Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022
5:30 p.m.

Agenda

Committee Members	AGENDA - AMENDED
Eileen Sullivan, 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., 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	**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-08-08-22/ for further information.

Monday, August 8, 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

Agendas are available within 24 hours of each meeting via the Clerk's Office, Valleywise Health Medical Center, 2601 East Roosevelt Street, Phoenix, Arizona 85008, Monday through Friday between the hours of 9:00 a.m. and 4:00 p.m. and on the internet at https://valleywisehealth.org/about/governing-council/ Accommodations for individuals with disabilities, alternative format materials, sign language interpretation, and assistive listening devices are available upon 72 hours advance notice via the Clerk's Office, Valleywise Health Medical Center, 2601 East Roosevelt Street, Phoenix, Arizona 85008, (602) 344-5177. To the extent possible, additional reasonable accommodations will be made available within the time constraints of the request.

8/2/2022 4:25 PM

ITEMS MAY BE DISCUSSED IN A DIFFERENT SEQUENCE

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 May 9, 2022

      ii. **Approve** Compliance and Quality Committee Meeting Minutes Dated June 13, 2022

End of Consent Agenda

Motion to Recess General Session and Convene in Executive Session

Executive Session:

E-1 Legal Advice; Records Exempt by Law from Public Inspection; A.R.S. § 38-431.03(A)(3) and A.R.S. § 38-431.03(A)(2)[1]: Annual Federally Qualified Health Center Clinics Patient Grievances and Complaints Report 15 min

[1] *Exemptions based upon, utilization review records and information per A.R.S. § 36-441 et. seq. Peer review, professional practice, quality assurance/improvement records and information per A.R.S. § 36-445 et. seq. Health care entity quality assurance activities, records and information per A.R.S. § 36-2401 et. seq.*

Recess Executive Session and Reconvene in General Session

General Session, Presentation, Discussion and Action:

2. Discuss Federally Qualified Health Center Clinics Patient Safety Report 10 min
   Crystal Garcia, Vice President, Surgical, Specialty, Quality and Safety

3. Discuss and Review Uniform Data System (UDS) Quality Metrics for the Federally Qualified Health Center Clinics for the second quarter of calendar year 2022 10 min
   Crystal Garcia, Vice President, Surgical, Specialty, Quality and Safety

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

5. Discuss and Review annual Compliance Education Training for Valleywise Health staff 10 min
   LT Slaughter, Chief Compliance Officer

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

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

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

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

Old Business:

None

Adjourn

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 1.

Consent Agenda

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 1.a.i.

Minutes:
May 9, 2022

Minutes

Valleywise Community Health Centers Governing Council
Compliance and Quality Committee
Valleywise Health Medical Center
May 9, 2022
5:30 p.m.

Voting Members Present:	Michelle Barker, Committee Chair - *participated remotely* Daniel Messick, Committee Vice Chair - *participated remotely* Liz McCarty, Member - *participated remotely*
Non-Voting Members Present:	Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics - *participated remotely* LT Slaughter, Chief Compliance Officer - *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*
Non-Voting Members Absent:	Christina Smarik-Snyder, M.D., Interim Medical Director, Ambulatory Services
Others/Guest Presenters:	Michael White, M.D., Chief Clinical Officer - *participated remotely* 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 all 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. Minutes:

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

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

VOTE: 3 Ayes: Chairman Barker, Vice Chairman Messick, Ms. McCarty
0 Nays
Motion passed.

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

Ms. Garcia gave an overview of UDS quality metrics for fiscal year end (FYE) 2021 and the first quarter of calendar year (CY) 2022.

She outlined metrics that required improvement such as controlling diabetes and hemoglobin A1c ranges and weight assessment and counseling for nutrition and physical activity for children and adolescents. Other measures that did not meet benchmark included cervical cancer screening, controlling high blood pressure, BMI screening and follow-up and clinical depression screening and follow-up.

Ms. Garcia presented bar graph data which compared information from FYE 2021 to fiscal year to date (FYTD) 2022, as of March. She spoke about the performance improvement action plans to improve measures.

She emphasized action plans for BMI screening and follow-up improvement.

There were changes made to requirements regarding data collection, stating that when a BMI was out of range, it was to be addressed during each subsequent visit. The ambulatory information technology (IT) team assessed the functionality within electronic privacy information center (EPIC) related to data collection recording. A new option was added in EPIC regarding the patient's follow-up plan when a BMI was out of healthy range. However, challenges existed within system utilization related to follow-up option capability as the system required an eligible professional to input data. Medical assistants were not eligible to input the data, therefore delays occurred in recording data.

Regarding cervical cancer screening, although the measure remained steady, quality work groups continued to analyze that screening reconciliations were appropriately recorded.

Ms. Garcia spoke about action plans to improve controlling high blood pressure which included quality focus group initiatives. She added that although the measure did not currently meet the benchmark, it had improved by 10% since the beginning of the calendar year.

She reviewed the action plan for screening for depression and follow-up plans. Chart review analysis demonstrated areas of the process which required improvement such as inaccuracy in data recording methods. Screening projects were initiated to improve accurate reporting of elements associated with the measure.

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

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

Ms. Garcia presented the National Research Corporation (NRC) RealTime platform patient satisfaction survey results for the third 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 overall NPS for the quarter was 70 with a patient response rate of 5,934.

Ms. Garcia highlighted patient satisfaction survey questions that indicated areas of opportunity to improve. She shared data about specific Federally Qualified Health Center (FQHC) clinics pointing out improvement at various locations, including Valleywise Community Health Center-Guadalupe.

Patient satisfaction results for the dental clinics were also presented.

Ms. Garcia described elements of the Valleywise Health organizational standard acknowledge, connect, communicate, every person, every time (ACCEPT) which aimed to improve patient experience. The goal was to provide a positive first impression to patients, visitors, and others. It aimed to deliver courtesy and respect and demonstrated compassion for those seeking health care services.

She provided select NRC RealTime patient satisfaction comments reported during the quarter.

4. Discuss and Review revised National Research Corporation (NRC) RealTime Platform Patient Satisfaction survey questions for the Federally Qualified Health Center Clinics

Ms. Garcia presented the updated NRC RealTime platform patient satisfaction survey questions. She described dynamics of the NRC RealTime starter kit, which included suggested patient satisfaction survey questions developed by NRC and was used as a tool to revise the survey questions. Survey questions were tailored to understand the patient experience on a more personalized level. Survey questions would include details mentioning the specific clinic visited by the patient.

She presented the updated questions to the committee which included questions about registration, ease of appointment, cleanliness of the facility and questions specific to telehealth, among others. She discussed next steps in the process of incorporating the updated questions.

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

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

He highlighted details on projects related to violent patients, information blocking rules, 340B drug pricing program compliance, the COVID-19 pandemic, Health Insurance Portability an Accountability Act (HIPAA) privacy controls and behavioral health models. He shared individual risk assessment priorities and discussed the risk assessment scoring system used to develop and monitor projects.

Mr. Slaughter provided details on internal audit work plans for the quarter which presented information on payroll review, Care Reimagined controls and monitoring, revenue cycle controls, and risk assessment planning and development.

Regarding the ethics point hotline, the one call made during the quarter, related to inappropriate behavior, was fully investigated. The benchmark for the number of days to close an investigation was 30 days or less, and it was noted that the average for the reported quarter was 33 days.

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

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

Mr. Slaughter presented the annual Compliance Officer's Work Plan for FY 2023 and highlighted upcoming projects associated with the FQHC clinics. Major projects included, but were not limited to, HIPAA electronic referrals, telemedicine training, resident model compliance, women's clinic review and focus on new facilities. He spoke about risk assessment and the scoring system used to develop the plan.

He elaborated on risks associated with the impacts of COVID-19 and emphasized the Public Health Emergency (PHE) status. The expansion of behavioral health services, incorporation of telehealth, challenges in workforce staffing, and staff turnover were also a focal point.

Mr. Slaughter included projected time frames for projects, audit timing, and estimated hours of completion for projects. He talked about risk ratings and post review ranking processes used. A control factor rating tool was used to mitigate potential risk.

Projects were based on the results of risk assessment interviews completed during the previous fiscal year. Factors depended on the probability of occurrence and significance of risk, with the goal to uncover elements that posed risk or strategic threat to the organization.

MOTION: Vice Chairman Messick moved to 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. Ms. McCarty seconded.

VOTE: 3 Ayes: Chairman Barker, Vice Chairman Messick, Ms. McCarty
0 Nays
Motion passed.

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

Mr. Slaughter presented the annual Internal Audit Work Plan for FY 2023 and gave an overview of upcoming projects related to the FQHC clinics.

Projects included but were not limited to, Care-Reimagined controls and monitoring review, internal and external patient referral assessments, FQHC grant reviews, site reviews, internal audit requests, along with other special projects. The plan was to ensure the achievement in operational effectiveness and overall compliance.

He included projected time frames and estimated hours of completion for each project. Projects were based on the results of completed risk assessments and focused on internal controls and risk factors. Standard risk assessment tools were used, and thorough reevaluations were constant.

MOTION: Chairman Barker moved to 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. Ms. McCarty seconded.

VOTE: 3 Ayes: Chairman Barker, Vice Chairman Messick, Ms. McCarty
0 Nays
Motion passed.

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

8. Chair and Committee Member Closing Comments/Announcements

There were no closing comments or announcements.

9. Review Staff Assignments

There were no staff assignments or follow up requests stemming from the meeting.

Ms. Talbot noted that an old business item related to the revised patient satisfaction survey questions was now considered satisfied.

Adjourn

MOTION: Ms. McCarty moved to adjourn the May 9, 2022 Valleywise Community Health Centers Governing Council's Compliance and Quality Committee meeting. Vice Chairman Messick seconded.

VOTE: 3 Ayes: Chairman Barker, Vice Chairman Messick, Ms. McCarty
0 Nays
Motion passed.

Meeting adjourned at 6:18 p.m.

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Cassandra Santos
Assistant Clerk

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 1.a.ii.

Minutes:
June 13, 2022

Minutes

Valleywise Community Health Centers Governing Council
Compliance and Quality Committee
Valleywise Health Medical Center
June 13, 2022
5:30 p.m.

Voting Members Present:	Michelle Barker, Committee Chair - *participated remotely* Daniel Messick, Committee Vice Chair - *participated remotely* Liz McCarty, Member - *participated remotely* Eileen Sullivan, Member - *participated remotely*
Non-Voting Members Present:	Barbara Harding, Chief Executive Officer, Federally Qualified Health Center Clinics - *participated remotely* Crystal Garcia, Vice President Surgical, Specialty, Quality and Safety - *participated remotely*
Non-Voting Members Absent:	LT Slaughter, Chief Compliance Officer Christina Smarik-Snyder, M.D., Interim Medical Director, Ambulatory Services Nelson Silva-Craig, Director of Nursing, Ambulatory Care Sandra Yuh, M.D., Federally Qualified Health Center Clinics Quality Medical Director
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 three of the four voting members of the Valleywise Community Health Centers Governing Council's Compliance and Quality Committee were present, which represented a quorum. Ms. Sullivan arrived after roll call.

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.

NOTE: Ms. Sullivan joined the meeting at 5:35 p.m.

General Session, Presentation, Discussion and Action:

1. Discuss and Review Quality of Care Audit for the Federally Qualified Health Center Clinics for Calendar Year 2021

Ms. Garcia highlighted key elements of the calendar year (CY) 2021 quality of care audit for the Federally Qualified Health Center (FQHC) clinics.

She explained that the Quality Assurance/Quality Improvement (QAQI) plan was updated to ensure Health Resources and Service Administration (HRSA) Compliance Manual requirements were addressed.

Ms. Garcia highlighted details on the initiatives geared toward driving up performance improvement.

She explained that a dedicated quality analyst worked closely with FQHC clinic leadership to support improvement efforts. Uniform Data System (UDS) quality metrics were discussed and monitored by the committee on a regular basis. Information and data were routinely gathered by the quality analyst to produce reports for the committee. Scheduled validations were conducted on the electronic health record (EHR) UDS reports to ensure appropriate data was being reported. National Research Corporation (NRC) RealTime platform patient satisfaction survey results and actions plans were reviewed to monitor and improve performance.

Ms. Garcia gave an overview of individual UDS quality metric outcomes for the reported calendar year. She pointed out the metrics that met benchmark and cited various action plans to improve those measures that did not.

Quality metrics highlighted included body mass index (BMI) screening and follow up, cervical cancer screening, childhood immunizations, colorectal cancer screening, controlling high blood pressure, controlling and monitoring diabetes and hemoglobin A1C levels, ischemic vascular disease (IVD), and screening for clinical depression and follow up.

Other metrics discussed included weight assessment and counseling for nutrition and physical activity for children and adolescents, tobacco use; screening and cessation intervention, statin therapy for the prevention and treatment of cardiovascular disease, breast cancer screening and human immunodeficiency virus (HIV) screening.

Chairman Barker asked whether the COVID-19 pandemic could be contributed to unfavorable outcomes, specifically related to BMI screening, controlling high blood pressure and clinical depression screening.

Ms. Garcia explained the national logic changes were made to BMI data collection requirements.

When a patient's BMI was out of range, it was to be addressed during each subsequent visit. The ambulatory information technology (IT) team assessed functionalities within electronic privacy information center (EPIC) as it pertained to data collection recording. The team added an option in EPIC utilized to record follow-up plans when a BMI was out of the healthy range. Similar logic changes were made to support clinical depression screening and follow up data. Standardized workflows were implemented to ensure accurate data collection and reporting in EPIC.

Regarding controlling blood pressure, hypertension focus workgroups were in place to develop and monitor action plans concentrated on improvement of the metric.

Ms. Harding added that the COVID-19 pandemic presented a multitude of challenges which may have contributed to unfavorable outcomes. Patients were hesitant to receive in-person care for preventative and routine screenings during the height of the pandemic, resulting in delayed care.

Chairman Barker asked whether lack of medication compliance or unaffordability may be a factor in some of the unfavorable outcomes.

General Session, Presentation, Discussion and Action:

1. Discuss and Review Quality of Care Audit for the Federally Qualified Health Center Clinics for Calendar Year 2021

Ms. Harding commented that the 340B drug pricing program allowed covered entities, such as Valleywise Health, to purchase outpatient medications at a discount. This amenity supported low cost medication for vulnerable patients in need of economical support. However, she believed that recent increases in gasoline costs could present potential barriers to patients.

Chairman Barker asked if the Governing Council would receive the quality of care audit information as presented.

Ms. Talbot said the information would be provided to the Governing Council at the July, 2022 meeting in the committee reports section of the packet.

Adjourn

MOTION: Ms. McCarty moved to adjourn the June 13, 2022 Valleywise Community Health Centers Governing Council's Compliance and Quality Committee meeting. Vice Chairman Messick seconded.

VOTE: 4 Ayes: Chairman Barker, Vice Chairman Messick, Ms. McCarty, Ms. Sullivan
0 Nays
Motion passed.

Meeting adjourned at 5:52 p.m.

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Cassandra Santos
Assistant Clerk

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 2.

Patient Safety Report

Federally Qualified Health Center (FQHC)

Patient Safety

January 2022-June 2022

Federally Qualified Health Center (FQHC)

11 Valleywise FQHCs serving Maricopa County

- FQHC - Phoenix
- FQHC – South Central
- FQHC – South Phoenix/Laveen
- FQHC – Guadalupe
- FQHC – Mesa
- FQHC - Chandler

Federally Qualified Health Center (FQHC)

11 Valleywise FQHCs serving Maricopa County

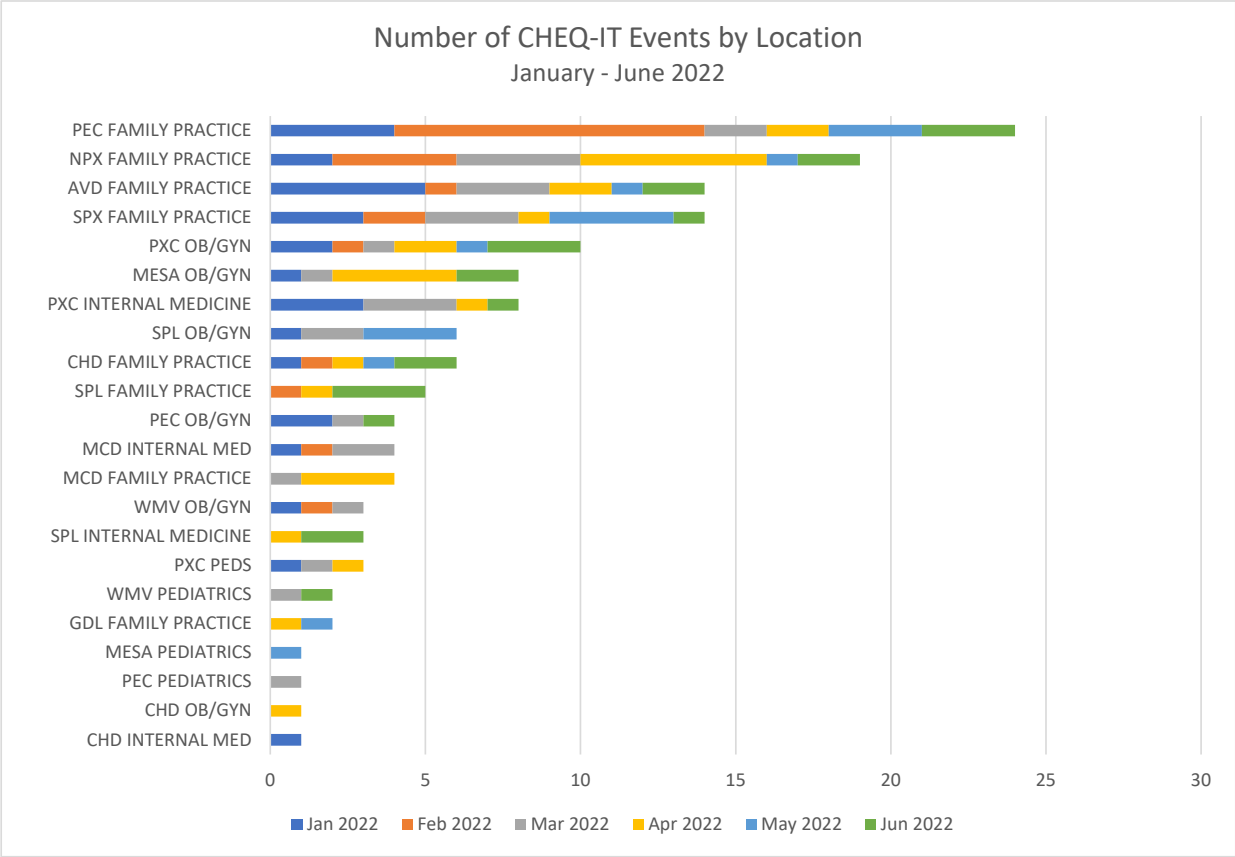
- FQHC - **Avondale**
- FQHC - **Peoria**
- FQHC – **North Phoenix**
- FQHC – **Maryvale**
- FQHC - **McDowell**

FQHC: Service Lines

- Family Practice
- Internal Medicine
- OB/GYN
- Pediatrics

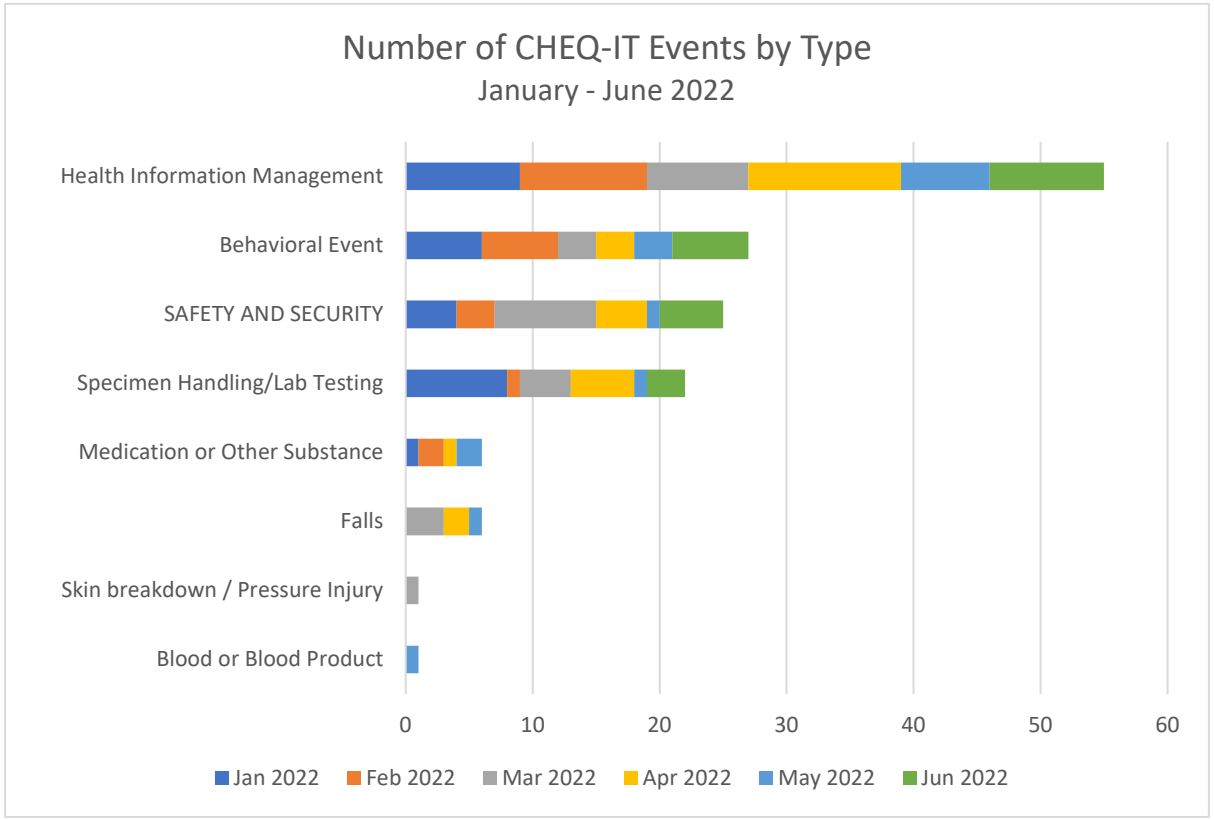
Currently, not all 'Service Lines' are available at all Valleywise FQHCs

CHEQ-IT Events by Location



- The highest number of occurrences reported are in Peoria Family Practice, North Phoenix Family Practice , Avondale Family Practice, and South Phoenix/Laveen Family Practice.
- Thank you for reporting!

CHEQ-IT Events by Type

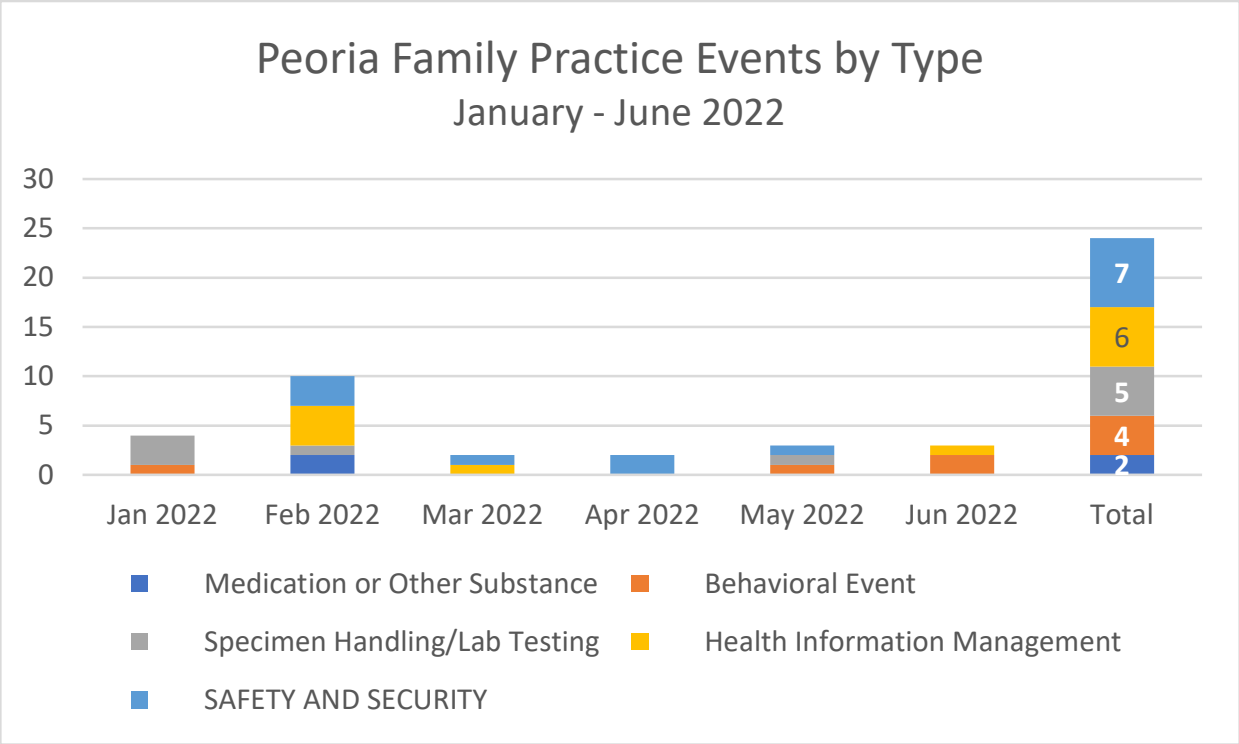


The most frequently reported types of events are Health Information Management, Behavioral Events, Safety and Security, followed by Specimen handling.

FQHC

PEC, NPX, AVD and SPX Family Practice Events

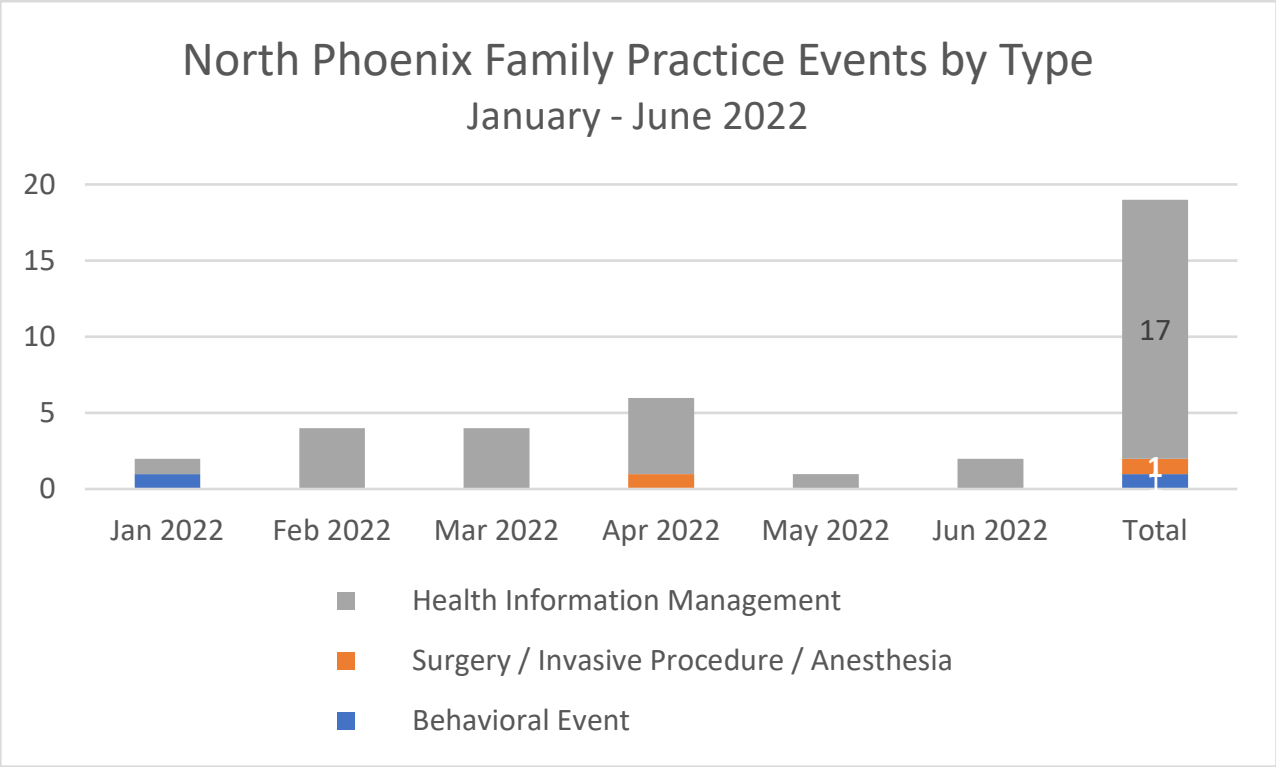
Peoria Family Practice:



The most frequent type of event occurring at PEC FP is Safety and Security (Nursing/Clinical intervention), followed by Health Information Management (incomplete Consent) and Specimen Handling (Incorrectly labeled specimen).

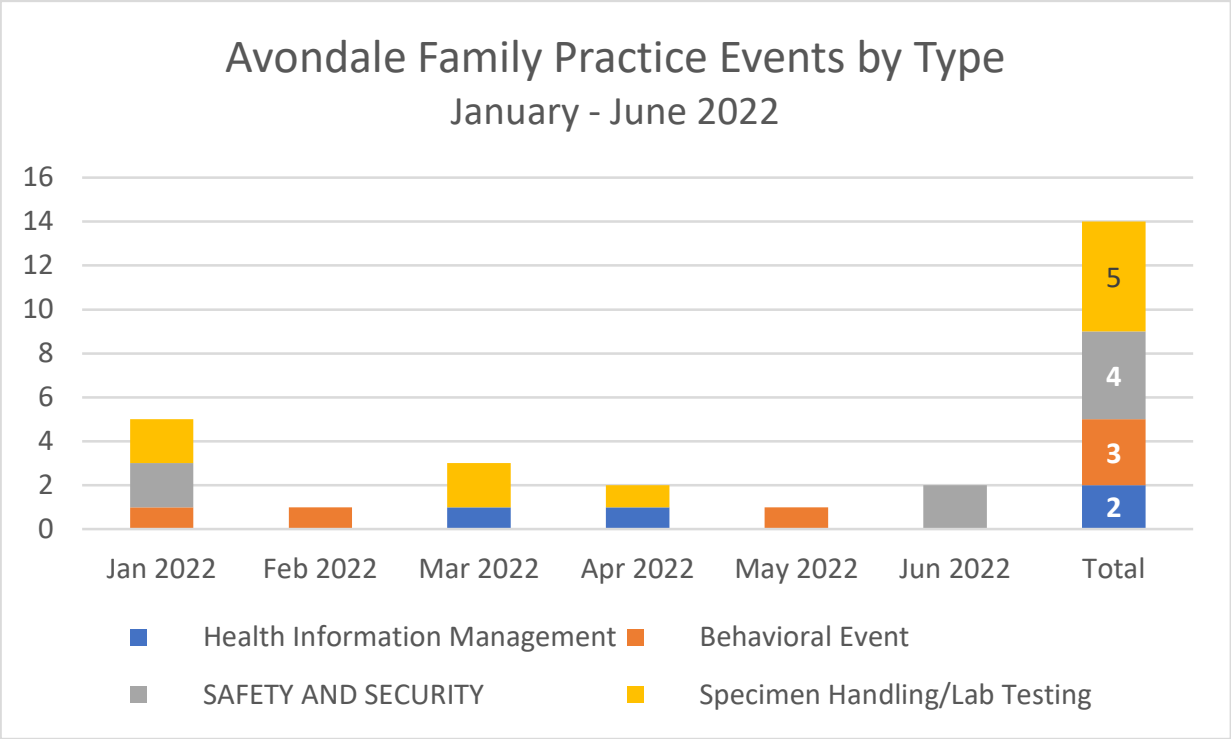
3 behavioral events (Against Medical Advice) occurred in May and June 2022.

North Phoenix Family Practice:



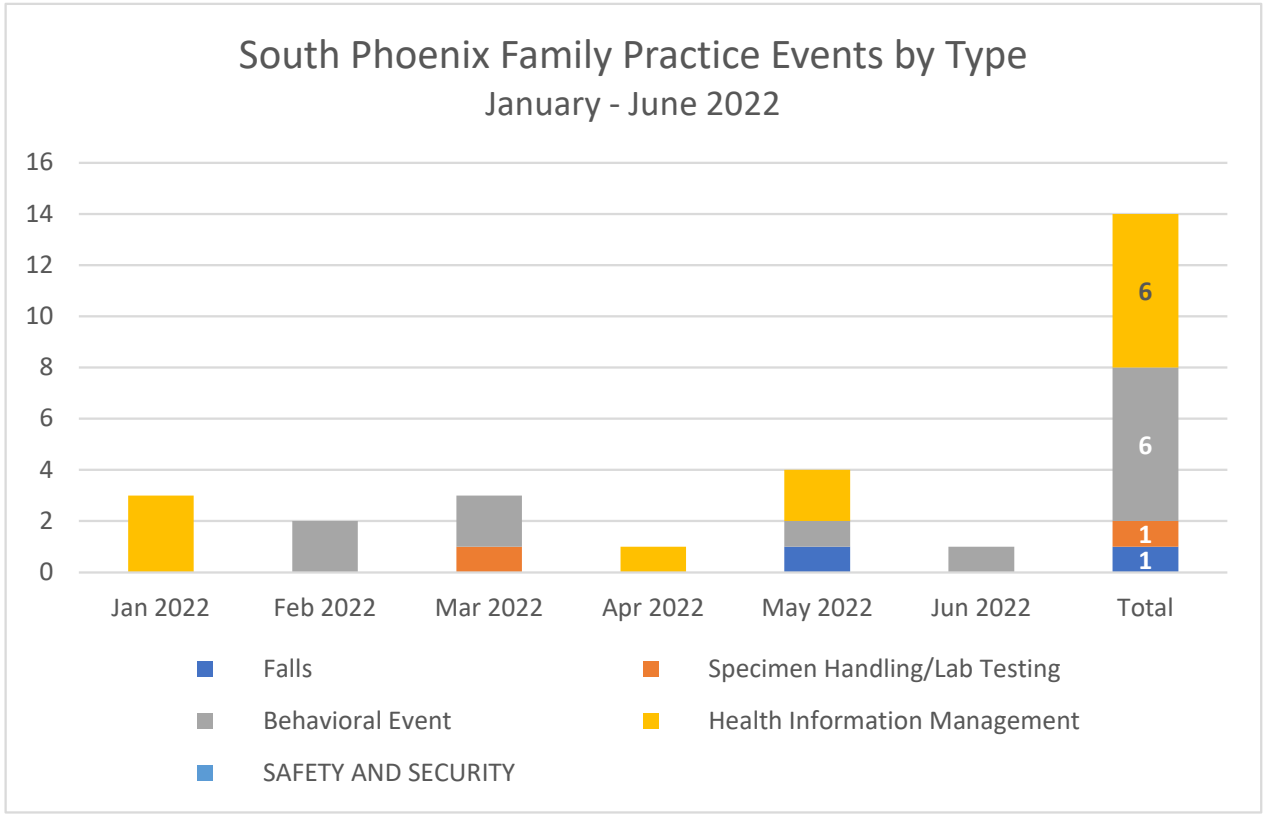
Most events were Health Information Management events regarding incomplete consent, mainly attributed to one provider.

Avondale Family Practice:



The most frequent type of event occurring at Avondale FP is Specimen Handling (Incorrectly labeled specimen or lab test not drawn) followed by Safety and Security (Nursing/Clinical intervention) and Behavioral events (Against medical advice).

South Phoenix/Laveen Family Practice:



Most events occurring at South Phoenix Family Practice are Health Information Management (Incomplete Consent) and Behavioral Event (Against Medical Advice).

FQHC's: What's Happening?

- A review of notable occurrences is now included in the daily leadership huddle.
- Incomplete consents are addressed through the peer review process.
- A Culture of Safety Survey (COSS) has been completed, and the results have been reviewed with Ambulatory leadership, including conducting multiple information sessions on how to navigate the COSS results
- Ambulatory leadership is now in the process of creating Action Plans in accordance with the COSS results, emphasizing Communication Openness, Organizational Learning, and Hospital Management Support for Patient Safety
- To further improve reporting and data collection, Patient Safety recommends reviewing Policy13502 S, entitled "Quality: Patient Safety Event Reporting" with staff, including but not limited to the newer clinics. The above referenced Policy delineates the process of CHEQ-IT event reporting, as well the categories of adverse occurrences that warrant reporting
- Please encourage staff to report adverse occurrences in accordance with the above referenced Policy!

QUESTIONS?

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 3.

UDS Quality Metrics

Reporting Group: UDS Data Quarter 2
Person Reporting: Crystal Garcia, VP of Specialty Srvs, Quality and Patient Safety
Reporting Month: August 2022

UDS Measures Meeting Benchmark – Reporting Year 2022

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Breast Cancer Screening	> 45.34%	58.56%	56.77%	57.49%
Cervical Cancer Screening	> 51.00%	49.77%	49.95%	51.22%
HIV Screening	> 32.29%	58.18%	63.10%	63.41%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	> 71.92%	68.40%	72.58%	76.84%
Colorectal Cancer Screening	> 40.09%	50.85%	43.16%	44.21%
Tobacco Use: Screening and Cessation Intervention	> 83.43%	87.78%	85.61%	86.40%
Ischemic Vascular Diseases (IVD): Use of Aspirin or Another Antithrombotic	> 78.80%	78.51%	79.28%	79.20%

- This group of UDS measures is meeting the UDS National Average as of the May 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.

UDS Measures Meeting Benchmark – End Year 2021

Trending towards benchmark in 2022 reporting year

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Diabetes: HbA1c Poor Control	< 35.60%	31.85%	**42.90%**	**38.95%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	> 65.13%	78.09%	**58.32%**	**61.07%**

- 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.
- This set of metrics is expected to improve as the CY progresses.

UDS Measures Not Meeting Benchmark

End Year 2021 & 2022 Reporting Year

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Body Mass Index (BMI) Screening and Follow-Up Plan	> 65.72%	34.26%	**31.00%**	**31.05%**
Controlling High Blood Pressure	> 57.98%	47.76%	**46.91%**	**49.18%**
Screening for Clinical Depression and Follow-Up Plan if Positive Screen	> 64.21%	48.73%	**44.79%**	**44.59%**

- This group of UDS measures is not meeting the UDS National Average as of the April 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.

UDS Measure with Logic Error

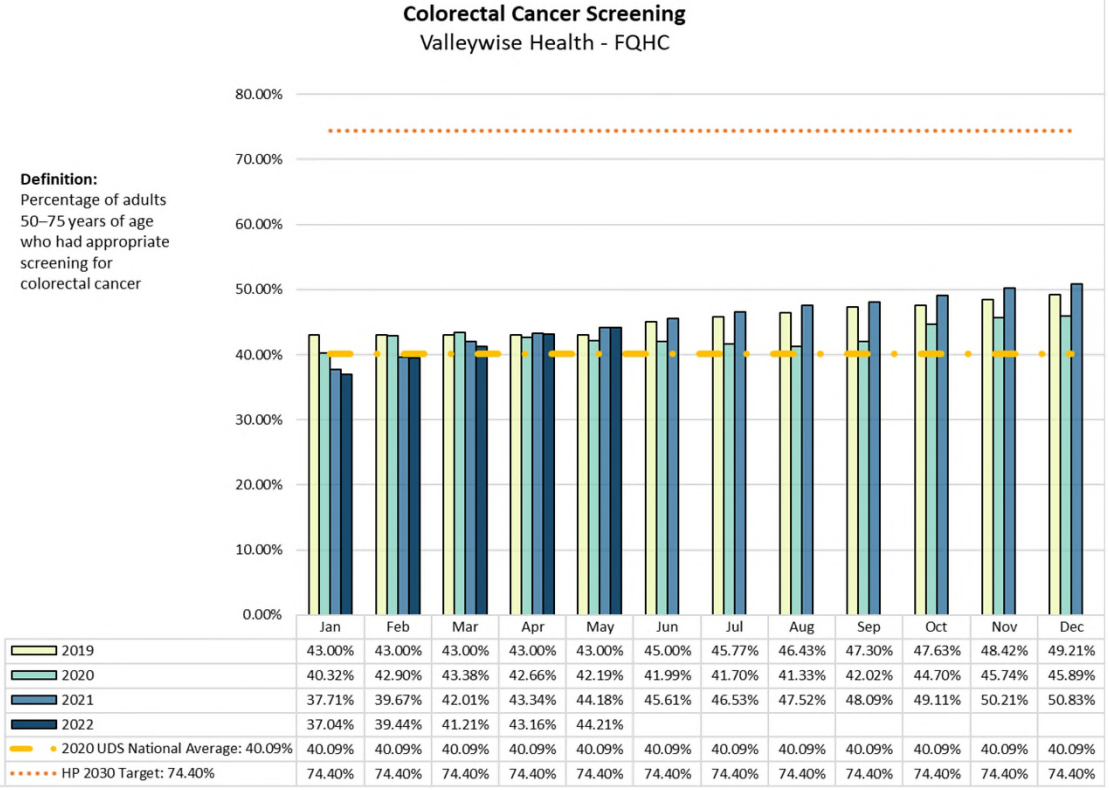
2022 Reporting Year

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Childhood Immunizations	> 40.42%	47.72%	46.36%	9.34%

- This UDS measure had a significant CMS logic change/discrepancy in May 2022 impacting performance rates - The fallout is not truly related to our performance.
- SBAR distributed outlining logic flaw which has eliminated counting vaccines on day of birth. This goes against standard best practice of Hepatitis B vaccine which is frequently given shortly after birth.
- This logic cannot be corrected until CMS reupdates the logic – FQHCs nationally are impacted.
- With the new CMS logic, our UDS numerator population (those that meet the measure) declined greater than 36%.

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

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Colorectal Cancer Screening	>40.09%	**50.85%**	**43.16%**	**44.21%**



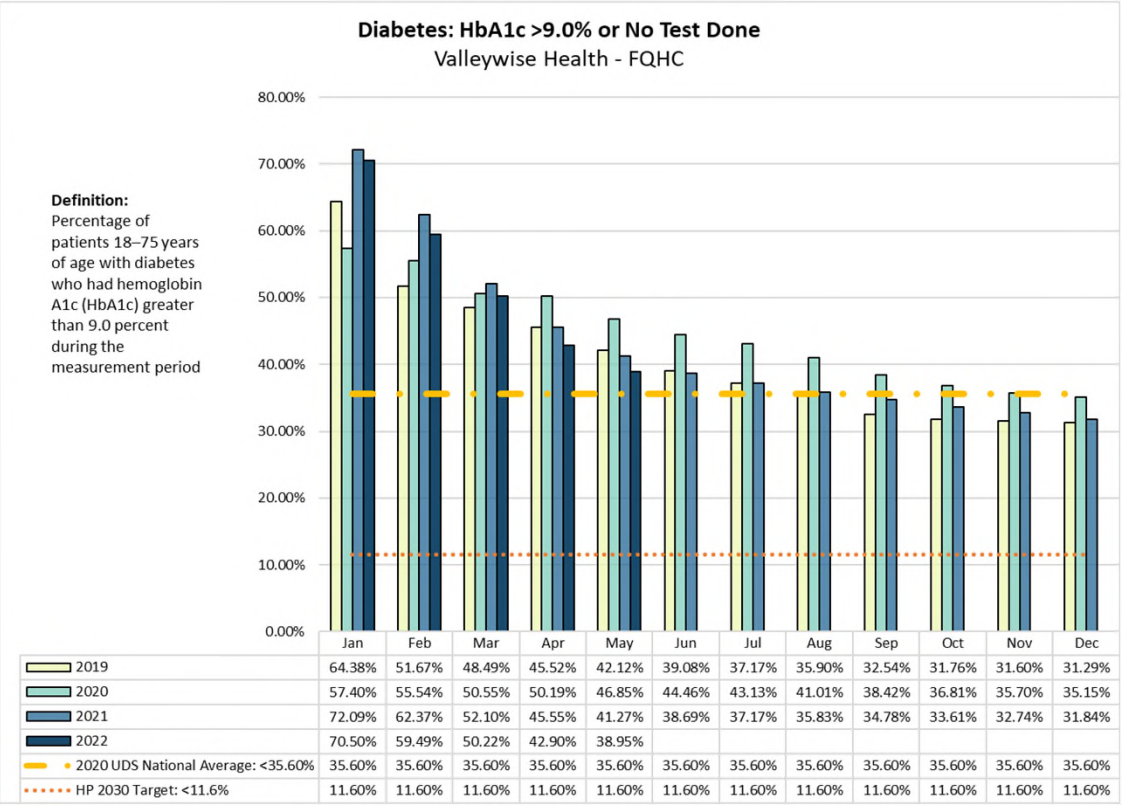
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2019	43.00%	43.00%	43.00%	43.00%	43.00%	45.00%	45.77%	46.43%	47.30%	47.63%	48.42%	49.21%
2020	40.32%	42.90%	43.38%	42.66%	42.19%	41.99%	41.70%	41.33%	42.02%	44.70%	45.74%	45.89%
2021	37.71%	39.67%	42.01%	43.34%	44.18%	45.61%	46.53%	47.52%	48.09%	49.11%	50.21%	50.83%
2022	37.04%	39.44%	41.21%	43.16%	44.21%							
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	April 2022	May 2022
Diabetes: Hemoglobin A1c Poor Control	<35.60%	31.85%	42.90%	38.95%



	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%	42.90%	38.95%							
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:
- Leadership meet to cover this topic and approval was given to allow for a standing order to be initiated
- **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

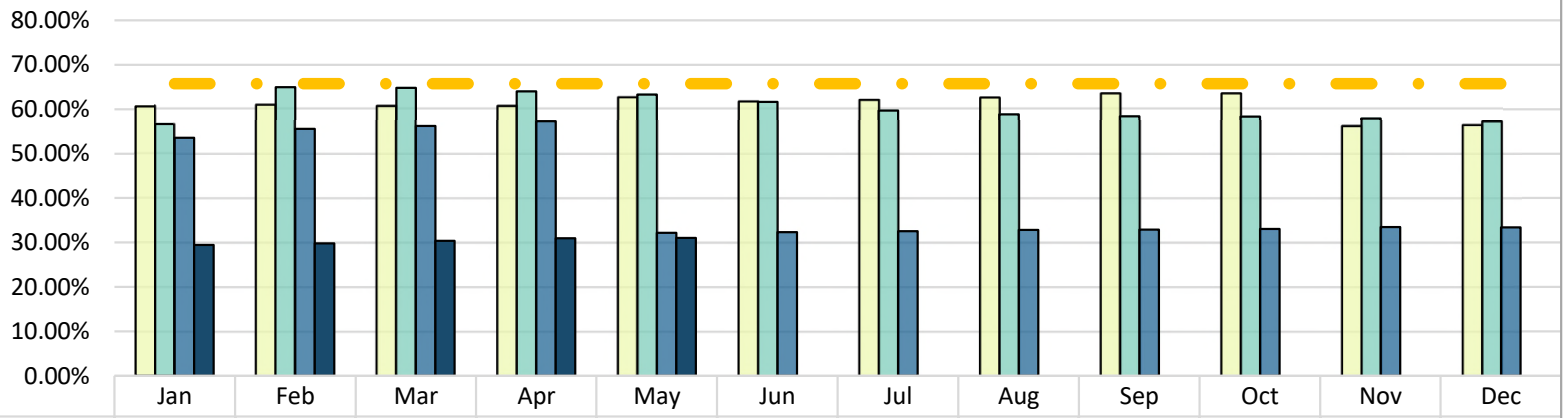
Measures Not meeting Benchmark

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Body Mass Index (BMI): Screening and Follow-Up Plan	>65.72%	**34.26%**	**31.00%**	**31.05%**

Body Mass Index (BMI) Screening and Follow Up Plan

Valleywise Health - FQHC

Definition: Percentage of patients aged 18 years and older with BMI documented during the most recent visit or within the previous 12 months to that visit and who had a follow-up plan documented if the most recent BMI was outside of normal parameters.



	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%	31.00%	31.05%							
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%

Measure Analysis and Actions

Body Mass Index (BMI): Screening and Follow-Up Plan

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.

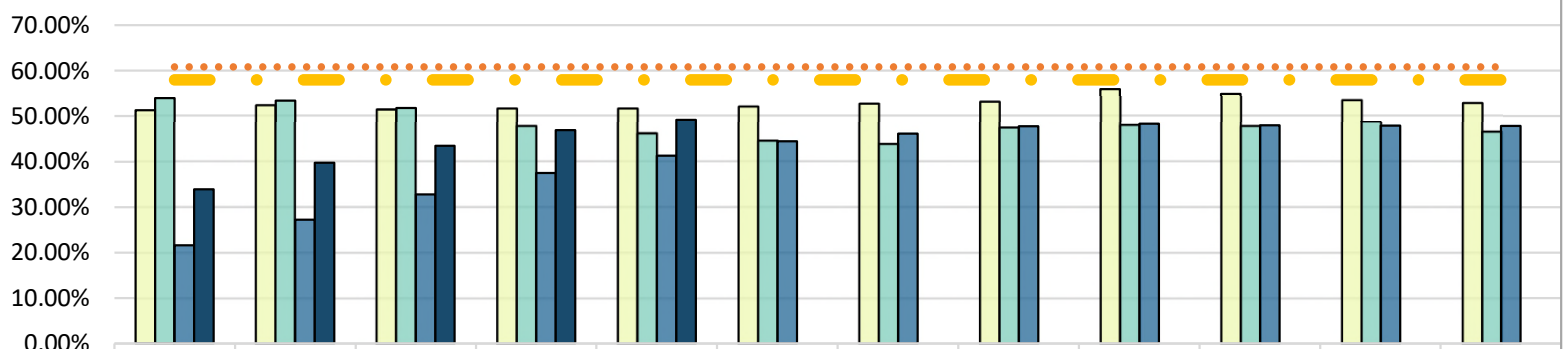
Action Items / Barriers:

- **Action:** Ambulatory IT team was able to operationalize a plan for logic in the EPIC background to pull BMI educational materials to the patient AVS when low/high to be given to every patient at every visit. Copyright details of printable follow-up education under current review for potential edits to shorten AVS printout length.
- **Action:** BPA button under review for instances when a patient is under BMI
- **Barrier:** none

Measures Not meeting Benchmark

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Controlling High Blood Pressure	>57.98%	**47.76%**	**46.91%**	**49.18%**

Definition:
Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period.



	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%	46.91%	49.18%							
2020 UDS National Average: 57.98%	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%

Measure Analysis and Actions

Controlling High Blood Pressure

Analysis:

The first month of post QI signage data was analyzed for North Phoenix location.

In May 2022 North Phoenix had an increase in BP recheck occurrences:

- (almost 10% higher than the baseline data comparison – Nov 2021)

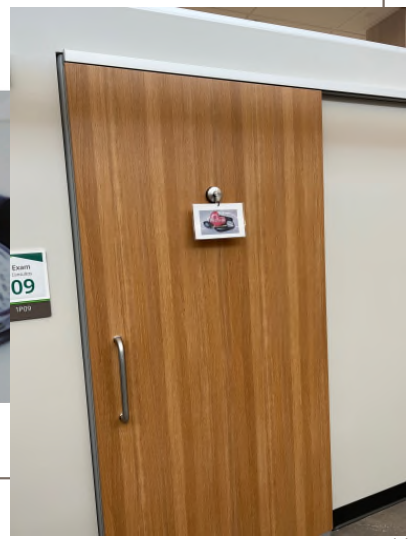
As a result, an increase was also observed in the total number of patients meeting the UDS (<140/90) after the BP re-check:

- (106 instances)

Data collection phase continues to August

Action Items / Barriers:

- **Action:** BP re-check QI signage project launched at North Phoenix to encourage more compliance with BP re-checks if over 140/90. In data collection phase currently.
- **Barrier**: none

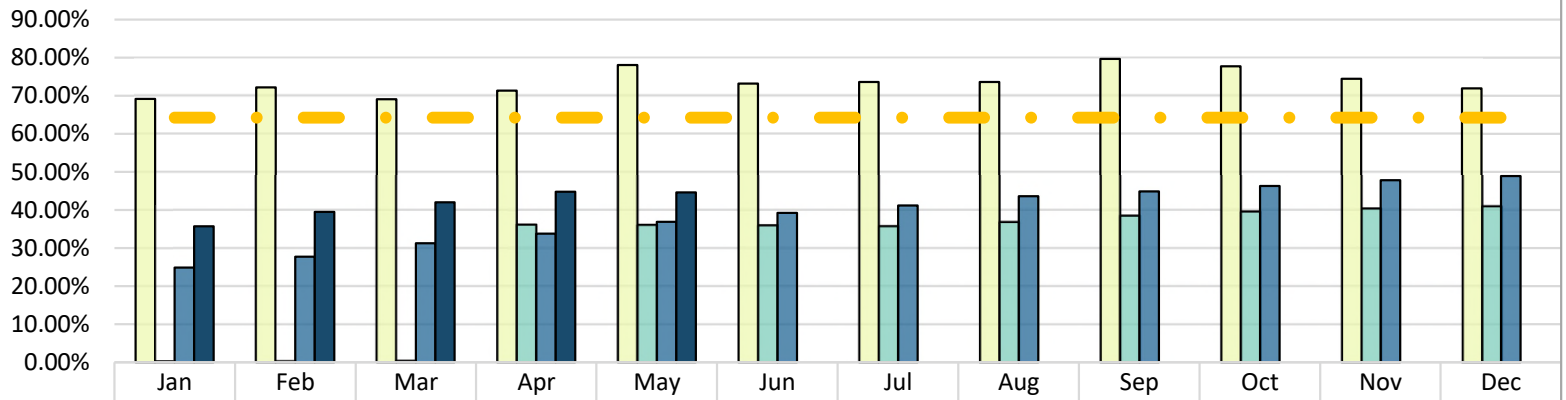


Measures Not meeting Benchmark

Measure	Benchmark	Final Year End 2021	April 2022	May 2022
Screening for Depression and Follow-Up Plan if Positive Screen	>64.21%	**48.73%**	**44.79%**	**44.59%**

Definition:
Percentage of patients aged 12 years and older screened for depression on the date of the visit or 14 days prior to the visit using an age-appropriate standardized depression screening tool and, if screening was positive, had a follow-up plan documented on the date of the visit

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%	44.79%	44.59%							
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%

Measure Analysis and Actions

Screening for Depression and Follow-Up Plan if Positive Screen

Analysis:

Depression screening is also a component of the social determinants of health (SDOH). New color icons have recently been updated in EPIC so now it is easier to visualize if the screening has yet to be completed during the measurement year. If depression screening icon is gray – this should prompt the provider to launch and complete the screening with patient.

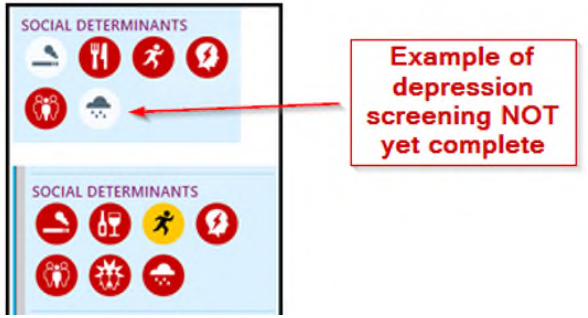
*Historical: The Ambulatory Build Team made a change to the PHQ2/PHQ9 screening tool in late 2019; the row "refused" was not mapped due to an EPIC Foundation issue. This impacted the total number of exclusions that should have been removed from the metric denominator. The new row for "refused" was mapped 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:** SBAR completion outlining color icons and flowsheet reminders

On Ambulatory Storyboard, SDOH results will now display as colored icons.
This has a hover-over feature the same as before.
Here are what the colors/display represent:

- Gray = the domain has not been assessed
- Yellow = medium risk area
- Red = high risk area
- Blank/not displayed = low risk



Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 4.

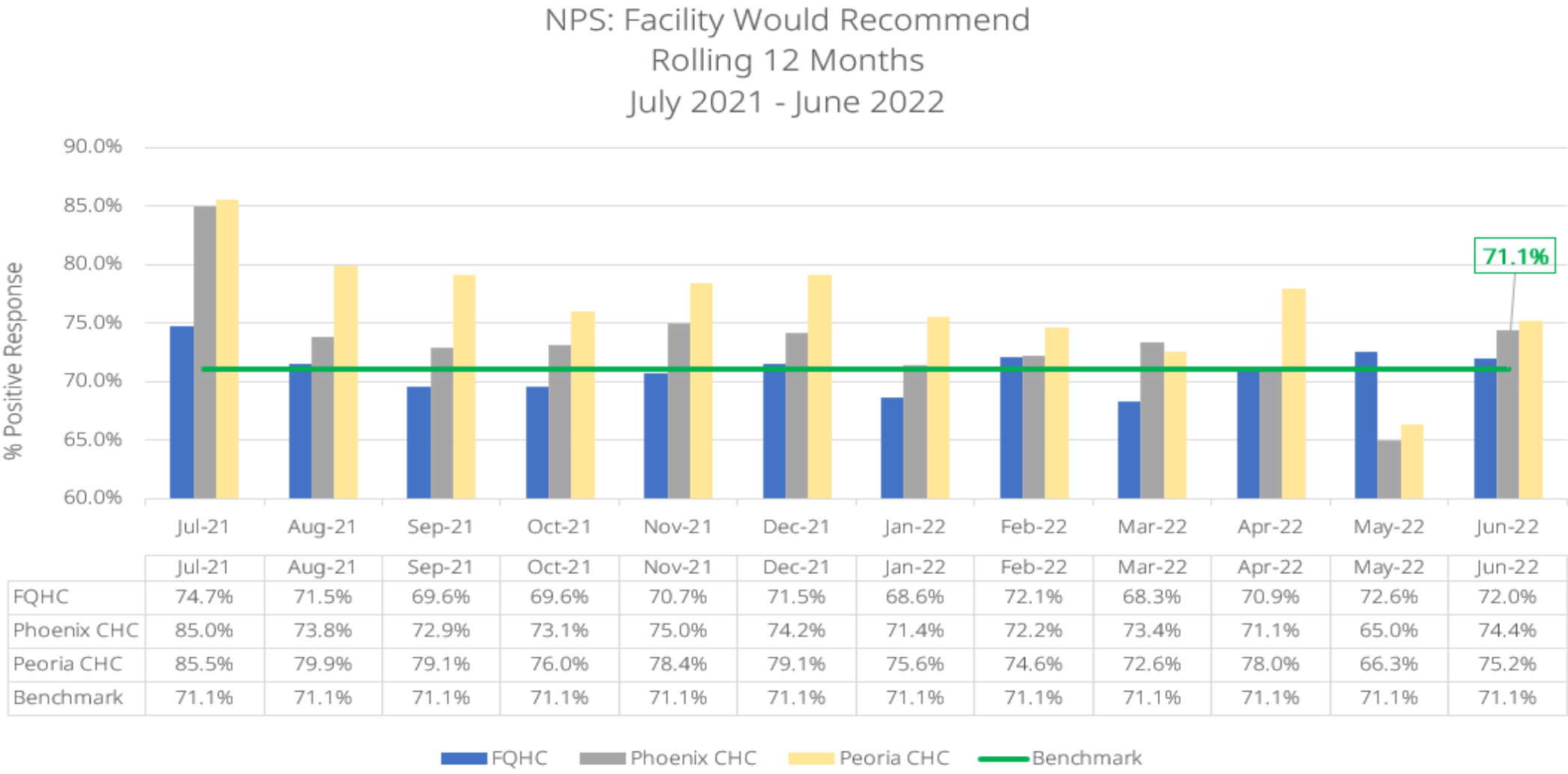
NRC RealTime Platform Patient Satisfaction

August 8, 2022

Patient Experience: NRC Real Time

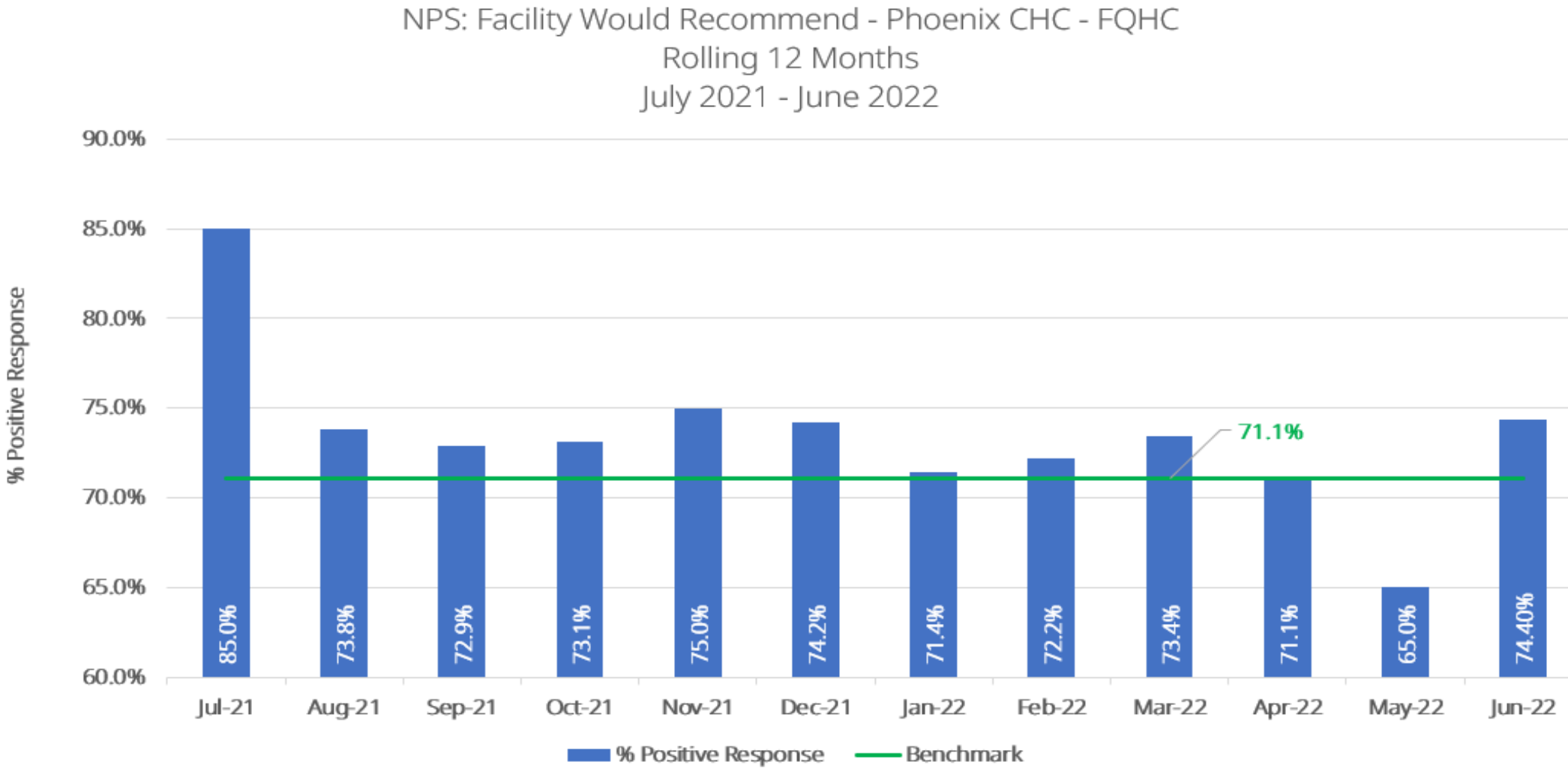
Person Reporting: Crystal Garcia, MBA/HCM, RN
Vice President of Quality Management and Patient Safety
Reporting period: Fiscal Year 2022, Quarter 4

Overview of Phoenix CHC, Peoria CHC, and FQHC

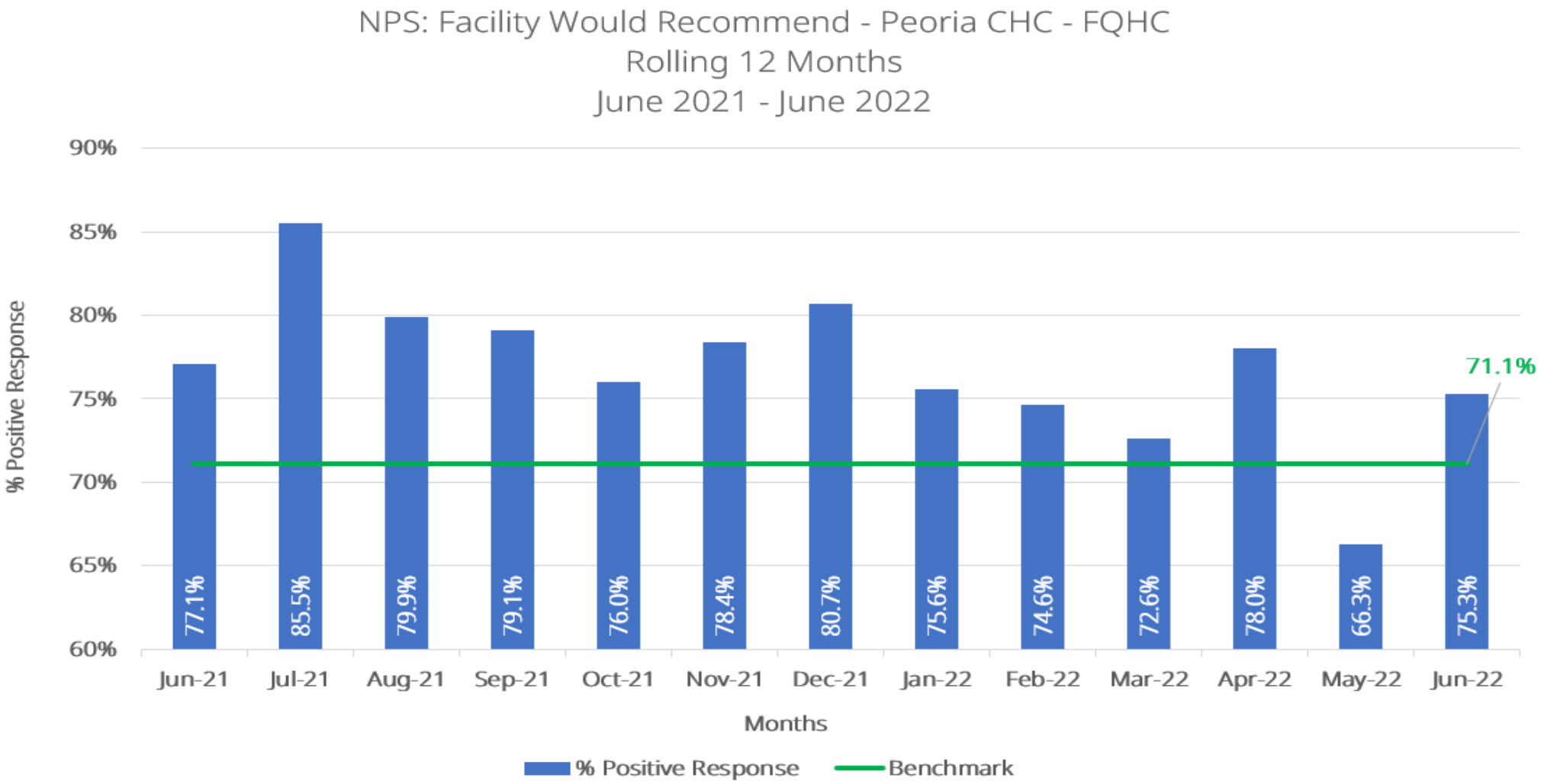


	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
FQHC	74.7%	71.5%	69.6%	69.6%	70.7%	71.5%	68.6%	72.1%	68.3%	70.9%	72.6%	72.0%
Phoenix CHC	85.0%	73.8%	72.9%	73.1%	75.0%	74.2%	71.4%	72.2%	73.4%	71.1%	65.0%	74.4%
Peoria CHC	85.5%	79.9%	79.1%	76.0%	78.4%	79.1%	75.6%	74.6%	72.6%	78.0%	66.3%	75.2%
Benchmark	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%	71.1%

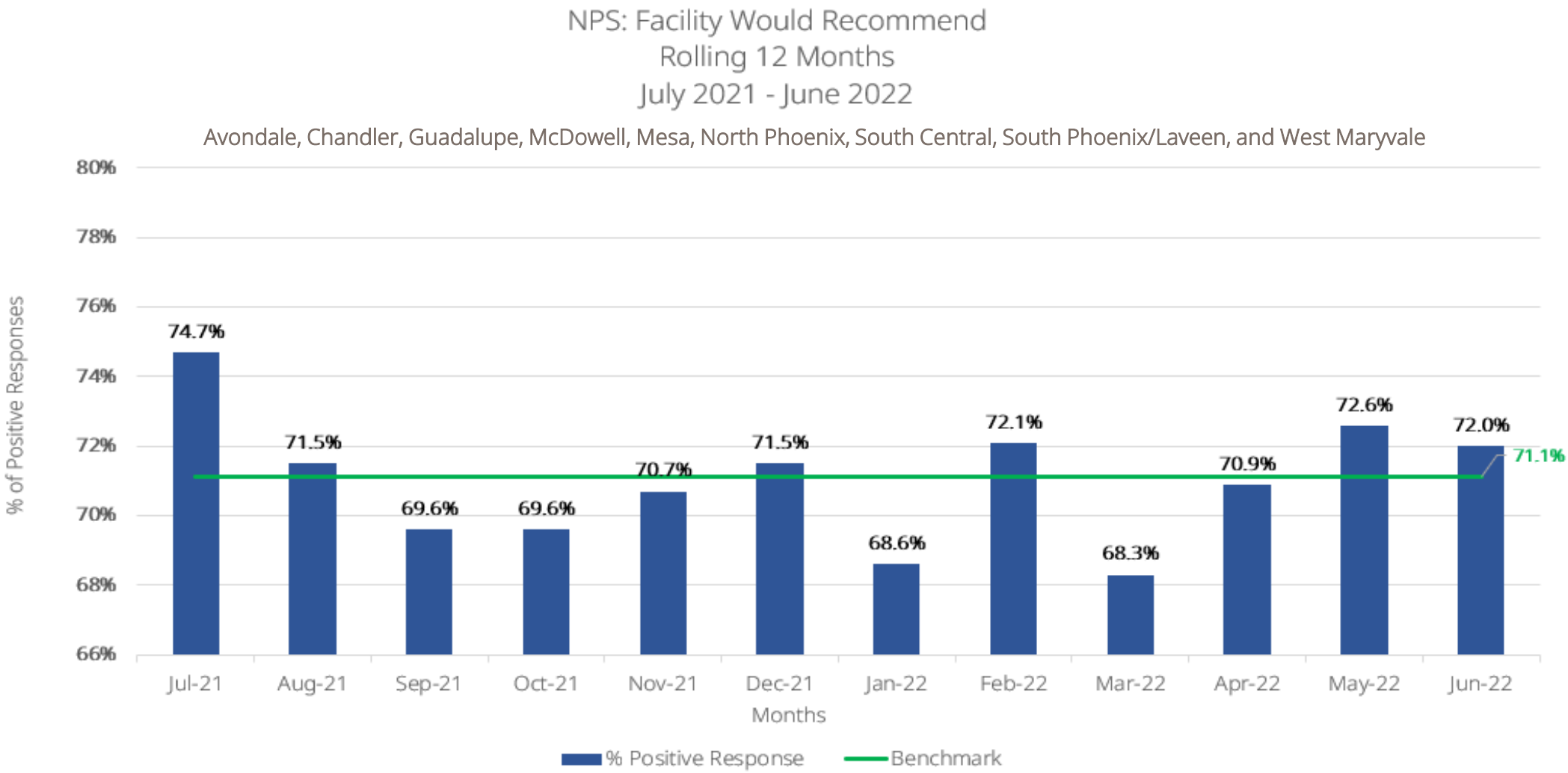
FQHC: Phoenix CHC – Rolling Year



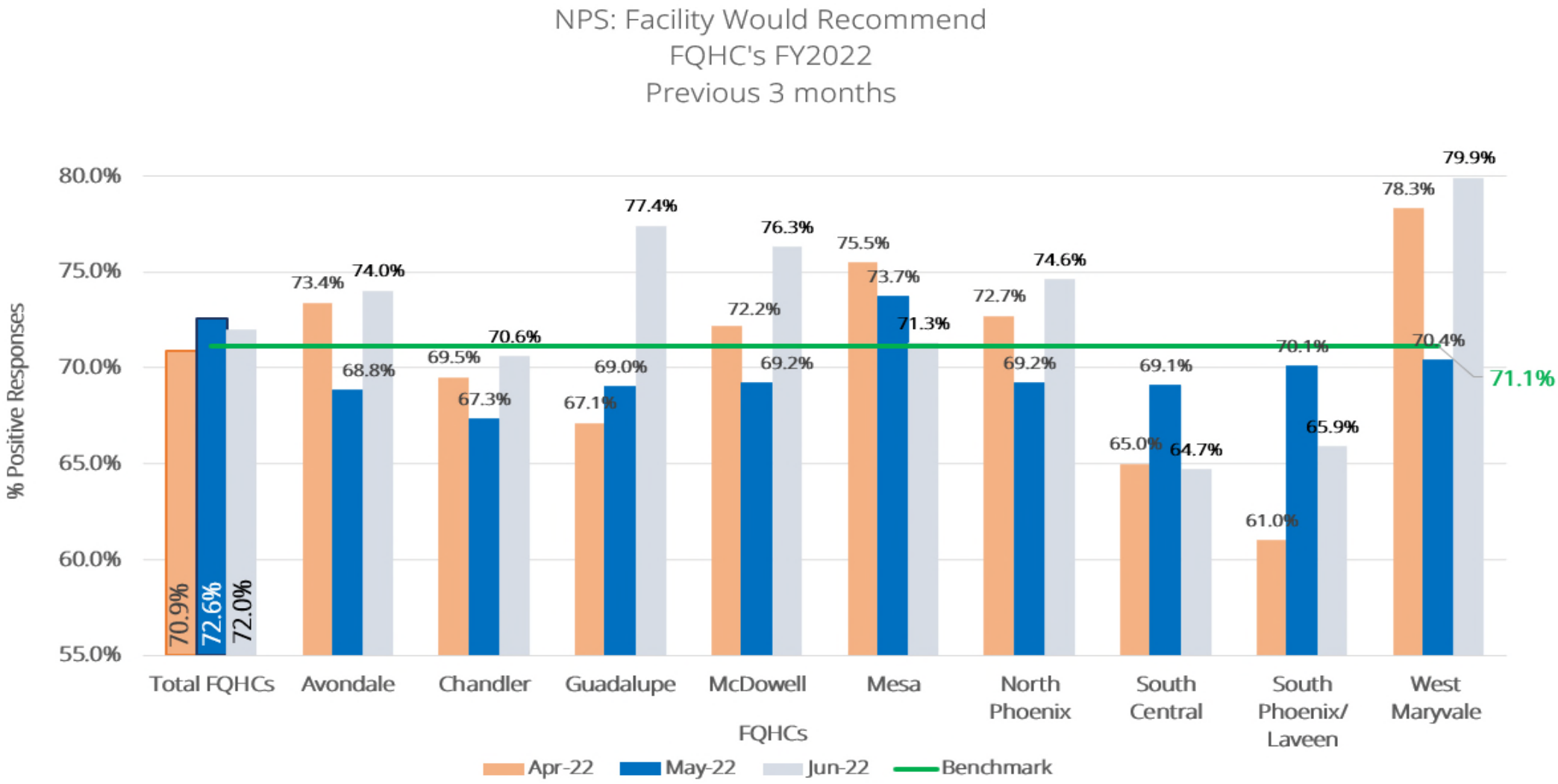
FQHC: Peoria CHC – Rolling Year



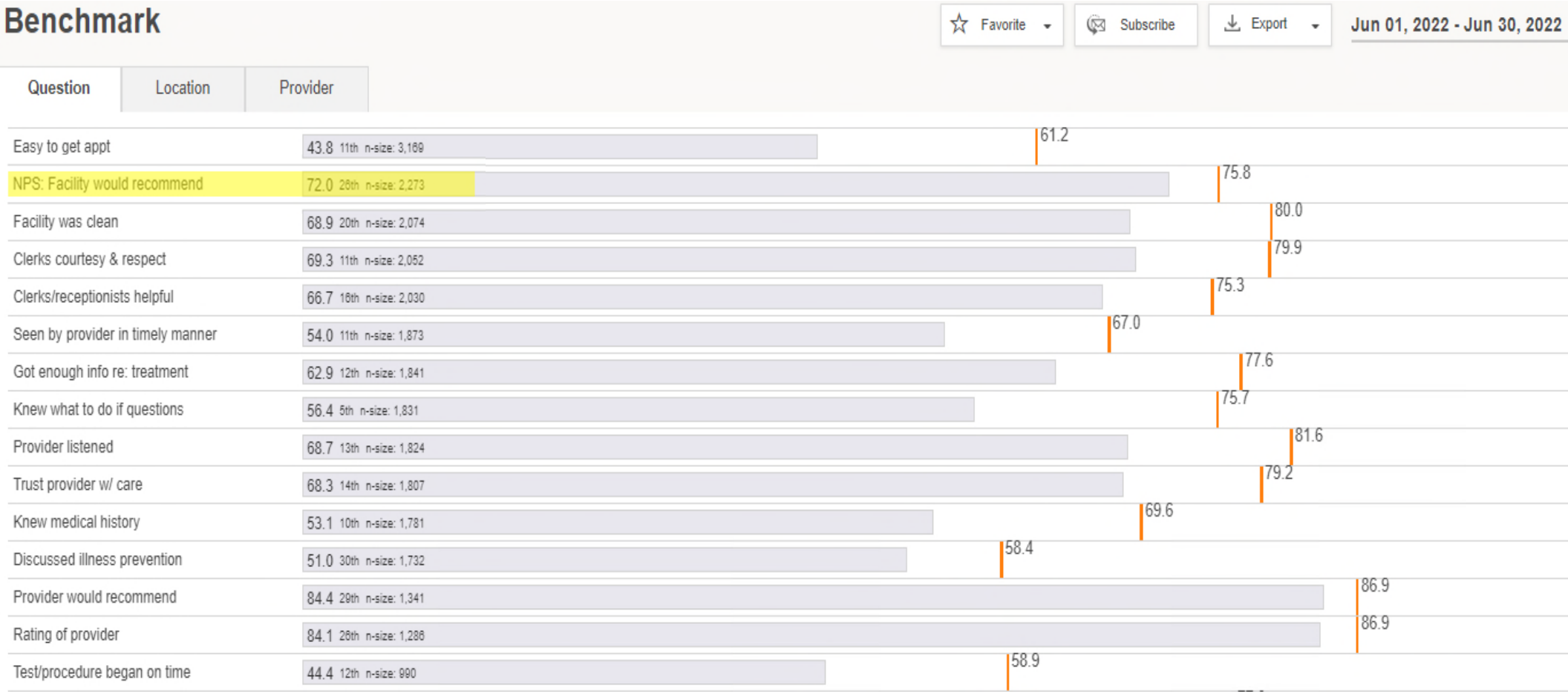
FQHCs: NPS – Facility Would Recommend - Rolling Year



FQHCs: NPS-Facility Would Recommend - Last 3 Months



FQHCs Combined: Overview



Avondale, Chandler, Guadalupe, McDowell, Mesa, North Phoenix, South Central, South Phoenix/Laveen, and West Maryvale

Phoenix CHC & Peoria CHC (FQHC): Comments

10 Extremely likely

RESP.DATE: 24 JUNE 2022 ENC.DATE: 23 JUNE 2022 COMMENT ADDED DATE: 28 JUNE 2022 FACILITY: PEC FAMILY PRACTICE PROVIDER: BYERS WENDY (1598049975)
SURVEY MODE: IVR QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

The provider was super receptive and addressed all of my concerns. I would recommend her to anybody.

10 Extremely likely

RESP.DATE: 29 JUNE 2022 ENC.DATE: 28 JUNE 2022 COMMENT ADDED DATE: 7 JULY 2022 FACILITY: PXC OB/GYN PROVIDER: BAMBULAS TAMMALYNN (1396768545)
SURVEY MODE: IVR QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

Very kind that the medical and office staff take good care of you, thank you.

2

RESP.DATE: 17 JUNE 2022 ENC.DATE: 10 JUNE 2022 COMMENT ADDED DATE: 23 JUNE 2022 FACILITY: PXC PEDS PROVIDER: ANDERSON MARIEL (1801476783) SURVEY MODE: EMAIL
QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

I didn't get a response in regards to my daughter's medical condition. It was confusing. They didn't tell me anything on her discharge papers in regards to the medication she was suppose to be taking or other treatments to help my daughter. I wish they were kinder and helped me with the information that I needed for my daughter.

FQHC: Comments

0 Not at all likely

. RESP.DATE: 30 JUNE 2022 ENC.DATE: 28 JUNE 2022 COMMENT ADDED DATE: 5 JULY 2022 FACILITY: GDL FAMILY PRACTICE PROVIDER: [redacted]

SURVEY MODE: IVR QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

I just want to start off by saying I never ever, ever get [redacted]. Ever. Again in my life. This woman had me walking out of that office, crying literally crying. I'm still still traumatize. As to how this lady responded to my help and how she was talking to me. The rudest person I've ever met in my life ever met in my life. She walked out of my appointment as I was talking to her no. Goodbye no. Thank you for visiting today. Can I schedule another appointment with you? She walked out and I needed to get a referral from her. I will never ever, ever recommend this lady. I don't even know why she is still there at this*

8

RESP.DATE: 25 JUNE 2022 ENC.DATE: 24 JUNE 2022 COMMENT ADDED DATE: 29 JUNE 2022 FACILITY: MESA LAB PROVIDER: LAB MESA (36704) SURVEY MODE: IVR

QUESTION POD: OUTPATIENT TESTING MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

I don't like how the doctor treated me during my appointment. I went for a pain in my rib and she didn't do anything about it. She just told me about my blood pressure and she told me she was going to have me do some blood work, but she never cared about why I went in that day. Thank you.

8

RESP.DATE: 21 JUNE 2022 ENC.DATE: 20 JUNE 2022 COMMENT ADDED DATE: 23 JUNE 2022 FACILITY: CHD LAB PROVIDER: ROOM CHANDLER (1008) SURVEY MODE: IVR

QUESTION POD: OUTPATIENT TESTING MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

Hi just don't really care for the receptionist and some of them on the phone. was not helpful, especially the people that take an appointment and people that check in.

FQHC: Comments

10 Extremely likely

RESP.DATE: 30 JUNE 2022 ENC.DATE: 29 JUNE 2022 COMMENT ADDED DATE: 5 JULY 2022 FACILITY: SPL LAB PROVIDER: ROOM SOUTH (34971) SURVEY MODE: IVR

QUESTION POD: OUTPATIENT TESTING MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

I was incredibly impressed with the facility. I felt like I had gone to a doctor's office in heaven. Every single thing that I thought could happen in the past of progression. You guys all had nail down. It was seamless from when I entered and got my appointment going to the nurse coming out and getting me to come in to go and see the doctor. The nurse was incredibly, warm, friendly and informative, I say the same about the doctor. I went and got my labs done and just walk from one area to another Labs were done instantly, and then the same goes for my prescriptions. They were done in about 6 minutes. I was very impressed with the cleanliness and I do come from a health care cleaning background. So I believe that my opinion counts a lot because I didn't see dust balls high, dusting dirty glass or anything. I was very very.*

10 Extremely likely

RESP.DATE: 29 JUNE 2022 ENC.DATE: 27 JUNE 2022 COMMENT ADDED DATE: 1 JULY 2022 FACILITY: MESA INTERNAL MEDICINE PROVIDER: BANDLAMURI SUNITHA (1366496812)

SURVEY MODE: IVR QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

Everyone was very friendly, they were very attentive. I really enjoyed the doctor. The receptionist was very nice. The lab tech was nice. The nursing assistants were also very kind. I had a good appointment and I look forward to going back.

10 Extremely likely

RESP.DATE: 29 JUNE 2022 ENC.DATE: 28 JUNE 2022 COMMENT ADDED DATE: 1 JULY 2022 FACILITY: MCD FAMILY PRACTICE PROVIDER: CHEW VICTORIA (1265804520)

SURVEY MODE: IVR QUESTION POD: MEDICAL PRACTICE MOST RECENT ACTIVITY: - NUMBER OF FOLLOW-UP ACTIONS: -

What Else Re: Experience:

My first experience with you guys was two years ago, and I loved it, and I wanted to come back so bad, and I am so happy that I'm back in Phoenix, and I could be seen by you guys. You guys are awesome. Everything is perfect, clean, tidy, respectful, anonymous. I love it. There's ... I don't have words to say thank you so many times. Thank you to everybody.

New Patient Experience

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

August 8, 2022

Item 5.

Compliance Education Training

FY2022 Compliance Training Report

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

FY2022 - Compliance Training Report

As of July 31, 2022, we achieved 98.4% overall completion rate for our compliance training. The delinquent employee list was sent to Human Resources by the Compliance Department. We are working with DMG and the Medical Executive Committee to follow-up and issue disciplinary actions on the non-compliant providers.

FY2022 - Compliance Training Report

As of 7/31/2022:

V.	Grand Total	
	Grand Total: All Not Completed Training	72
	Grand Total Completed	4,464
	Grand Total Assigned	4,536
	Grand Total: Percent of All Assigned Completed Training	98.4%

FY2022 - Compliance Training Report

Compliance Training FY2022		7/31/2022
I.	**Population: VWH Employees**	
	Total VWH Employees Not Completed Training	10
	Number of VWH Employees Completed	3,634
	Number of VWH Employees	3,644
	Percent of VWH Employees Completed Training	99.7%
II.	**Population: DMG Providers**	
	Total DMG Providers Not Completed Training	24
	Number of DMG Providers Completed	466
	Number of DMG Providers	490
	Percent of DMG Providers Completed Training	95.1%
III.	**Population: DMG Contractors**	
	Total of DMG Contractors Not Completed Training	35
	Number of DMG Contractors Completed	156
	Number of DMG Contractors	191
	Percent of DMG Contractors Completed	81.7%
IV.	**Population: Residents**	
	Total Residents Not Completed Training	3
	Number of Residents Completed	208
	Number of Residents	211
	Percent of Residents Completed Training	98.6%
V.	**Grand Total**	
	Grand Total: All Not Completed Training	72
	Grand Total Completed	4,464
	Grand Total Assigned	4,536
	Grand Total: Percent of All Assigned Completed Training	98.4%

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 6.

Compliance and Internal Audit Reports, Ethics Line Report

Q4 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: Q4 FY2022
Chief Compliance Officer/Privacy Officer

Q4 FY2022 Compliance and Internal Audit Work Plan Update – FQHC

- 1.0 – Q4 FY2022 Compliance Work Plan - FQHC
- 2.0 – Q4 FY2022 Internal Audit Work Plan - FQHC
- 3.0 - Ethics Line Reports - FQHC

1.0 – Q4 FY2022 Compliance Work Plans – FQHC

Data Dictionary for the Compliance and Internal Audit Work Plan

ABN – Advance Beneficiary Notice – 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.
ACN – Arizona Care Network – An Accountable Care Organization that operate in Arizona.
AHCCCS – Arizona Healthcare Cost Containment System – State of Arizona's name for the Medicaid state plan.
Medicare PPS – Medicare Prospective Payment System – A fixed based Medicare payment model.
MU – Meaningful Use – A term used in the Affordable Care Act 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 Q4 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	Flowcharted the different Behaviroal Health Models	Completed	5	3
CQ4.2 HIPAA Privacy Controls	Q4	200 Hours	Risk Assessment of the Privacy Contrls.	Completed	5	2
RO4 Risk Assessment and 2023 Compliance Plan Development	Quarterly	120 Hours		Completed		
Special Projects and Other Compliance Requests	On-going	TBD				
Compliance Planning, Administration and Meetings	Quarterly	TBD				

2.0 – Q4 FY2022 Internal Audit Work Plans – FQHC

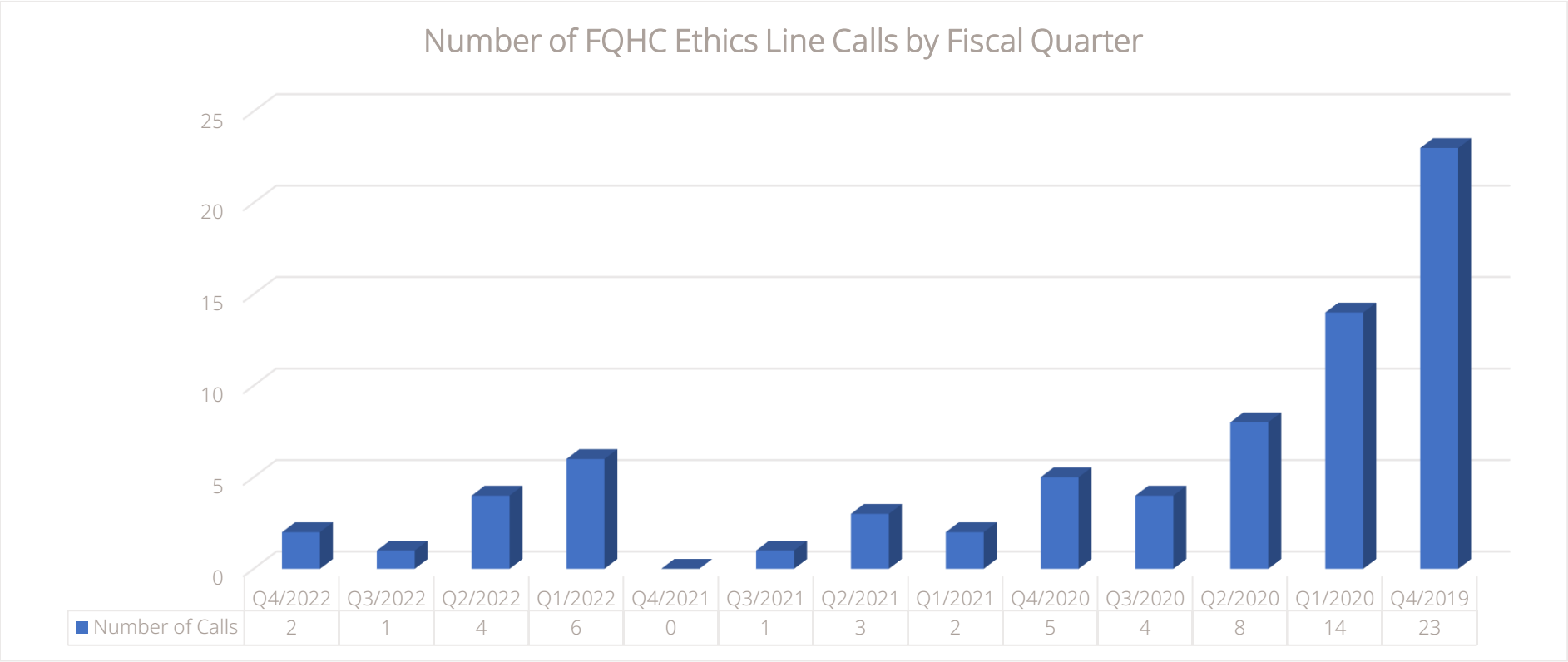
2.1 Q4 FY2022 Internal Audit Work Plan – FQHC

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	Posponed 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	Reviewed controls for Reaeach in the FQHCs.	Completed	5	3
IQ4.2 Revenue Cycle Controls - Back End	Q4	150 Hours	Focued on E&M Coding and Billing. Training will be conducted in August 2022.	Completed	5	3
IQ4.3 Care Re-Imagined (Prop 480) Controls and Monitoring Review	Q4	100 Hours	Monitoring construction controls	On-going	5	2
Risk Assessment and 2023 Internal Audit Plan Development	Quarterly	120 Hours		Completed		
Special Projects and Other Internal Audit Requests	On-going	TBD				
Internal Audit Planning, Administration and Meetings	Quarterly	TBD				

3.0 – Q4 FY2022 Ethics Line Reports (04/01/2022 through 06/30/2022) – FQHC Only

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



3.2 – Q4 FY2022 Issue Type, Alert Status and Primary Outcome Report

Count of Primary Case Outcome	Column Labels	
Row Labels	Green	Grand Total
Health Insurance Portability and Accountability Act (HIPAA)	1	1
Unfair Employment Practices	1	1
Grand Total	**2**	**2**

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)

Q4 FY2022 Relevant Issue Definitions

Health Insurance Portability and Accountability ACT (HIPAA) – This Category should be selected if there is a concern with the improper use or disclosure of Protected Health Information. Protected Health Information is information that:

(1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) that identifies the individual; or (ii) for which there is a reasonable basis to believe the information can be used to identify the individual.

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.

3.3 – Q4 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:

Q4 FY2022 Average Days to Close = 12

Comparable:

Q4 FY2021 Average Days to Close = 0 (No cases closed this quarter.)
Q4 FY2020 Average Days to Close = 24

Previous Quarter’s Indicators (Supplemental Data)

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)

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.

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.

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 7.

Closing Comments and Announcements
(No Handout)

Valleywise Community Health Centers Governing Council

Compliance and Quality Committee Meeting

August 8, 2022

Item 8.

Staff Assignments
(No Handout)