Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022
5:30 p.m.

Agenda

Valleywise Health

Committee Members
Michelle Barker, DHSc, Committee Chair
Daniel Messick, Committee Vice Chair
Liz McCarty, Member
Barbara Harding, CEO, FQHC Clinics, Non-Voting Member
LT Slaughter, CCO, Non-Voting Member
Christina Smarik-Snyder, M.D., Interim FQHC Medical Director, Non-Voting Member
Nelson Silva-Craig, Director of Nursing, Ambulatory Care, Non-Voting Member
Crystal Garcia, VP, Surgical, Specialty, Quality and Safety, Non-Voting Member
Sandra Yuh, M.D., FQHC Quality Medical Director, Non-Voting Member

AGENDA
Compliance and Quality Committee of the Valleywise Community Health Centers Governing Council

Mission Statement of the
Valleywise Community Health Centers Governing Council
Serve the population of Maricopa County with excellent, comprehensive health and wellness in a culturally respectful environment.

· Valleywise Health Medical Center · 2601 East Roosevelt Street · Phoenix, Arizona 85008 ·

Meeting will be held remotely. Please visit https://valleywisehealth.org/events/valleywise-community-health-centers-governing-councils-compliance-and-quality-committee-meeting-05-09-22/ for further information.

Monday, May 9, 2022
5:30 p.m.

One or more of the members of the Valleywise Community Health Centers Governing Council's Compliance and Quality Committee may be in attendance telephonically or by other technological means. Committee members participating telephonically or by other technological means will be announced at the meeting.

Please silence any cell phones, pagers, computers, or other sound devices to minimize disruption of the meeting.

Call to Order

Roll Call

Call to the Public
This is the time for the public to comment. The Compliance and Quality Committee may not discuss items that are not specifically identified on the agenda. Therefore, pursuant to A.R.S. § 38-431.01(H), action taken as a result of public comment will be limited to directing staff to study the matter, responding to any criticism, or scheduling a matter for further consideration and decision at a later date

General Session, Presentation, Discussion and Action:

1. Approval of Consent Agenda: 5 min
    Any matter on the Consent Agenda will be removed from the Consent Agenda and discussed as a regular agenda item upon the request of any voting Committee member.

    a. Minutes:

        i. **Approve** Compliance and Quality Committee Meeting Minutes Dated February 14, 2022

_____End of Consent Agenda_____

2. Discuss and Review Uniform Data System (UDS) Quality Metrics for the Federally Qualified Health Center Clinics for the first quarter of calendar year 2022 15 min
    Crystal Garcia, Vice President, Surgical, Specialty, Quality and Safety

3. Discuss and Review National Research Corporation (NRC) RealTime Platform Patient Satisfaction data for the Federally Qualified Health Center Clinics for the third quarter of fiscal year 2022 10 min
    Crystal Garcia, Vice President, Surgical, Specialty, Quality and Safety

4. Discuss and Review revised National Research Corporation (NRC) RealTime Platform Patient Satisfaction survey questions for the Federally Qualified Health Center Clinics 10 min
    Crystal Garcia, Vice President, Surgical, Specialty, Quality and Safety

5. Discuss and Review the Compliance and Internal Audit Work Plans and Ethics Line Report for the Federally Qualified Health Center Clinics for the third quarter of fiscal year 2022 10 min
    LT Slaughter, Chief Compliance Officer

6. Discuss, Review and **Make Recommendations** to the Valleywise Community Health Centers Governing Council to **Approve** the annual Compliance Work Plan for the Federally Qualified Health Center Clinics for fiscal year 2023 15 min
    LT Slaughter, Chief Compliance Officer

7. Discuss, Review and **Make Recommendations** to the Valleywise Community Health Centers Governing Council to **Approve** the annual Internal Audit Work Plan for the Federally Qualified Health Center Clinics for fiscal year 2023 15 min
    LT Slaughter, Chief Compliance Officer

8. Chair and Committee Member Closing Comments/Announcements 5 min
    Compliance and Quality Committee

9. Review Staff Assignments 5 min
    Cassandra Santos, Assistant Clerk

    Old Business:

    November 8, 2021
    Future agenda item: Discuss revised National Research Corporation (NRC) RealTime Platform Patient Satisfaction survey questions for Valleywise Health's Federally Qualified Health Center Clinics

<u>Adjourn</u>

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 1.

Consent Agenda

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 1.a.i.

Minutes:
February 14, 2022

<table>
<tr><td align="center">Minutes</td></tr>
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<tr><td align="center">**Valleywise Community Health Centers Governing Council**
Compliance and Quality Committee
Valleywise Health Medical Center
February 14, 2022
5:30 p.m.</td></tr>
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Voting Members Present:	Michelle Barker, Committee Chair *- participated remotely* Liz McCarty, Member *- participated remotely*
Voting Members Absent:	Daniel Messick, Committee Vice Chair
Non-Voting Members Present:	Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics *- participated remotely* LT Slaughter, Chief Compliance Officer *- participated remotely* Christina Smarik-Snyder, M.D., Interim Medical Director, Ambulatory Services *- participated remotely* Nelson Silva-Craig, Director of Nursing, Ambulatory Care *- participated remotely* Crystal Garcia, Vice President Surgical, Specialty, Quality and Safety *- participated remotely* Sandra Yuh, M.D., Federally Qualified Health Center Clinics Quality Medical Director *- participated remotely*
Others/Guest Presenters:	Melanie Talbot, Chief Governance Officer *– participated remotely*
Recorded by:	Cassandra Santos, Assistant Clerk *- participated remotely*

Call to Order

Chairman Barker called the meeting to order at 5:30 p.m.

Roll Call

Ms. Talbot called roll. Following roll call, it was noted that two of the three voting members of the Valleywise Community Health Centers Governing Council's Compliance and Quality Committee were present, which represented a quorum.

For the benefit of all participants, Ms. Talbot named the committee members participating remotely.

Call to the Public

Chairman Barker called for public comment.

There were no comments.

General Session, Presentation, Discussion and Action:

1.   Approval of Consent Agenda:

      a.   <u>Minutes:</u>

            i.   Approve Compliance and Quality Committee Meeting Minutes Dated November 8, 2021

MOTION: Ms. McCarty moved to approve the consent agenda. Chairman Barker seconded.

VOTE: 2 Ayes: Chairman Barker, Ms. McCarty
0 Nays
1 Absent: Vice Chairman Messick
Motion passed.

2.   Discuss and Review Select Data Points of the Draft Calendar Year 2021 Uniform Data System (UDS) Submission to Health Resources and Services Administration (HRSA)

Ms. Harding presented select data points from the calendar year (CY) 2021 Uniform Data System (UDS) Submission to Health Resources and Services Administration (HRSA), for the Federally Qualified Health Center (FQHC) clinics.

The report provided standardized information about the operations and performance of community health centers, including patient demographics such as race, age, ethnicity, gender identity, sexual orientation, demographic characteristics, income, and by zip code.

She discussed and compared statistics and trends from CYs 2017 through 2021. There were consistent growth trends within various populations over the years.

Identifying health outcomes by race and ethnicity, as well as staffing and utilization, clinical, and general financial aspects were important trends to consider.

Examples of select patient characteristics included a patient's income associated with Federal Poverty Level (FPL) guidelines and uninsured patients.

Ms. Harding shared statistics related to patients that spoke another language other than English.

She described the sexual orientation and gender identity (SOGI) data collection process which included information related to a patient's sexual orientation, gender identity, and preferred pronouns.

Statistics demonstrated steady improvement in collecting SOGI data from CYs 2017 to 2021, which was attributed to staff's implementation of a data collection task team.

Ms. Harding referenced patient income statistics and noted that staff focused on developing effective ways to collect the data, with stable improvement shown year over year.

She explained the unique unduplicated patient count which meant each patient was counted only once for a visit regardless of the number of visits throughout the reported calendar year.

The reported unduplicated patient count for CY 2021 was 83,659. Due to the COVID-19 pandemic, the unduplicated patient count reported for CY 2020 had a significant decrease compared to 2019. While the unduplicated patient count had increased in CY 2021, the count was lower than pre-pandemic levels.

General Session, Presentation, Discussion and Action, cont.:

2.   Discuss and Review Select Data Points of the Draft Calendar Year 2021 Uniform Data System (UDS) Submission to Health Resources and Services Administration (HRSA), cont.

Ms. Harding explained that continued decrease in the unduplicated patient count could become detrimental to the organization's community market share, a key indicator of market competitiveness.

Chairman Barker asked if the unduplicated patient count was expected to return to pre-pandemic levels and whether the decrease indicated that patients were receiving services elsewhere.

Ms. Harding said that the goal was to grow the overall patient base and increase the community market share. She compared annual market share growth to other local FQHC organizations and confirmed the possibly of patient loss CY 2021.

She briefly spoke about challenges associated with appointment fill rates within the ambulatory setting

Ms. Harding explained the challenges related to provider vacancies, which ultimately affected the appointment fill rate. Many of the clinics were not meeting the benchmark of greater than 85 percent, indicating patient access was not being met, therefore affecting patient satisfaction.

The appointment no-show rate was the percentage of appointments for which patients did not show and affected resource utilization and anticipated revenue. When an appointment was scheduled and missed, this was commonly referred to as a missed opportunity. The metric showed improvement within previous years as a result of staffing conducting appointment reminder calls, appointment confirmations by automated systems, and other initiatives.

It was important to maximize provider utilization, improve the appointment fill rate and reduce the number of missed opportunities. It was a challenging balance to maintain, especially factoring in provider shortages and other factors.

3.   Discuss and Review Uniform Data System (UDS) Quality Metrics for the Federally Qualified Health Center Clinics for the fourth quarter of calendar year 2021

Ms. Garcia gave an overview of UDS quality metrics for 2021 calendar year end (CYE). She highlighted metrics that had opportunity to improve, including but not limited to, body mass index (BMI) screening and controlling high blood pressure, cervical cancer screening, and screening for depression and follow up. However, breast cancer and colorectal cancer screening reached their benchmarks.

She gave an update on UDS quality metrics for the fourth quarter of CY 2021 and noted metrics that had required improvement and ones that met the benchmark. She pointed out metrics that showed consistent improvement compared to the previous reported quarters.

There were changes made to the BMI screening requirements which required staff to seek alternative ways to collect data accurately. BMI focus workgroups were launched to address challenges in achieving the measure. National changes were implemented that stated when a patient's BMI was out of range, it should be addressed during each visit. Action plans were incorporated to support improvement of the metric.

Ms. Garcia noted consistent improvement, month over month during CY 2021, related to cervical cancer screening. Although the metric did not meet benchmark it was within 1.5% of the UDS national average. Action plans and workgroups were created to continue improvement.

Ms. Garcia emphasized the metric related to controlling high blood pressure which required improvement. She presented action plans that supported improvement of the metric such as policy change and the development of a focus workgroup.

General Session, Presentation, Discussion and Action, cont.:

4.　　Discuss and Review National Research Corporation (NRC) RealTime Platform Patient Satisfaction data for the Federally Qualified Health Center Clinics for the second quarter of fiscal year 2022

Regarding screening for depression and follow up, Ms. Garcia shared details related to the measure in electronic medical record (EMR). There were changes made to improve screening and action plans that concentrated on improvement of the metric.

Chairman Barker applauded staff for consistent efforts to improve outcome measures.

The committee briefly discussed the consistent improvement of various metrics, year over year.

Ms. Garcia presented the National Research Corporation (NRC) RealTime platform patient satisfaction survey results for the second quarter of fiscal year (FY) 2022.

The net promotor score (NPS) was calculated from the survey question that asked patients to rate the likelihood they would recommend the facility to family or friends. The NPS for the second quarter was 71.7 with a patient response rate, or n-size of 5,683.

Ms. Garcia pointed out patient satisfaction survey questions with negative gaps or areas with opportunity to improve. She shared the NPS for specific FQHC clinics highlighting recent improvement within various locations.

She shared dynamics of the NRC RealTime starter kit which included suggested patient satisfaction survey questions, used as a tool to revise the current survey questions. The revised questions would be shared at the next committee meeting.

Ms. Garcia announced the Valleywise Health Service Excellence Committee which was recently developed specifically to assist patients within the ambulatory setting.

She described components of the Valleywise Health organizational standard acknowledge, connect, communicate, every person, every time (ACCEPT) which aimed to improve the patient experience. Using ACCEPT helped to provide a positive first impression to patients, visitors, and one another. It showed courtesy and respect and aimed to demonstrate compassion for those seeking services at Valleywise Health.

Ms. Garcia shared patient satisfaction results for Valleywise Community Health Centers and FQHC clinics located at Valleywise Comprehensive Health Centers, stating that the majority met benchmark. Patient satisfaction results for the dental clinics were also highlighted.

She shared NRC RealTime patient satisfaction comments received from the second quarter.

Ms. Garcia pointed out that the n-size for each individual clinic was displayed within the report.

5.　　Discuss and Review the Compliance and Internal Audit Work Plans and the Ethics Line Report for the Federally Qualified Health Center Clinics for the second quarter of fiscal year 2022

Mr. Slaughter outlined the compliance report for the FQHC clinics for the second quarter of FY 2022.

He highlighted compliance work plan projects including but not limited to, the COVID-19 pandemic, HRSA operational site visit (OSV) compliance follow-up, new facility reviews, telehealth, and resident model compliance. He shared individual risk assessment priorities and discussed the risk assessment scoring system used to develop and monitor projects.

General Session, Presentation, Discussion and Action, cont.:

5.   Discuss and Review the Compliance and Internal Audit Work Plans and the Ethics Line Report for the Federally Qualified Health Center Clinics for the second quarter of fiscal year 2022, cont.

Mr. Slaughter gave an update on details of the internal audit work plan such as quality reporting barriers, Care Reimagined controls and monitoring, FQHC grant reviews, business continuity assessment, and specialty referral assessment.

There were four calls made to the ethics point hotline during the quarter, all of which were investigated.

Mr. Slaughter compared trending statistics for previous reporting periods and mentioned that the benchmark for the number of days to close an investigation was 30 days or less. The average day to close an investigation during the second quarter was 36 days.

6.   Chair and Committee Member Closing Comments/Announcements

There were no closing comments or staff assignments.

7.   Review Staff Assignments

Ms. Talbot reviewed staff assignments and follow up stemming from the meeting.

Adjourn

MOTION: Ms. McCarty moved to adjourn the February 14, 2022 Valleywise Community Health Centers Governing Council's Compliance and Quality Committee meeting. Chairman Barker seconded.

VOTE: 2 Ayes: Chairman Barker, Ms. McCarty
0 Nays
1 Absent: Vice Chairman Messick
Motion passed.

Meeting adjourned at 6:22 p.m.

_____
Cassandra Santos
Assistant Clerk

Valleywise Community Health
Centers Governing Council

Compliance and Quality
Committee Meeting

May 9, 2022

Item 2.

UDS Quality Metrics

Qtr 1 CY2022 Data

Patient Care & Safety Committee Report

Reporting Group: **Ambulatory Quality Initiative Workgroup – UDS Reporting**
Person Reporting: Crystal Garcia, VP of Specialty Srvs, Quality and Patient Safety
Reporting Month: May 2022

Measures Meeting Benchmark – Reporting Year 2022

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Breast Cancer Screening	> 45.34%	58.56%	54.73%	55.90%
Childhood Immunizations	> 40.42%	47.72%	41.67%	45.28%
HIV Screening	> 32.29%	58.18%	62.75%	62.82%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	> 71.92%	68.40%	72.48%	72.72%
Colorectal Cancer Screening	> 40.09%	50.85%	39.44%	41.21%
Tobacco Use: Screening and Cessation Intervention	> 83.43%	87.78%	83.13%	84.75%
Ischemic Vascular Diseases (IVD): Use of Aspirin or Another Antithrombotic	> 78.80%	78.51%	79.64%	78.74%

- This group of UDS measures is meeting the UDS National Average as of the March 2022 calendar reporting year.

- This group of measures also trended above or close to benchmark in the prior 2021 reporting year.

- This set of metrics has historically been consistent with regards to meeting/exceeding UDS national averages.

Measures Meeting Benchmark –
End Year 2021 <u>Prior</u> to New 2022 Reporting Year Reset

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Diabetes: HbA1c Poor Control	< 35.60%	31.85%	59.49%	50.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	> 65.13%	78.09%	44.94%	52.94%

- This group of UDS measures *was* meeting the UDS National Average at year end 2021.

- After the new 2022 calendar reporting year re-set they are currently sitting outside the benchmark.

- <u>This set of metrics is expected to improve as the CY progresses.</u>

Measures Outside Benchmark
End Year 2021 & 2022 Reporting Year

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Cervical Cancer Screening	> 51.00%	49.77%	48.17%	49.03%
Body Mass Index (BMI) Screening and Follow-Up Plan	> 65.72%	34.26%	29.80%	30.42%
Controlling High Blood Pressure	> 57.98%	47.76%	39.72%	43.48%
Screening for Clinical Depression and Follow-Up Plan if Positive Screen	> 64.21%	48.73%	39.48%	42.05%

- This group of UDS measures is not meeting the UDS National Average as of the March 2022 calendar reporting year.

- They also trended outside of benchmark in the prior 2021 reporting year.

- This set of metrics has been the most challenging for VH to meet the UDS national averages.

Measure(s) Trending – Meeting Benchmark with Ongoing Action Items

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Colorectal Cancer Screening	>40.09%	50.85%	39.44%	41.21%

Colorectal Cancer Screening
Valleywise Health - FQHC

Definition: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	43.00%	43.00%	43.00%	43.00%	43.00%	45.00%	45.77%	46.43%	47.30%	47.63%	48.42%	49.21%
2020	40.32%	42.90%	43.38%	42.66%	42.19%	41.99%	41.70%	41.33%	42.02%	44.70%	45.74%	45.89%
2021	37.71%	39.67%	42.01%	43.34%	44.18%	45.61%	46.53%	47.52%	48.09%	49.11%	50.21%	50.83%
2022	37.04%	39.44%	41.21%									
2020 UDS National Average: 40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%	40.09%
HP 2030 Target: 74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%	74.40%

Action Items / Barriers:

- **Action:** Quality focus workgroup efforts remain on the colorectal screening contest – this will be the continued emphasis for the remainder of the 2022 measurement calendar year

- **Barrier:** none

Measure(s) Trending – Recently Not Meeting Benchmark with Ongoing Action Items

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Diabetes: Hemoglobin A1c Poor Control	<35.60%	31.85%	59.49%	50.22%

Diabetes: HbA1c >9.0% or No Test Done
Valleywise Health - FQHC

Definition:
Percentage of patients 18-75 years of age with diabetes who had a hemoglobin A1c >9.0% or no test completed during the measurement period.

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	64.38%	51.67%	48.49%	45.52%	42.12%	39.08%	37.17%	35.90%	32.54%	31.76%	31.60%	31.29%
2020	57.40%	55.54%	50.55%	50.19%	46.85%	44.46%	43.13%	41.01%	38.42%	36.81%	35.70%	35.15%
2021	72.09%	62.37%	52.10%	45.55%	41.27%	38.69%	37.17%	35.83%	34.78%	33.61%	32.74%	31.84%
2022	70.50%	59.49%	50.22%									
2020 UDS National Average: <35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%	35.60%
HP 2030 Target: <11.6%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%	11.60%

Action Items / Barriers:

- The focus remains on the continuation of operationalizing the standing POC A1c order protocol:

- **Action:** Leadership meeting to cover this topic and the possibility of amending the diabetes protocol to allow for a standing order

- **Action:** Screen shots of POC A1c billing to validate charges/billing side is accurate even if provider is not originating the order first

- **Barrier:** none

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Measures <u>Not</u> meeting Benchmark

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Body Mass Index (BMI): Screening and Follow-Up Plan	>65.72%	**34.26%**	**29.80%**	**30.42%**

Definition: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the

Body Mass Index (BMI) Screening and Follow Up Plan
Valleywise Health - FQHC

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	60.63%	60.84%	60.56%	60.56%	62.46%	61.56%	61.88%	62.43%	63.37%	63.37%	56.21%	56.46%
2020	56.65%	64.97%	64.77%	63.99%	63.31%	61.62%	59.72%	58.80%	58.37%	58.35%	57.92%	57.29%
2021	53.54%	55.61%	56.21%	57.31%	32.20%	32.31%	32.58%	32.81%	32.92%	33.05%	33.46%	33.44%
2022	29.45%	29.80%	30.42%									
2020 UDS National Average: 65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%	65.72%

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Measure Analysis and Actions

Analysis:

The BMI must be addressed when out of range every time it is generated, or a patient will fall out of meeting the measure guideline. The follow-up plan is most often the piece missing for this measure. Although the BMI is being generated; the f/u plan when outside of 'normal' parameters is deficient.

*Historical: Body Mass Index (BMI) Screening and Follow-Up Plan formerly looked back 12 months for the follow up plan based on the encounter date. This logic was changed (effective 7/15/21) to look back 12 months from the last intervention. This dramatically impacts the way in which a patient meets the measure. What this means is previously BMI had to be addressed one time during the last 12 months. Now, BMI and the plan must be done every visit when not in range. This change should be noted when comparing year over year for the measure.

Action Items / Barriers:

- **Action:** Ambulatory IT team to assess the functionality of using Care Gaps within EPIC as an option for addressing the follow up plan requirement when patient BMI is out of healthy range.

- **Barrier:** F/U plan portion of the measure requires the 'eligible professional' completing the follow up action to be done by the provider - the MA cannot solely complete this task – work surrounding the BPA button for MA's will not be moved forward at this time

Measures <u>Not</u> meeting Benchmark

Measure	Benchmark	Final Year End 2021	February 2022	February 2022
Cervical Cancer Screening	>51.00%	**49.77%**	**48.17%**	**49.03%**

Definition:
Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:

Women aged 21-64 who had a cervical cytology performed every 3 years.

Women aged 30-64 who had cervical cytology/HPV co-testing performed every 5 years.

Cervical Cancer Screening
Valleywise Health - FQHC

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	47.00%	48.00%	45.20%	45.66%	46.00%	46.00%	46.82%	46.90%	47.20%	47.46%	47.25%	47.42%
2020	46.63%	49.53%	47.90%	47.24%	45.47%	45.97%	45.40%	44.45%	44.83%	45.23%	45.62%	45.59%
2021	45.37%	45.82%	46.68%	46.93%	48.74%	48.83%	48.95%	49.13%	49.63%	49.67%	49.56%	49.58%
2022	46.59%	48.17%	49.03%									
●● 2020 UDS National Average: 51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%	51.00%
●●●● HP 2030 Target: 84.3%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%	84.30%

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Measure Analysis and Actions

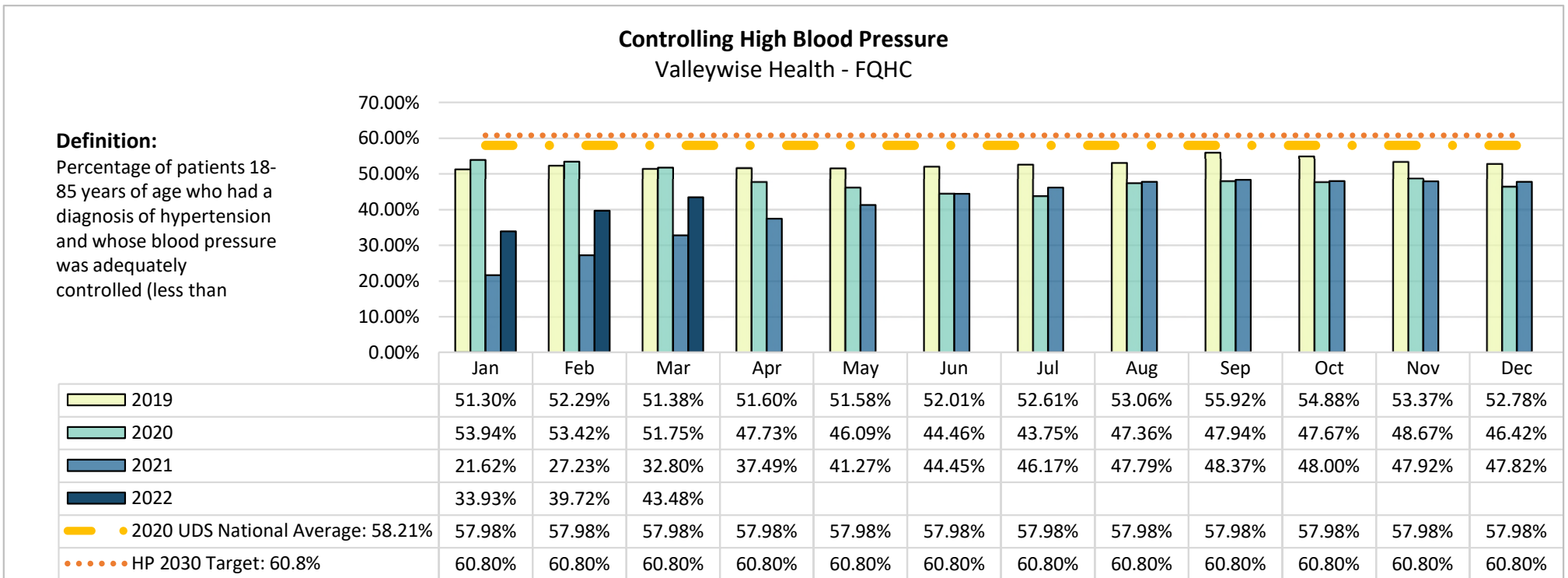| Analysis:	Action Items / Barriers:
The Cervical/Breast Cancer Screening Quality Workgroup is shifting focus to looking at if screenings are being reconciled appropriately to be included in the numerator.	• **Action:** Sample chart reviews for the NPX population who are overdue for cervical cancer screenings will be completed using March 2022 data – drill down to gain further insight if members showing 'not met' have really 'met' the measure but have not been reconciled in a manner where such is counted in the UDS report set. • **Barrier:** none

Measures <u>Not</u> meeting Benchmark

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Controlling High Blood Pressure	>58.21%	**47.76%**	**39.72%**	**43.48%**

Definition:
Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than

Controlling High Blood Pressure
Valleywise Health - FQHC

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	51.30%	52.29%	51.38%	51.60%	51.58%	52.01%	52.61%	53.06%	55.92%	54.88%	53.37%	52.78%
2020	53.94%	53.42%	51.75%	47.73%	46.09%	44.46%	43.75%	47.36%	47.94%	47.67%	48.67%	46.42%
2021	21.62%	27.23%	32.80%	37.49%	41.27%	44.45%	46.17%	47.79%	48.37%	48.00%	47.92%	47.82%
2022	33.93%	39.72%	43.48%									
2020 UDS National Average: 58.21%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%	57.98%
HP 2030 Target: 60.8%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%	60.80%

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Measure Analysis and Actions

Analysis:

This metric has improved by 10% since the start of the CY. The quality focus group has several initiatives to continue trends in a positive direction.

The new Ambulatory Hypertension Management Policy was approved by MEC on April 12, 2022.

The BP log has been converted to a combination English/Spanish version and submitted to the forms committee for entry into compliance 360.
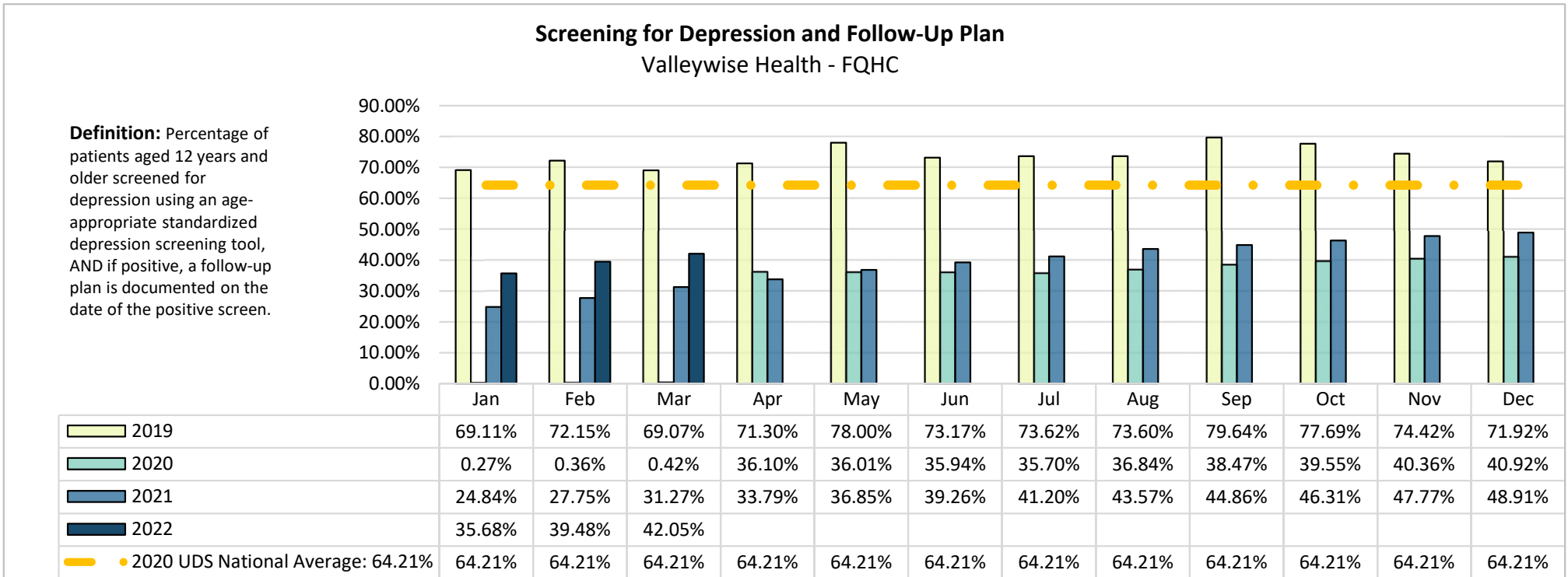
Action Items / Barriers:

- **Action:** BP re-check QI signage project being prepared for pilot at North Phoenix to encourage more compliance with BP re-checks if over 140/90

- **Barrier:** none

Measures <u>Not</u> meeting Benchmark

Measure	Benchmark	Final Year End 2021	February 2022	March 2022
Screening for Depression and Follow-Up Plan if Positive Screen	>64.21%	**48.73%**	**39.48%**	**42.05%**

Definition: Percentage of patients aged 12 years and older screened for depression using an age-appropriate standardized depression screening tool, AND if positive, a follow-up plan is documented on the date of the positive screen.

Screening for Depression and Follow-Up Plan
Valleywise Health - FQHC

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	69.11%	72.15%	69.07%	71.30%	78.00%	73.17%	73.62%	73.60%	79.64%	77.69%	74.42%	71.92%
2020	0.27%	0.36%	0.42%	36.10%	36.01%	35.94%	35.70%	36.84%	38.47%	39.55%	40.36%	40.92%
2021	24.84%	27.75%	31.27%	33.79%	36.85%	39.26%	41.20%	43.57%	44.86%	46.31%	47.77%	48.91%
2022	35.68%	39.48%	42.05%									
2020 UDS National Average: 64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%	64.21%

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Measure Analysis and Actions

Analysis:

Chart review analysis has demonstrated some areas of fall outs include depression screening results not being captured in the flowsheet. Some information is in the note which cannot be pulled into the UDS report. Also, exclusion/exception analysis continues to complicate the outcome of this measure.

*Historical: The Ambulatory Build Team made a change to the PHQ2/PHQ9 screening tool in late 2019; the row "refused" was not mapped due to an EPIC Foundation issue. This impacted the total number of exclusions that should have been removed from the metric denominator. The new row for "refused" was mapped and put into production end March of 2021. This change should be noted when comparing year over year for the measure.

Action Items / Barriers:

- **Action:** Doctoral student PHQ2/9 screening project and Guadalupe clinic.

- **Barrier:** The measure logic lookback period is set up in a manner where nearly every person falling in the numerator is screened and resulted 'negative'. Several of the members who screened positive and received follow up plans end up being 'excluded' in future months on a return visit due to a depression or bipolar diagnosis on the 'lookback period'. This creates a scenario where despite great follow up care – those patients may not improve our UDS numbers.

Valleywise Community Health
Centers Governing Council

Compliance and Quality
Committee Meeting

May 9, 2022

Item 3.

NRC RealTime Platform
Patient Satisfaction

May 9, 2022

Patient Experience:
NRC Real Time

Person Reporting: Crystal Garcia, MBA/HCM, RN
Vice President of Quality Management and Patient Safety
Reporting period: Fiscal Year 2022, Quarter 3

NRC Real Time
Qtr 3 FY22

Patient Experience (Ambulatory)	Reporting Program	Bench Mark	FY21 Year to Date	Desired Direction	Jul 2021	Aug 2021	Sep 2021	Qtr 1 (FY 2022)	Oct 2021	Nov 2021	Dec 2021	Qtr 2 (FY 2022)	Jan 2022	Feb 2022	Mar 2022	Qtr 3 (FY 2022)	Qtr 4 (FY 2022)	FY22 year to Date
Family Health Centers - FQHC																		
VMHC Net Would Recommend Facility																		
Real Time: NPS Would you recommend this facility? **FQHC** (OVERALL)	In-house	>71.1	72.7	⬆	74.7	71.0	70.5	70.8	70.4	70.7	73.2	71.4	68.6	72.2	70.7	70.5		70.9
n-size					170	1540	2672	4382	2816	2468	2408	7692	2729	2597	3106	8432		20506
Real Time: NPS Would you recommend this facility? (CHC: PXC Adolescent/ PXC Peds Combined)	In-house	>71.1	76.3	⬆	No Data	75.0	76.2	75.8	79.7	74.2	80.0	78.1	78.7	73.3	74.3	75.2		76.5
n-size					0	60	105	165	133	93	80	306	75	90	109	274		745
Real Time: NPS Would you recommend this facility? (CHC: PXC Women's Services)	In-house	>71.1	75.1	⬆	No Data	61.2	72.5	68.0	74.6	75.2	81.8	76.8	65.9	74.4	67.1	69.0		71.9
n-size					0	103	153	256	177	137	121	435	123	125	146	394		1085
Real Time: NPS Would you recommend this facility? (CHC: PXC Internal Medicine)	In-house	>71.1	70.8	⬆	No Data	68.3	68.7	68.5	66.7	68.8	78.2	70.5	60.0	66.9	78.4	83.8		69.2
n-size					0	123	198	321	189	125	124	438	165	133	153	451		1210
Real Time: NPS Would you recommend this facility? (McDowell Healthcare Center)	In-house	>71.1	80.9	⬆	61.9	81.5	77.1	77.1	70.5	76.6	79.8	76.0	76.1	75.6	75.5	75.8		76.2
n-size					21	124	170	315	183	248	228	659	230	238	229	697		1671

NRC Real Time
Qtr 3 FY22

Patient Experience (Ambulatory)	Reporting Program	Bench Mark	FY21 Year to Date	Desired Direction	Jul 2021	Aug 2021	Sep 2021	Qtr 1 (FY 2022)	Oct 2021	Nov 2021	Dec 2021	Qtr2 (FY 2022)	Jan 2022	Feb 2022	Mar 2022	Qtr 3 (FY 2022)	Qtr 4 (FY 2022)	FY22 Year to Date
Family Health Centers - FQHC																		
VMHC Net Would Recommend Facility																		
Real Time: NPS Would you recommend this facility? (Avondale Family Health Center)	In-house	>71.1	✖ 65.4	⬆	84.3	75.6	66.0	▣ 70.7	64.0	68.8	69.4	▣ 67.2	74.0	72.7	69.4	✓ 72.0		▣ 69.9
n-size					51	180	335	566	392	340	317	1049	362	344	373	1079		2694
Real Time: NPS Would you recommend this facility? (Chandler Family Health Center)	In-house	>71.1	▣ 70.8	⬆	56.0	57.0	63.1	✖ 60.6	67.3	72.9	74.8	✓ 71.5	65.5	70.7	63.4	▣ 66.3		▣ 67.1
n-size					25	142	244	411	269	258	238	765	330	273	317	920		2096
Real Time: NPS Would you recommend this facility? (Mesa Family Health Center)	In-house	>71.1	▣ 69.1	⬆	92.0	63.5	60.5	✖ 63.7	64.4	72.7	73.8	▣ 70.2	48.7	65.7	75.1	▣ 67.8		▣ 67.9
n-size					25	126	215	366	225	231	206	662	78	230	273	581		1609
Real Time: NPS Would you recommend this facility? (South Central Family Health Center)	In-house	>71.1	▣ 72.7	⬆	100.0	70.5	65.3	▣ 66.8	73.1	63.1	64.2	▣ 66.9	60.4	74.5	67.6	▣ 66.9		▣ 66.9
n-size					1	105	268	374	279	271	268	818	351	271	346	968		2160
Real Time: NPS Would you recommend this facility? (West Maryvale Family Health Center)	In-house	>71.1	✓ 82.2	⬆		Starts in December					84.0	✓ 84.0	77.2	81.9	73.2	✓ 77.2		▣ 78.2
n-size											81	81	149	138	164	451		532

Patient Experience (Ambulatory)	Reporting Program	Bench Mark	FY21 Year to Date	Desired Direction	Jul 2021	Aug 2021	Sep 2021	Qtr 1 (FY 2022)	Oct 2021	Nov 2021	Dec 2021	Qtr 2 (FY 2022)	Jan 2022	Feb 2022	Mar 2022	Qtr 3 (FY 2022)	Qtr 4 (FY 2022)	FY22 Year to Date
Family Health Centers - FQHC																		
VMHC Net Would Recommend Facility																		
Real Time: NPS Would you recommend this facility? (Guadalupe Family Health Center)	In-house	>71.1	73.2	⬆	No Data	73.9	83.1	80.0	70.2	68.9	50.0	64.0	64.0	70.9	53.9	62.2		66.5
n-size					0	46	89	135	104	90	78	272	89	79	102	270		677
Real Time: NPS Would you recommend this facility? (North Phoenix Family Health Center)	In-house	>71.1	75.6	⬆	73.5	74.5	68.3	71.0	73.2	75.0	67.8	72.1	72.6	66.0	71.7	70.3		71.2
n-size					34	145	219	398	265	304	276	845	292	259	336	887		2130
Real Time: NPS Would you recommend this facility? (South Phoenix/Laveen Family Health Center)	In-house	>71.1	74.2	⬆	61.5	74.3	75.8	74.7	75.3	64.5	78.3	72.5	71.7	74.7	76.0	74.2		73.7
n-size					13	113	186	312	190	186	166	542	205	162	254	621		1475
Real Time: NPS Would you recommend this facility? (Peoria Family Health Center)	In-house	>71.1	70.6	⬆	No Data	75.8	74.0	74.6	71.0	68.0	77.5	72.2	68.8	75.3	71.6	71.8		72.6
n-size					0	190	338	528	310	194	231	735	295	263	310	868		2131
Real Time: NPS Would you recommend this facility? (Maryvale Family Health Center)	In-house	>71.1	82.2	⬆	No Data	75.5	84.3	81.2	77.1	No Data	No Data	77.1	Retired					79.9
n-size					0	94	166	260	109	0	0	109						369

NRC Real Time
Qtr 3 FY22

Patient Experience (Ambulatory)	Reporting Program	Bench Mark	FY21 Year to Date	Desired Direction	Jul 2021	Aug 2021	Sep 2021	Qtr1 (FY2022)	Oct 2021	Nov 2021	Dec 2021	Qtr2 (FY2022)	Jan 2022	Feb 2022	Mar 2022	Qtr3 (FY2022)	Qtr4 (FY2022)	FY22 Year to Date
Dental																		
Net Would Recommend Facility																		
Real Time: NPS Would you recommend this facility? DENTAL (OVERALL)	In-house	>78.5	72.7	⬆	74.5	80.9	71.6	75.7	67.9	73.4	72.8	71.5	74.7	79.0	65.8	72.5		73.2
Real Time: NPS Would you recommend this facility? (PXC DENTAL)	In-house	>78.5	71.9	⬆	72.4	80.4	66.7	73.6	65.4	75.0	64.7	68.0	69.2	81.1	65.7	71.5		71.1
Real Time: NPS Would you recommend this facility? (PXC DENTAL PEDS)	In-house	>78.5	79.7	⬆	90.0	84.2	76.0	82.8	50.0	88.2	70.0	71.4	85.7	88.9	88.0	87.5		81.4
Real Time: NPS Would you recommend this facility? (MCD DENTAL)	In-house	>78.5	75.6	⬆	61.9	94.4	64.3	73.6	69.6	30.8	100.0	62.8	58.3	92.9	30.0	56.5		64.8
Real Time: NPS Would you recommend this facility? (MSA DENTAL)	In-house	>78.5	79.5	⬆	87.5	86.4	61.1	78.6	90.9	100.0	Retired							82.4
Real Time: NPS Would you recommend this facility? (CHD DENTAL)	In-house	>78.5	55.8	⬆	50.0	38.5	43.8	43.9	76.5	75.0	83.3	78.7	65.0	62.1	75.9	67.9		66.1
Real Time: NPS Would you recommend this facility? (AVD DENTAL)	In-house	>78.5	68.3	⬆	73.3	95.0	86.4	86.0	61.5	72.2	47.4	60.0	95.2	75.0	47.4	73.2		73.6
Real Time: NPS Would you recommend this facility? (PEC DENTAL)	In-house	>78.5	94.1	⬆	87.1	80.8	84.6	84.3	80.0	80.6	86.5	83.0	75.0	84.6	74.1	76.7		81.8

NRC Real Time
All Questions - FQHC
Qtr 3 FY22

QUESTION SUMMARY

Question	YTD	Last 3 Months	Last Month	n-size	Score	Bench mark	Gap	
Rating of provider	84.8	85.1	85.3	5,502	84.7	86.8	-2.1	
Provider would recommend	83.8	84.1	83.7	5,713	83.8	86.7	-2.9	
NPS: Facility would recommend	70.3	71.4	71.7	5,934	70.0	75.9	-5.9	
Clerks courtesy & respect	69.8	70.7	70.9	3,797	69.4	79.9	-10.5	
Clerks/receptionists helpful	68.0	68.5	67.9	3,746	68.0	76.0	-8.0	
Provider listened	67.5	67.8	69.0	7,748	67.1	81.5	-14.4	
Trust provider w/ care	67.0	67.1	67.3	7,672	66.9	79.4	-12.5	
Facility was clean	66.0	67.2	66.3	3,831	66.0	79.9	-13.9	
Got enough info re: treatment	61.1	61.4	61.6	7,848	61.0	77.3	-16.3	
Knew what to do if questions	56.4	56.4	57.4	7,488	56.1	75.5	-19.4	
Quality of video/call	55.7	54.6	55.4	2,820	55.8	66.9	-11.1	
Comfort w/ online interaction	54.9	54.1	56.8	2,919	54.4	68.4	-14.0	
Seen by provider in timely manner	53.1	53.5	53.9	7,988	52.9	66.8	-13.9	
Knew medical history	52.2	52.2	53.4	7,581	51.8	69.4	-17.6	
Discussed illness prevention	50.1	50.3	51.0	7,348	49.9	58.2	-8.3	

New Patient Experience

ACCEPT

Acknowledge
Connect
Communicate
Every Person
Every Time

An On-Stage Patient Experience Standard

Next Steps

January 2022: Complete education about ACCEPT & begin implementing

February: Demonstrate ACCEPT consistently; refreshers as needed, audit progress

March & Beyond: Audit & provide refreshers as needed

FQHC Comments FY22 Qtr 3

What Else Re: Experience:

They treated me very cordially and professionally. Both the translator and the doctor are very kind. Thank you for your attention.

What Else Re: Experience:

I really liked how my doctor treated me, I felt calm with confidence and I liked that she had a lot of interest in her patients in person as care, she gave us very many very good things, she recommended vitamins, I felt very good, I wish there were more doctors like her, thank you.

What Else Re: Experience:

I would like radiology and gastroenterology to be there, it also makes it difficult not to have to go to a different one because it is more comfortable for me and the (unreadable), thank you.

What Else Re: Experience:

I reached the provider in person. She was able to take care of me quickly. She's the best provider that I've had. I brought my family member to her, my family member, which is my sister, absolutely loved how she took care of her on her first visit, and we are absolutely happy with her service. We wish all cover, all providers could be as wonderful and accommodating as she is.

What Else Re: Experience:

The service is really good. Prompt response to getting appointments an things, the only complaint I have is getting through the line, sometimes the lines are ridiculous and we get a lot of the we get the patient assistance people instead of the office and that happens a lot. Other than that. The doctors are very professional, very knowledgeable, very friendly. And that's it.

FQHC Comments FY22 Qtr 3

What Else Re: Experience:
It took forever to get into my lab appointment. The lab personnel was awful, she wouldn't contact the provider, even though she could have, and for the medical assistant, she was a little rude, especially when calling for us to come into the room. We were in the education room, and she was just not very personable when I told her we were here. She kept calling our name, even though I said I was here.

What Else Re: Experience:
The only thing I didn't like is that my appointment was at 3 pm and the doctor saw me until 5, that's why I had to wait 2 hours for them to see me, if they make the appointment so that the (unreadable) didn't wait for when the appointment time they feel like serving customers.

What Else Re: Experience:
I wanted to say that they never gave me the prescription.

What Else Re: Experience:
Yes, my doctor is very thorough. I was totally impressed and recommend him to all. He is very good. He has patience goes over everything with you and not in a rush. I really like him. He's the best. Thank you.

Thank you

Valleywise
Health

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 4.

NRC RealTime Platform Patient Satisfaction Survey Questions

Valleywise Health

May 9, 2022

Patient Experience: NRC Real Time Survey Questions

Person Reporting: Crystal Garcia, MBA/HCM, RN
Vice President of Specialty Services, Quality Management and Patient Safety

NRC Real Time
Starter Kit Questions

- Service Excellence Committee created specifically for Ambulatory setting

- Reviewed the new Starter Kit Questions and Optional questions at Ambulatory Service Excellence Committee.

- Emailed Ambulatory Leadership the various Starter Kit Questions/Optional questions asking for Feedback

- Reviewed and determined that each area is getting the appropriate question pods asked

- Ensure the Clinic Visit is represented on the NRC Call

NRC Real Time
Current Medical Practice Pod

	MEDICAL PRACTICE/TELEHEALTH QUESTION POD				
ID	Question Text	Question Scale	Logic	Dashboard	Overall Key Metric
1133	Was it easy to get an appointment when you wanted?	No, Yes somewhat, Yes mostly, Yes definitely			
2419	How did you schedule your appointment?	MyChart, In Person, Phone			
1035	Were you seen by this provider in a timely manner?	No, Yes somewhat, Yes mostly, Yes definitely		1	
1036	Did this provider give you enough information about your health and treatment?	No, Yes somewhat, Yes mostly, Yes definitely			
1037	Did this provider listen carefully to you?	No, Yes somewhat, Yes mostly, Yes definitely		2	
1027	Did you trust this provider with your care?	No, Yes somewhat, Yes mostly, Yes definitely			
1038	Did this provider seem to know your medical history?	No, Yes somewhat, Yes mostly, Yes definitely			
1034	Did you know what to do if you had more questions after your visit?	No, Yes somewhat, Yes mostly, Yes definitely			
1095	Did this provider talk about how to prevent illness or injury?	No, Yes somewhat, Yes mostly, Yes definitely		3	
Gate	Was your visit done virtually, such as by telephone, or other electronic device?	Yes/No			
1215	Was this method of connecting with a care provider easy to use?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = Yes		
2999	Were you comfortable interacting with your provider online?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = Yes		
1228	Was the quality of the video or call good enough?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = Yes		
1052	Was the facility clean?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = No		
1555	Did clerks and receptionists treat you with courtesy and respect?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = No		
1110	Were clerks and receptionists at this facility as helpful as you thought they should be?	No, Yes somewhat, Yes mostly, Yes definitely	If Gate = No		
14	For these next questions, please listen very carefully, as you will be using a response scale from 0 to 10 and it is very important that we get an accurate response from you.	NA	IVR only		
1039	How likely would you be to recommend this provider to your family and friends?	Likely 0-10			NPS
138	Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?	0-10 Rate facility			
1065	What else would you like to say about your experience?	Open Ended			

NRC Real Time
New Medical Practice Pod

	MEDICAL PRACTICE QUESTION POD - Include Pediatric questions			
ID	**Question Text**	**Question Scale**	**Dashboard**	**Overall Key Metric**
1133	Was it easy to get an appointment when you wanted?	No, Yes somewhat, Yes mostly, Yes definitely		
1113	Were registration staff at this facility as helpful as you thought they should be?	No, Yes somewhat, Yes mostly, Yes definitely		
1066	Were you seen by a care provider in a timely manner?	No, Yes somewhat, Yes mostly, Yes definitely		
1056	Did the care providers explain things in a way you could understand?	No, Yes somewhat, Yes mostly, Yes definitely		
1081	Did the care providers listen carefully to you?	No, Yes somewhat, Yes mostly, Yes definitely		
1062	Did the care providers give you enough information about your health and treatment?	No, Yes somewhat, Yes mostly, Yes definitely		
1063	Did the care providers seem to know your medical history?	No, Yes somewhat, Yes mostly, Yes definitely		
1052	Was the facility clean?	No, Yes somewhat, Yes mostly, Yes definitely		
14	For these next questions, please listen very carefully, as you will be using a response scale from 0 to 10 and it is very important that we get an accurate response from you.	NA		
1017	How likely would you be to recommend this facility to your family and friends?	Likely 0-10		NPS
1065	What else would you like to say about your experience?	Open Ended		

NRC Real Time
New Telehealth Question Pod

	Telehealth Question POD - Include Pediatric questions			
ID	**Question Text**	**Question Scale**	**Dashboard**	**Overall Key Metric**
1217	Did the care provider listen carefully to you?	No, Yes somewhat, Yes mostly, Yes definitely		
1215	Was this method of connecting with a care provider easy to use?	No, Yes somewhat, Yes mostly, Yes definitely		
1066	Were you seen by a care provider in a timely manner?	No, Yes somewhat, Yes mostly, Yes definitely		
1218	Did the care provider seem to know your medical history?	No, Yes somewhat, Yes mostly, Yes definitely		
2999	Were you comfortable interacting with your provider online?	No, Yes somewhat, Yes mostly, Yes definitely		
14	For these next questions, please listen very carefully, as you will be using a response scale from 0 to 10 and it is very important that we get an accurate response from you.	NA		
1017	How likely would you be to recommend this facility to your family and friends?	Likely 0-10		NPS
1065	What else would you like to say about your experience?	Open Ended		

NRC Real Time
New Dental Question Pod

DENTAL QUESTION POD - Include Pediatric questions				
ID	Question Text	Question Scale	Dashboard	Overall Key Metric
1206	Did the dental providers give you enough information about your health and treatment?	No, Yes somewhat, Yes mostly, Yes definitely		
1207	Did the dental providers listen carefully to you?	No, Yes somewhat, Yes mostly, Yes definitely		
2412	Did the staff explain what to do if you had questions or concerns after leaving?	No, Yes somewhat, Yes mostly, Yes definitely		
1493	Did staff members treat you with courtesy and respect?	No, Yes somewhat, Yes mostly, Yes definitely		
1117	Did staff members explain things in a way you could understand?			
1017	How likely would you be to recommend this facility to your family and friends?	Likely 0-10		NPS
1065	What else would you like to say about your experience?	Open Ended		

NRC Real Time
Starter Kit Questions
Next Steps:

- Service Excellence Committee met April 28th, 2022, for approval of Starter Kit Questions

- Review and discuss at Compliance and Quality Council May 9, 2022.

- Work with IT and NRC to ensure the new questions and timeframes are appropriate.

- Goal of Full Implementation of the new Starter Kit questions July 1, 2022, to begin the new Fiscal Year 2023.

Thank you

Valleywise
Health

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 5.

Compliance and Internal Audit Work Plans and Ethics Line Report

Q3 FY2022 FQHC Compliance and Internal Audit Work Plan Update - Compliance and Quality Committee

Valleywise Health

Reporting Group: Compliance and Internal Audit
Person Reporting:
L.T. Slaughter, Jr., CPA, CGMA, CHC, CISSP, CISA, MBA
or Elena Landeros, Compliance Coordinator
Reporting period: Q3 FY2022
Chief Compliance Officer/Privacy Officer

Q3 FY2022 Compliance and Internal Audit Work Plan Update – FQHC

- 1.0 – Q3 FY2022 Compliance Work Plan - FQHC

- 2.0 – Q3 FY2022 Internal Audit Work Plan - FQHC

- 3.0 - Ethics Line Reports - FQHC

1.0 – Q3 FY2022 Compliance Work Plans – FQHC

Data Dictionary for the Compliance and Internal Audit Work Plan

<u>ABN – Advance Beneficiary Notice</u> – A Medicare rule that requires communication to a Medicare beneficiary that a test or procedure is not medically necessary and they will be liable for the test or procedure.

<u>ACN – Arizona Care Network</u> – An Accountable Care Organization that operate in Arizona.

<u>AHCCCS – Arizona Healthcare Cost Containment System</u> – State of Arizona's name for the Medicaid state plan.

<u>Medicare PPS –</u> Medicare Prospective Payment System – A fixed based Medicare payment model.

<u>MU – Meaningful Use</u> – A term used in the Affordable Care Act to evaluate the implementation of Electronic Health Records and qualify for receiving incentive payments.

<u>NAP – New Access Point</u> – A process where you receive a HRSA grant to open a new FQHC site.

<u>OSV – Operational Site Visit</u> – The name for the HRSA audit of FQHCs at it relates to the HRSA Compliance Manual.

<u>Prop 480 (Care-Reimagined)</u> – Referendum passed by the voters of Maricopa County to fund the re-construction of Maricopa County Special Health Care District d/b/a Valleywise Health.

340b – A HRSA sponsored discount drug program.

1.1 Q3 FY2022 Compliance Work Plan – FQHC

The FY2022 compliance projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of compliance with regulations, as well as the identification of value-added recommendations. The FY2022 compliance work plan represents compliance activities based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Re-assessment and Selection Q3						
CQ3.1 Violent Patients	Q3	100 Hours	Monitoring violent patient workgroups and physical barriers	On-going	5	3.5
CQ3.2 Information Blocking Rules	Q3	200 Hours	Monitoring Information Blocking workgroups and implementation of the rules	On-going	5	3
CQ3.3 Pharmacy 340b Compliance	Q3	150 Hours	Monitoring 340b compliance with the 340b working group	On-going	5	2
Risk Re-assessment and Selection Q4						
CQ4.1 Clinic Behavioral Health Models	Q4	150 Hours			5	
CQ4.2 HIPAA Privacy Controls	Q4	200 Hours			5	
RO4 Risk Assessment and 2023 Compliance Plan Development	Quarterly	120 Hours				
Special Projects and Other Compliance Requests	On-going	TBD				
Compliance Planning, Administration and Meetings	Quarterly	TBD				

2.0 – Q3 FY2022 Internal Audit Work Plans – FQHC
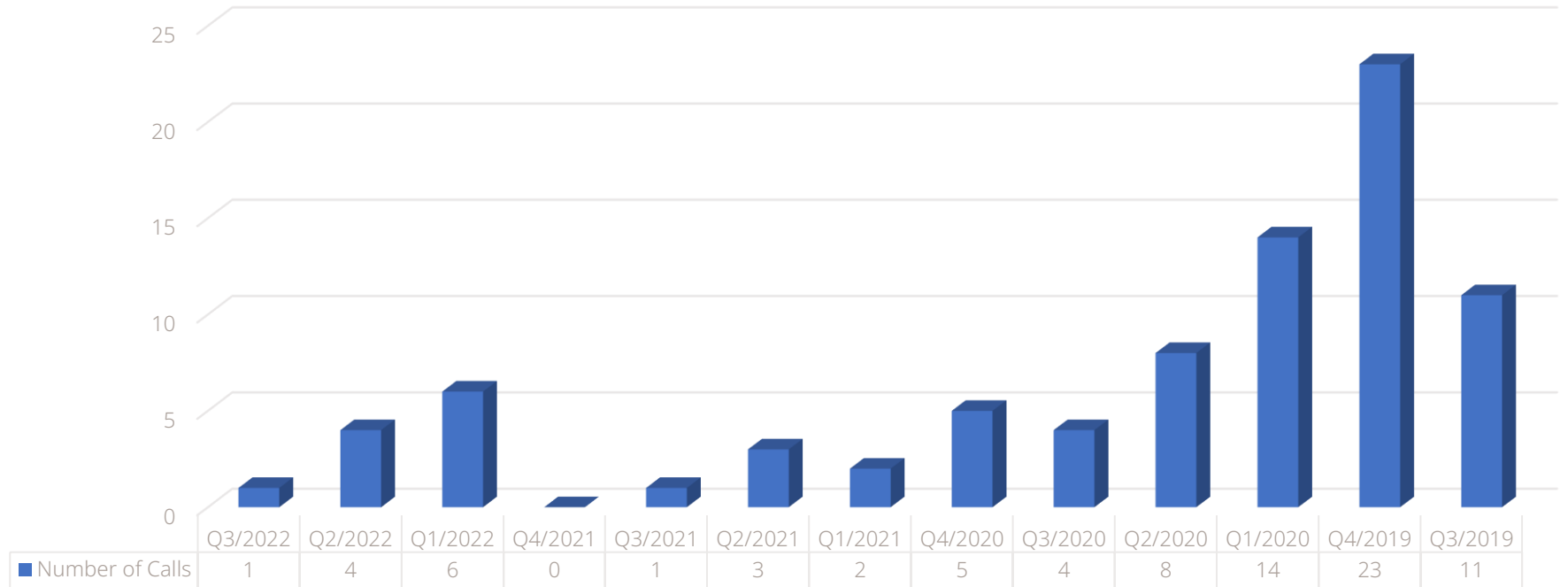
2.1 Q3 FY2022 Internal Audit Work Plan – FQHC

The FY2022 internal audit projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of internal controls as well as the identification of value-added recommendations. The FY2022 audit plan represents audits based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
IQ3.1 Payroll Review	Q3	100 Hours	Planning in Q4 due to Kronos issue	On-going	5	5
IQ3.2 Regulatory Sign Reviews	Q3	200 Hours	Monitoring sign controls and developing a database	On-going	5	3
IQ3.3 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q3	150 Hours	Monitoring construction controls	On-going	5	2
Risk Re-assessment and Selection Q4						
IQ4.1 Research in the FQHCs	Q4	150 Hours			5	
IQ4.2 Revenue Cycle Controls - Back End	Q4	150 Hours			5	
IQ4.3 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q4	100 Hours			5	
Risk Assessment and 2023 Internal Audit Plan Development	Quarterly	120 Hours				
Special Projects and Other Internal Audit Requests	On-going	TBD				
Internal Audit Planning, Administration and Meetings	Quarterly	TBD				

3.0 – Q3 FY2022 Ethics Line Reports (01/01/2022 through 03/31/2022) – FQHC Only

3.1 – FQHC Ethics Line Report (Three-Year Trending by Quarter)

Number of FQHC Ethics Line Calls by Fiscal Quarter

	Q3/2022	Q2/2022	Q1/2022	Q4/2021	Q3/2021	Q2/2021	Q1/2021	Q4/2020	Q3/2020	Q2/2020	Q1/2020	Q4/2019	Q3/2019
Number of Calls	1	4	6	0	1	3	2	5	4	8	14	23	11

3.2 – Q3 FY2022 Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Column Labels	
Row Labels	Green	Grand Total
Inappropriate Behavior	1	1
Grand Total	1	1

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization

(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization

(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization

(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

3.2 – Q3 FY2022 Relevant Issue Definitions

Inappropriate Behavior - Statements or actions that are not harassing in nature but are believed to be unsuitable for the workplace.

3.3 – Q3 FY2022 (FQHC Only) Average Days to Close (and Same Quarter Last Two Previous Years)

Benchmark:

Average Days to Close Benchmark = 30 days or less

Results:

Q3 FY2022 Average Days to Close = 33

Comparable:

Q3 FY2021 Average Days to Close = 11

Q3 FY2020 Average Days to Close = 20

Previous Quarter's Indicators (Supplemental Data)

Q2 FY2022 Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Alert Level	
Row Labels	Green	Grand Total
⊟ Unsubstantiated	4	4
Discrimination	1	1
Inappropriate Behavior	2	2
Unfair Employment Practices	1	1
Grand Total	4	4

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization
(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization
(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization
(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

Q2 FY2022 Relevant Issue Definitions

Discrimination – Statements or actions based on age, race, color, national origin, sexual orientation, gender, disability or religion that are the basis for employment, promotion or compensation decisions.

Inappropriate Behavior - Statements or actions that are not harassing in nature but are believed to be unsuitable for the workplace.

Unfair Employment Practices - Employment decisions, practices or disciplinary actions that are believed to be unfair regardless of whether they are the result of job performance, changes in business needs or other business-related decisions.

Q1 FY2022 Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Alert Level	
Row Labels	Green	Grand Total
In Process	2	2
Harassment - Workplace	1	1
Unfair Employment Practices	1	1
Insufficient Information	1	1
Unfair Employment Practices	1	1
Unsubstantiated	3	3
Inappropriate Behavior	1	1
Unfair Employment Practices	2	2
Grand Total	6	6

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization
(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization
(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization
(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

Q1 FY2022 Relevant Issue Definitions

Harassment/Workplace - Persistent statements, conduct or actions that are uninvited, degrading, offensive, humiliating or intimidating and create an unpleasant or hostile environment.

Inappropriate Behavior - Statements or actions that are not harassing in nature but are believed to be unsuitable for the workplace.

Unfair Employment Practices - Employment decisions, practices or disciplinary actions that are believed to be unfair regardless of whether they are the result of job performance, changes in business needs or other business-related decisions.

Q4 FY2021 Issue Type, Alert Status and Primary Outcome Report

No FQHC Cases Reported in Q4 FY2021 !!!

Q3 FY2021 Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Alert Level	
Row Labels	Green	Grand Total
⊟ Harassment - Workplace	1	1
Substantiated	1	1
Grand Total	1	1

Legend of Terms:

Referred - These cases are sent to Risk Management or Human Resources for low risk or a repeat caller

Unsubstantiated - After investigation of the case the allegation was not supported by evidence

Substantiated - After investigation of the case the allegation was supported by evidence

Alert Level Definition (All Alert Levels for the Quarter are Listed Above)

Green - Need to address in normal investigation cycle and low regulatory or monetary impact of the organization
(Green Example - A call about an employee not agreeing with their evaluation)

Yellow - Expedited investigation required and moderate regulatory or monetary impact to the organization
(Yellow Example - A call about a potential medium level HIPAA violation or patient safety)

Red - Immediate Investigation required and potential high regulatory or monetary impact to the organization
(Red Example - A call about a large HIPAA violation, a large theft or fraud/abuse or a major patient safety issue)

Q3 FY2021 Relevant Issue Definitions

Harassment/Workplace - Persistent statements, conduct or actions that are uninvited, degrading, offensive, humiliating or intimidating and create an unpleasant or hostile environment.

Valleywise Community Health
Centers Governing Council

Compliance and Quality
Committee Meeting

May 9, 2022

Item 6.

Compliance Work Plan
FY 2023

FY2023 FQHC - Compliance Work Plan - Compliance and Quality Committee

Reporting Group: Compliance
Person Reporting:
L.T. Slaughter, Jr., CPA, CGMA, CHC, CISSP, CISA, MBA
or Elena Landeros, Compliance Coordinator
Reporting period: FY2023
Chief Compliance Officer/Privacy Officer

1.0 – FY2023 Compliance Work Plans – FQHC

Data Dictionary for the Compliance and Internal Audit Work Plan

.
AHCCCS – Arizona Healthcare Cost Containment System – State of Arizona's name for the Medicaid state plan.

Information Blocking Rules - 21st Century Cares Act enables better access of medical information to patients.

Medicare PPS – Medicare Prospective Payment System – A fixed based Medicare payment model.

EHR Incentive Payments– A term used in the Affordable Care Act (for ACHCCS Medicaid) to evaluate the implementation of Electronic Health Records and qualify for receiving incentive payments.

NAP – New Access Point – A process where you receive a HRSA grant to open a new FQHC site.

OSV – Operational Site Visit – The name for the HRSA audit of FQHCs at it relates to the HRSA Compliance Manual.

Prop 480 (Care-Reimagined) – Referendum passed by the voters of Maricopa County to fund the re-construction of Maricopa County Special Health Care District d/b/a Valleywise Health.

340b – A HRSA sponsored discount drug program.

1.1 FY2023 Compliance Work Plan – FQHC

The FY2023 compliance projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of compliance with regulations, as well as the identification of value-added recommendations. The FY2023 compliance work plan represents compliance activities based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1						
CQ1.1 HIPAA Electronic Referrals and SER table	Q1	100 Hours				
CQ1.2 E&M and Telemedicine Training	Q1	150 Hours				
Risk Re-assessment and Selection Q2						
CQ2.1 Women's Clinic Review and New Facilities	Q2	150 Hours				
CQ2.2 Resident Model Compliance	Q2	100 Hours				

1.2 FY2023 Compliance Work Plan – FQHC

The FY2023 compliance projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of compliance with regulations, as well as the identification of value-added recommendations. The FY2023 compliance work plan represents compliance activities based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Re-assessment and Selection Q3						
CQ3.1 Information Blocking Rules	Q3	100 Hours				
CQ3.2 Pharmacy 340b Compliance	Q3	150 Hours				
Risk Re-assessment and Selection Q4						
CQ4.1 Clinic Behavioral Health Models	Q4	150 Hours				
CQ4.2 Provider-Based Review	Q4	150 Hours				
RQ4 Risk Assessment and 2024 Compliance Plan Development	Quarterly	120 Hours				
Special Projects and Other Compliance Requests	On-going	TBD				
Compliance Planning, Administration and Meetings	Quarterly	TBD				

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 7.

Internal Audit Work Plan FY 2023

FY2023 FQHC Internal Audit Work Plan - Compliance and Quality Committee

Reporting Group: Internal Audit
Person Reporting:
L.T. Slaughter, Jr., CPA, CGMA, CHC, CISSP, CISA, MBA
or Elena Landeros, Compliance Coordinator
Reporting period: FY2023
Chief Compliance Officer/Privacy Officer

1.0 – FY2023 Internal Audit Work Plans – FQHC

Data Dictionary for the Compliance and Internal Audit Work Plan

.
AHCCCS – Arizona Healthcare Cost Containment System – State of Arizona's name for the Medicaid state plan.

Information Blocking Rules - 21st Century Cares Act enables better access of medical information to patients.

Medicare PPS – Medicare Prospective Payment System – A fixed based Medicare payment model.

E&M - Evaluation and Management Services as updated on January 1, 2021.

NAP – New Access Point – A process where you receive a HRSA grant to open a new FQHC site.

OSV – Operational Site Visit – The name for the HRSA audit of FQHCs at it relates to the HRSA Compliance Manual.

Prop 480 (Care-Reimagined) – Referendum passed by the voters of Maricopa County to fund the re-construction of Maricopa County Special Health Care District d/b/a Valleywise Health.

340b – A HRSA sponsored discount drug program.

1.1 FY2023 Internal Audit Work Plan – FQHC

The FY2023 internal audit projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of internal controls as well as the identification of value-added recommendations. The FY2023 audit plan represents audits based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Assessment and Selection Q1 (Current State Assessment)						
IQ1.1 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q1	150 Hours				
IQ1.2 E&M and Telemedicine Auditing	Q1	150 Hours				
Risk Re-assessment and Selection Q2						
IQ2.1 FQHC Grants Reviews	Q2	200 Hours				
IQ2.2 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q2	100 Hours				

1.1 FY2023 Internal Audit Work Plan – FQHC

The FY2023 internal audit projects are listed below with proposed timing and estimated hours. Each project will, at a minimum, include a focus on the adequacy of internal controls as well as the identification of value-added recommendations. The FY2023 audit plan represents audits based on the results of the risk assessment and may be subject to change based on changes in risk, priorities and Valleywise Health initiatives throughout the fiscal year.

Project Name	Audit Timing	Est. Audit Hours	Current Status	Completion Status	Initial Risk Rating	Post Review Ranking
Risk Re-assessment and Selection Q3						
IQ3.1 Regulatory Sign Reviews	Q3	100 Hours				
IQ3.2 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q3	150 Hours				
Risk Re-assessment and Selection Q4						
IQ4.1Referrals and After Visit Summaries	Q4	150 Hours				
IQ4.2 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q4	100 Hours				
Risk Assessment and 2024 Internal Audit Plan Development	Quarterly	120 Hours				
Special Projects and Other Internal Audit Requests	On-going	TBD				
Internal Audit Planning, Administration and Meetings	Quarterly	TBD				

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Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 8.

Closing Comments and Announcements
(No Handout)

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

May 9, 2022

Item 9.

Staff Assignments
(No Handout)