
Measure	HEDIS Goal 2019	HEDIS Actual	2017 UDS Actual	2018 UDS Actual	FCHC Goal 2019
Chlamydia Screening in Women 16-24 Sexually Active	56.69%	20.00%			25%
F/U Care for Children Prescribed ADHD Medication	31.71%	62.50%			70%
Well-Child Visit 3-7 yrs	60.71%	31.34%			40%
Well-Child Visit 0-15 mos.	50.00%	47.61%			50%

Not measured by agency

ADMINISTRATIVE

Foothills Community Health Care, Inc. **Policy No: HR045**

TITLE: Risk Management					**APPLICABLE TO: All Staff**	
Origination Date	7/2013				**Supersedes Policy**	Risk Management S011 7/2013 AR015 01/2017
Review Date	6/2019				**Cross Reference**	Quality Improvement Program 2019
Revised Date	6/2019				**Effective Date**	6/2019

1. PURPOSE

The Risk Management Plan is designed to support the mission and vision of Foothills Community Health Care as it pertains to clinical risk and patient safety. It addresses visitor, third party, volunteer, and employee safety as well as potential business, operational, and property risks.

2. GUIDING PRINCIPLES

The Risk Management Plan is an overarching, conceptual framework that guides the development of a program for risk management and patient safety initiatives and activities. The plan is operationalized through a formal, written risk management and patient safety program. This document serves as a formal, written plan for the risk management and patient safety program.

The Patient Safety and Risk Management Program supports the Foothills Community Health Care philosophy that patient safety and risk management are everyone's responsibility. Teamwork and participation among management, providers, volunteers, and staff are essential for an efficient and effective patient safety and risk management program. All staff are key to successful implementation of the risk management program and are expected to be knowledgeable about and participate in risk management activities; to assist with the implementation of recommended improvements; and to identify risk events and opportunities for improvement. The program will be implemented through the coordination of multiple organizational functions and the activities of multiple staff members.

Foothills Community Health Care supports the establishment of a just culture that emphasizes implementing evidence-based best practices, learning from error analysis, and providing constructive feedback rather than blame and punishment. In a just culture, unsafe conditions and hazards are readily and proactively identified, medical or patient care errors are reported and analyzed, mistakes are openly discussed, and suggestions for systemic improvements are welcomed. Individuals are still held accountable for compliance with patient safety and risk management practices. As such, if evaluation and investigation of an error or event reveal reckless behavior or willful violation of policies, disciplinary actions can be taken.

The Foothills Community Health Care Risk Management Plan stimulates the development, review, and revision of the organization's practices and protocols in light of identified risks and chosen loss prevention and reduction strategies. Principles of the Plan provide the foundation for developing key policies and procedures for risk management activities, including the following:

- Claims and insurance management
- Complaint resolution
- Confidentiality and release of information
- Compliance efforts
- Safe and secure use of technology
- Event investigation, root-cause analysis, and follow-up
- Proactive analyses (e.g., failure mode and effects analysis, proactive risk assessments)
- Provider and staff education (including such items as documentation practices and effective tracking)
- Competency validation, credentialing and privileging requirements, and background checks
- Systems for monitoring and tracking referrals (specialty care, hospital and or emergency department admissions) and diagnostic laboratory values and other tests
- Reporting and management of adverse events and near misses
- Trend analysis of events, near misses, and claims
- Implementing performance improvement strategies to mitigate risk

2.1 Leadership

The success of the Foothills Community Health Care Patient Safety and Risk Management Program requires top-level commitment and support. The governing board or designee authorizes the formal program and adoption of this Plan as noted by their signature.

The governing board and senior executives are committed to promoting the safety of all patients, visitors, employees, volunteers, and other individuals involved in operations of the organization. The Patient Safety and Risk Management Program is designed to reduce system-related errors and potentially unsafe conditions by implementing continuous improvement strategies to support an organizational culture of safety.

3. PROGRAM GOALS AND OBJECTIVES

The Patient Safety and Risk Management Program goals and objectives include the following:

- Continuously improve patient safety and minimize or prevent the occurrence of errors, events, and system breakdowns leading to harm of patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities
- Minimize adverse effects of errors, events, and system breakdowns when they do occur
- Minimize losses to the organization overall by proactively identifying, analyzing, preventing, and controlling potential clinical, business, financial, and operational risks
- Facilitate compliance with regulatory, legal, and accrediting agency requirements (e.g., Patient-Centered Medical Home, The Joint Commission, Accreditation Association of Ambulatory Health Care)
- Protect human and intangible resources (e.g., reputation)

4. SCOPE AND FUNCTIONS OF THE PROGRAM

The Foothills Community Health Care Patient Safety and Risk Management Program interfaces with many operational departments and services throughout the health center, as well as HRSA.

4.1 Functional Interfaces

Functional interfaces with the patient safety and risk management program include areas such as credentialing and privileging, information technology, event reporting and investigation, performance assessment and improvement, volunteers, infection control, and administration. All areas work together on risk reduction strategies and methods as defined in this plan (Attachment 1).

4.2 Risk Management Program Functions

Risk management functional responsibilities include the following:

a) Developing systems for and overseeing the reporting of adverse events, near misses, and potentially unsafe conditions. Reporting responsibilities may include internal reporting as well as external reporting to regulatory, governmental, or voluntary agencies. This includes the development and implementation of event reporting policies and procedures.
b) Ensuring the collection and analysis of data to monitor the performance of processes that involve risk or that may result in serious adverse events, near misses, and potentially unsafe conditions; providing feedback to providers and staff; and using this data to facilitate systems improvements to reduce the probability of occurrence of future related events (e.g., preventive screening, diagnostic testing, medication use processes, perinatal care). Risk assessment tools include the use of failure mode and effects analysis, system analysis, root-cause analysis, and other tools.
c) Overseeing the organizational risk informational management system (RIMS) for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of adverse events, claims, finances, and effectiveness of the risk management program. This system may utilize and include, but is not limited to, attorney requests for medical records, x-rays, laboratory reports; event reports; medical record reviews; patient complaints; and results of failure mode and effects analysis of high-risk processes, as well as root-cause analyses of sentinel events.
d) Ensuring compliance with data collection and reporting requirements of governmental, regulatory, and accrediting agencies.
e) Facilitating and ensuring the implementation of patient safety initiatives such as improved tracking systems for preventive screenings and diagnostic tests, medication safety systems, and falls prevention programs.
f) Facilitating and ensuring provider and staff participation in educational programs on patient safety and risk management.
g) Facilitating a culture of safety in the organization that embodies an atmosphere of mutual trust in which all providers and staff members can talk freely about safety problems and potential solutions without fear of retribution. This ordinarily involves performing safety culture surveys and assessments.
h) Proactively advising the organization on strategies to reduce unsafe situations and improve the overall environmental safety of patients, visitors, staff, and volunteers.

i) Preventing and minimizing the risk of liability to the health center, and protecting the financial, human, and other tangible and intangible assets of the health center.
j) Decreasing the likelihood of claims and lawsuits by developing a patient and family communication and education plan. This includes communicating and disclosing errors and events that occur in the course of patient care with a plan to manage any adverse effects or complications.
k) Investigating and assisting in claim resolution to minimize financial exposure in coordination with the liability insurer and its representatives.
l) Reporting claims and potentially compensable events (PCEs) to the appropriate entity, including medical malpractice insurance providers or U.S. Department of Health and Human Services Federal Tort Claims Act (FTCA) claims (as appropriate) and other insurers in accordance with the requirements of the insurance policy/contract and FTCA requirements.
m) Supporting quality assessment and improvement programs throughout the organization.
n) Implementing programs that fulfill regulatory, legal, and accreditation requirements.
o) Establishing an ongoing Patient Safety/Risk Management Committee composed of representatives from key clinical and administrative departments and services.
p) Monitoring the effectiveness and performance of risk management and patient safety actions. Performance monitoring data may include the following:

- Claims and claim trends
- Culture of safety surveys
- Event trending data
- Ongoing risk assessment information
- Patient's or family's perceptions of how well the organization meets their needs and expectations
- Quality performance data
- Research data

q) Completing insurance and deeming applications.
r) Developing and monitoring effective handoff processes for continuity of patient care.

5. ADMINISTRATIVE AND COMMITTEE STRUCTURE AND MECHANISMS FOR COORDINATION

The Patient Safety and Risk Management Program is administered through Chief Medical Officer CMO as the risk manager and is overseen by chief executive officer (CEO)/ and the chief medical officer (CMO). The risk manager interfaces with administration, staff, medical providers, and other professionals and has the authority to cross operational lines in order to meet the goals of the program. The risk manager (or alternate as designated) chairs the activities of the Patient Safety/Risk Management Committee. The committee meets regularly and includes representatives from key clinical and support services. The composition of the Patient Safety/Risk Management Committee is designed to facilitate the sharing of risk management knowledge and practices across multiple disciplines; to optimize the use of key findings from risk management activities in making recommendations; and to reduce the overall likelihood of adverse events and improve patient safety. The committee's activities are an integral part of a patient safety and quality improvement and evaluation system.

Documentation of the designation of the risk manager is contained in the Patient Safety/Risk Management Plan. The risk manager is responsible for overseeing day-to-day monitoring of

patient safety and risk management activities and for investigating and reporting to the insurance carrier actual or potential clinical, operational, or business claims or lawsuits arising out of the organization, according to requirements specified in the insurance policy or contract. The risk manager serves as the primary contact between the organization and other external parties on all matters relative to risk identification, prevention, and control, as well as risk retention and risk transfer. The risk manager oversees the reporting of events to external organizations, per regulations and contracts, and communicates analysis and feedback of reported risk management and patient safety information to the organization for action.

6. REPORTING REQUIREMENTS, MONITORING, AND CONTINUOUS IMPROVEMENT

The Patient Safety/Risk Management Committee reviews risk management activities regularly. The risk manager reports activities and outcomes (e.g., claims activity, risk and safety assessment results, event report summaries, and trends) regularly to leadership and the governing board. This report informs them of efforts made to identify and reduce risks, reports on the success of these activities, and communicates outstanding issues that need input or support for action or resolution. Data reporting may include event trends, claims analysis, frequency and severity data, credentialing activity, relevant provider and staff education, and risk management/patient safety activities. In accordance with the organization's bylaws, recommendations from the Patient Safety/Risk Management Committee are submitted as needed to the board for approval. Performance improvement goals are developed to remain consistent with the stated risk management and patient safety goals and objectives (Attachment 2).

Documentation is in the form of risk management meeting minutes.

7. CONFIDENTIALITY

Any and all documents and records that are part of the patient safety and risk management process shall be privileged and confidential to the extent provided by state and federal law. Confidentiality protections may include attorney/client privilege, attorney work product, Patient Safety Organization, and peer review protections.

The signatures below represent an acceptance of the Patient Safety and Risk Management Program.

Date: _____

Risk Manager Approval: _____

Date: _____

Administrator/CEO Approval: _____

Date: _____

Medical Director/CMO Approval (if applicable): _____-_____

Date: _____

Governing Board Approval: _____

Definitions

- **Adverse event or incident:** An undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services.
- **Claims management:** Activities undertaken by the risk manager to exert control over potential or filed claims against the organization or its providers. These activities include identifying potential claims early, notifying the organization's liability insurance carrier or defense counsel of potential claims and lawsuits, evaluating liability and associated costs, identifying and mitigating potential damages, assisting with the defense of claims by scheduling individuals for deposition, providing documents or answers to written interrogatories, implementing alternate dispute-resolution tactics, and investigating adverse events or incidents.
- **Enterprise risk management (ERM):** "Enterprise risk management in healthcare promotes a comprehensive framework for making risk management decisions which maximize value protection and creation by managing risk and uncertainty and their connections to total value." (ASHRM, 2012) ERM is further defined by RIMS (the risk management society™) as a strategic business discipline that supports the achievement of an organization's objectives by addressing the full spectrum of its risks and managing the combined impact of those risks as an interrelated risk portfolio. ERM represents a significant evolution beyond previous approaches to risk management. ERM does the following:
    - Encompasses all areas of organizational exposure to risk (e.g., financial, operational, reporting, compliance, governance, strategic, reputational)
    - Prioritizes and manages those exposures as an interrelated risk portfolio rather than as individual "silos"
    - Evaluates the risk portfolio in the context of all significant internal and external environments, systems, circumstances, and stakeholders
    - Recognizes that individual risks across the organization are interrelated and can create a combined exposure that differs from the sum of the individual risks
    - Provides a structured process for the management of all risks, whether those risks are primarily quantitative or qualitative in nature
    - Views the effective management of risk as a competitive advantage
    - Seeks to embed risk management as a component in all critical decisions throughout the organization
- **Failure mode and effects analysis:** A proactive method for evaluating a process to identify where and how it might fail and for assessing the relative impact of different failures in order to identify the parts of the process that are most in need of improvement.
- **Hazards:** Situations with the potential to cause harm.
- **Loss control/loss reduction:** The minimization of the severity of losses through methods such as claims investigation and administration, early identification and management of events, and minimization of potential loss of reputation.
- **Loss prevention:** The minimization of the likelihood (probability) of a loss through proactive methods such as risk assessment and identification; staff and volunteer education, credentialing, and development; policy and procedure implementation, review, and revision; preventive maintenance; quality/performance review and improvement; root-cause analysis; and others.
- **Near miss:** An event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient owing to a lapse in verification of patient identification but caught at the last minute by chance). Near misses are opportunities for learning and afford the chance to develop preventive strategies and actions. Near misses receive the same level of scrutiny as adverse events that result in actual injury.

- **Patient Safety Goals:** National Patient Safety Goals (NPSGs) for ambulatory care, established by the Joint Commission. The purpose of NPSGs is to improve patient safety by focusing on problems in healthcare safety and how to solve them. For 2016 goals, see Attachment 2.
- **Potentially compensable event (PCE):** An unusual occurrence or serious injury for which there is neither an active claim nor institution of formal legal action but that, in the organization's judgment, is reportable to the party (or parties) providing the medical malpractice insurance. Examples include delay or failure in diagnosing a patient's condition, an adverse reaction to treatment, significant complaints from a patient or family regarding care or treatment (actual or perceived), and an attorney request for medical records, among others.
- **Risks:** The probability that a specific adverse event will occur in a specific time period or as a result of a specific situation.
- **Risk analysis:** Determination of the causes, potential probability, and potential harm associated with an identified risk and alternatives for addressing the risk. Examples of risk analysis techniques include failure mode and effects analysis, systems analysis, root-cause analysis, and tracking and trending of adverse events and near misses.
- **Risk assessment:** Activities undertaken in order to identify potential risks and unsafe conditions inherent in the organization or within targeted systems or processes. By conducting a risk assessment, organizations capture feedback on issues that may affect quality of care, efficiency, or costs. Examples of tools utilized include risk matrices, structured surveys, quality measures, and review of patient complaints to identify issues.
- **Risk avoidance:** The risk assessment technique that entails eliminating hazards, activities, and exposures that place an organization's valuable assets (patients) at risk. Examples include protective safeguards (through policy, training, or technology), the informed consent process, and compliance with regulations.
- **Risk control:** Treatment of risk using methods aimed at eliminating or lowering the probability of an adverse event (e.g., loss prevention through a falls prevention program, procuring bariatric chairs [for waiting rooms and exam areas] to accommodate obese or overweight patients); eliminating, reducing, or minimizing harm to individuals; and minimizing the financial severity of losses when they occur (e.g., loss reduction through patient follow-up regarding abnormal lab results).
- **Risk financing:** Financing strategies including all the ways of generating funds to pay for losses that risk control techniques do not entirely prevent. These treatment techniques include risk retention and risk transfer. They involve analysis of the costs associated with quantifying risk and funding for it, such as through general liability insurance.
- **Risk identification:** The process used to identify situations, policies, or practices that could result in the risk of patient harm or financial loss. Sources of information include proactive risk assessments, closed claims data, adverse event reports, past accreditation or licensing surveys, medical records, clinical and risk management research, walk-through inspections, safety and quality improvement committee reports, insurance company claim reports, risk analysis methods such as failure mode and effects analysis and systems analysis, and informal communication with healthcare providers.
- **Risk information management system (RIMS):** A computerized system used for data collection and processing, information analysis, and generation of statistical trend reports for the identification and monitoring of events, claims, finances, and more.
- **Risk management:** Clinical and administrative activities undertaken to identify, evaluate, prevent, and control the risk of injury to patients, staff, visitors, volunteers, and others and to reduce the risk of loss to the organization itself. Activities include the process of making and carrying out decisions that will prevent or minimize clinical, business, and operational risks.
- **Risk retention:** Internally driven financing mechanisms (e.g., self-insured retentions) intended to pay for accidental and uninsurable losses.

- **Risk transfer:** Techniques involving the process of shifting the financial burden of losses to an external party or parties (e.g., insurance, contracts).
- **Root-cause analysis:** A process for identifying the basic or causal factor(s) that underlie the occurrence or possible occurrence of an adverse event. This problem solving method is used for identifying the root causes of faults or problems. A factor is considered a root cause if its removal from the problem-fault-sequence prevents the final undesirable event from recurring; whereas a causal factor is one that affects an event's outcome, but is not a root cause.
- **Sentinel event:** Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse event.
- **Trigger methodology:** A method of measuring harm related to the occurrence of adverse events. The method utilizes a clearly defined list of patient events (also known as a "trigger tool") against which patient medical records are screened. Screening criteria are based on high-risk areas, or areas identified as "red flags" through event reporting or as a result of a severe adverse event (e.g., new diagnosis of cancer, use of more than five medications, high-risk pregnancy).
- **Unsafe or hazardous condition:** Any set of circumstances (exclusive of a patient's own disease process or condition) that significantly increases the likelihood of a serious adverse outcome for a patient or likelihood of a loss due to an accident or injury to a visitor, employee, volunteer, or other individual.

The Joint Commission
National Patient Safety Goals for Ambulatory Care 2016

The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them.

Identify patients correctly

NPSG.01.01.01	Use at least two ways to identify patients. For example, use the patient's name *and* date of birth. This is done to make sure that each patient gets the correct medicine and treatment.
NPSG.01.03.01	Make sure that the correct patient gets the correct blood when they get a blood transfusion.

Use medicines safely

NPSG.03.04.01	Before a procedure, label medicines that are not labeled. For example, medicines in syringes, cups, and basins. Do this in the area where medicines and supplies are set up.
NPSG.03.05.01	Take extra care with patients who take medicines to thin their blood.
NPSG.03.06.01	Record and pass along correct information about a patient's medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor.

Prevent infection

NPSG.07.01.01	Use the hand cleaning guidelines from the Centers for Disease Control and Prevention or the World Health Organization. Set goals for improving hand cleaning. Use the goals to improve hand cleaning.
NPSG.07.05.01	Use proven guidelines to prevent infection after surgery.

Prevent mistakes in surgery

UP.01.01.01	Make sure that the correct surgery is done on the correct patient and at the correct place on the patient's body.
UP.01.02.01	Mark the correct place on the patient's body where the surgery is to be done.
UP.01.03.01	Pause before the surgery to make sure that a mistake is not being made.