

2025 Q1 Quarterly Risk Assessment

- FTCA requires one risk assessment to be completed each quarter.
- The one required risk assessment for Q1 is complete, making the requirement at 100% compliance through Q1.
- The tool used for the Q1 Risk Assessment is called the ECRI Managing Risks in Ambulatory Care: Clinical Management Tool
 - 140 Criteria Audited
 - 126/140 compliant (90%)
 - Action Plan to correct other 14 criteria done and under way.



Managing Risks in Ambulatory Care: Clinical Management

ECRI Institute's INsight® Survey and managing risks related to this topic ar ethod to survey staff ranging from frontling

Ambulatory care facilities are exposed to many risks associated with provider activities. Risk managers face the challenges of controlling risks in nonhospital settings; ambulatory care facilities are often in remote an geographically dispersed locations: furthermore, office cultures differ, as do levels of risk management and patient safety knowledge, experience, and interest. This self-assessment questionnaire (SAQ) is designed to aid the risk manager in meeting these challenges. Specifically, this SAQ addresses clinical management systems in the ambulatory care setting.

Some portions of this SAQ will need to be addressed by the corporate or system risk manager. The manager at the ambulatory care facility can address other sections. Once the SAQ is completed, a plan should be established for addressing the shortcomings that the SAQ reveals. Subsequently, the SAQ can be completed in

Questions in this SAQ are derived from published literature and the recommer medical specialty societies, nursing associations, and other professional organizations. The professional standards and practice guidelines referenced are those that were in effect at the time this SAQ was written. However, standards and guidelines are revised and updated on an ongoing basis, and the most current information should be consulted where applicable. ECRI Institute recommends completing this SAD annually nd whenever significant organizational changes occur.

Where pertinent, some of the sources for the questions are given. The list of sources reflects important standards, guidelines, and other documents in support of the question; however, it is not intended to be a comprehensive list. This SAQ is intended to provide an overview of the subject matter. Additional resources an available elsewhere in the membership including toolkits addressing telephone triage and developing policies ocedures. Many of the questions for this SAO are based on material from the following sources

- ▶ 31 USC §§ 3729-3733. False Claims Act. (1863)
- 42 USC § 12101 et seg. Americans with Disabilities Act (ADA). (1990)
- ▶ 42 USC § 1320a-7b. Criminal penalties for acts involving federal health care programs (Anti-Kickbac
- ▶ 42 USC § 263a; Pub. L. 100-578. Clinical Laboratory Improvement Amendments. (1988

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	Yes	No	N/I*	N/A	Comments
g. Is there an audit trail that shows any entries and changes made in the medical record?	х				
h. Is a system in place to back up data, both on-site and in an off-site location?	х				
 i. Is there an alternative, paper-based process for completing medical record information in case of interruption in access to the EHR (e.g., power failure, computer error)? 	х				
j. Is a process in place to incorporate temporary paper records into the electronic record in case of EHR downtime?	х				

Informed Consent

В.	Are practitioners and facility managers familiar with informed consent laws and regulations?	Х		
Э.	Is informed consent obtained and documented for all invasive procedures or treatments associated with more than a minimal amount of risk and for those required by law?	х		
00.	Are informed consent discussions documented by the practitioner in the patient's office medical record?	х		
01.	Is specific informed consent for HIV testing obtained and documented?	х		
12	Is informed consent obtained and	Y		

103.	Is there an active, integrated, organized, written plan outlining the quality improvement (QI) program to the organization?

e or	X	×	There's a plan for the Ryan White program not primary-care an separate Continuou Quality Improvement Program for the herocenter as a whole.	n d
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	Clinical Risk Management Program
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		Yes	No	N/I*	N/A	Comments
104.	Is the plan reviewed on an annual basis to ensure it remains effective?	X	×			
105.	Does at least one practitioner participate in the QI program?		х			A practitioner has not been present in the OI program activities due to a vacant Medical Director position, however the position has been filled and practitioner involvement will resume moving forward.
	Is there a person designated to oversee QI activities?	X	x			Quality Management Coordinator
107.	Are proactive risk analyses of high-risk processes conducted annually?	X				
108.	Does the QI team:					
	 Audit critical processes (e.g., follow up on disginosite tests, text results, and communication of same)? 		X			Critical processes such as follow up on diagnostic tests, test; results, and similar communication is conducted daily prior to patients; appointments' via previsit planning print outs by the care team. However, there is no formal audit form to document this process.
1	b. Analyze data to identify gaps and opportunities for improvement?	X				
1	c. Compare facility performance against internal and external benchmarks?	X				
	d. Work together to prioritize opportunities for improvement?	X				
l	 e. Implement corrective actions based on QI findings? 	X				
	f. Reevaluate effectiveness of changes?	X				
	g. Modify again, if necessary?	X				
	h. Report actions to the governing body?	X				

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Risk Assessments

Person responsible	Measure/ Key Performance Indicator	Threshold	Q1
RM	# Completed annual high-risk assessments	≥ 2/yr	
RM	# Completed quarterly assessments	Min 1/qtr	1
RM	% Open action plans	<u><</u> 75%	100%

Q1 2025 Incident Reporting and Peer Reviews

- FTCA requires SNCHC to track the quantity and level of severity of all incidents.
- Last year 70 incidents were reported
- Q1 of 2025 there were 18 incidents reported, 0 of which were sentinel events, and 1 of which was high risk.
- 5/18 incidents required root cause analysis and follow up.
- The average score for Provider Peer Reviews in Q1 was 95%.

Adverse Events/ Incident Reports					
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1		
Center staff	# Sentinel Incidents	Total /qtr.	0		
Center staff	# High Risk Incidents	Total /qtr.	1		
Center staff	# Medium Risk Incidents	Total /qtr.	15		
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2		
Quar	terly Incident Totals	Prior Year - 70	18		
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5		
Medical Director	# Peer review audits completed (5/provider/qtr)	80%	95%		

Q1 2025 FTCA Required Annual Training Compliance

- There are five FTCA required trainings that all clinical staff MUST participate in each year.
- By the end of Q1, 88.1% of SNCHC's clinical staff had completed the annual required trainings for FTCA.
- FTCA requires that the Risk Manager take two FTCA risk related trainings each year.
- The Risk Manager, Dave Kahananui, has already completed his two annual trainings.

Training and Education					
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1		
FQHC Leadership	Planning , review and completion of annual OB training.	≥90% by year- end	97.30%		
FQHC Leadership	Planning , review and completion of annual High Risk Area (Safe Injection) training.	≥90% by year- end	89.33%		
FQHC Leadership	Planning , review and completion of annual High Risk Area (Hand Hygiene) training.	≥90% by year- end	84.26%		
FQHC Leadership	Planning , review and completion of annual HIPAA training.	≥90% by year- end	81.51%		
FQHC Leadership	Planning , review and completion of annual Infection Prevention (BBP) training.	≥90% by year- end	86.90%		
RM	Annual Training Completion Rate Goal of 90%	≥90% by year- end	88.10%		
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%		

Q1 2025 Risk and Patient Safety Activities

- Patient satisfaction score averaged 98%.
- 2 grievances filed and resolved.
- No pharmacy packaging and labeling errors.
- No HIPAA breaches.
- All referrals ordered were processed and sent.
- 41.51% of Pts eligible for Pregnancy Intention Screening were screened.
- No pregnant patients have documentation of which trimester they were in when first seen.
- No SNCHC patients who have had a baby this year have birthweight/race data documented for their newborn.
- 97% of LIP/OLCPs were credentialed at the end of Q1.

Risk and Patient Safety Activities				
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98%	
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	
Compliance/R M	HIPAA breaches	Total # of breaches	0	
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	100%	
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total#	1325	
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total #	550	
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	41.51%	
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	18	
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	18	
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total#	0	
RM/HR	Credentialing and privileging file review rate	100%	97%	

Q1 2025 Claims Management

 No claims were reported or filed in Q1.

Claims Management			
Person responsible	Measure/ Key Performance Indicator	Threshold	Q1
CM	# Claims submitted to HHS	NA	0
CM	# Claims settled or closed	NA	0
CM	# Claims open	NA	0
CM	# Lawsuits filed	NA	0
CM	# Lawsuits settled	NA	0
CM	# Lawsuits litigated	NA	0

