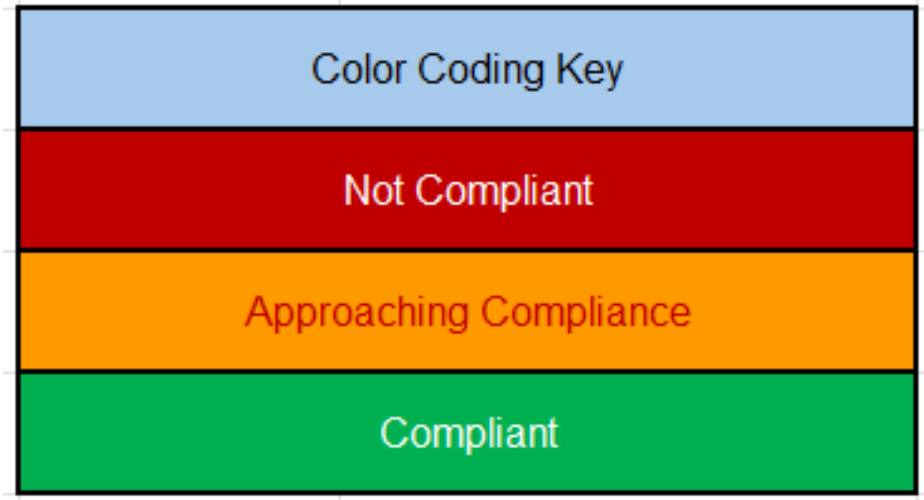
2025 Annual Risk Management Report

SOUTHERN NEVADA
Community
HEALTH CENTER

2025 Annual Risk Management Report

- Grading Scale
- FTCA program requirements mandate that quarterly risk assessments, quarterly risk management reports, and the annual risk management report be presented to the Board for review and approval.



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2025 Annual Risk Assessment Report

- FTCA requirements mandate that a risk assessment be conducted once per quarter.
- Two of the quarterly risk assessments should be related to areas of high-risk.

Risk Assessments							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	**3**
RM	# Completed quarterly assessments	Min 1/qtr.	**1**	**1**	**1**	**1**	**4**
RM	% Open action plans	≤75%	**0%**	**0%**	**20%**	**33%**	**22%**

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2025 Annual Incident Reporting and Peer Reviews

- FTCA requires SNCHC to track the quantity and level of severity of all incidents.
- 87 incidents were reported in 2025 (24% increase in the number of incidents reported YOY)
- 12 incidents reported in 2025 had a high-risk severity.
- 20/87 incidents required root cause analysis and follow up.
- The average score for Provider Peer Reviews in 2025 was 96%.

Adverse Events/ Incident Reports							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	**0**
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	**12**
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	**66**
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	**9**
Quarterly Incident Totals		Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20
Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	**95%**	**95%**	**98%**	**96%**	**96.00%**

Severity of incident:

- **Low** (Simple in nature, low risk level, requires issue filing and closure.)
- **Medium** (Multiple causes, medium risk level, requires some follow-up, then filing and closure.)
- **High** (High risk to safety of the team, the patients, and/or the brand, high risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)
- **Sentinel** (Dangerous risk of injury or death as well as safety of the team, the patients, and/or the brand, highest risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

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2025 Annual FTCA Required Annual Training Compliance

- There are five FTCA required trainings that all clinical staff MUST participate in each year.
- By the end of Q4, 100% of SNCHC's clinical staff had completed 2025's annual required trainings for FTCA.
- FTCA requires that the Risk Manager take two FTCA risk related trainings each year.
- The Risk Manager, Dave Kahananui, completed the two required annual trainings in May of 2025.

Training and Education							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total Completion Rate**
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	**100.00%**
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	**100.00%**
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	**100.00%**

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2025 Annual Risk and Patient Safety Activities

- Patient satisfaction score averaged 98% for 2025.
- 3 grievances filed in 2025 all of which were resolved.
- No pharmacy packaging and labeling errors in 2025.
- 0 HIPAA breaches during 2025.
- 97% of all referrals ordered were processed and sent in 2025.
- 47.8% of Pts eligible for Pregnancy Intention Screening were screened.
- 17 pregnant patients were referred out for OB care to contracted providers. Manual process tracking this measure.
- 1 health center patient who had a baby in 2025 had birthweight/race data documented for their newborn.
- 100% of LIP/OLCPs had current credentialing at the end of 2025.

Risk and Patient Safety Activities							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	**0%**
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	0	0	**0**
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	96%	97%	98%	97%	**97%**
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	**37.6%**	**45.2%**	**54.8%**	**56.0%**	**47.8%**
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	527	588	643	646	2404
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1403	1301	1174	1154	5032
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19	0	66
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	4	2	6	5	17
QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*

SOUTHERN NEVADA Community HEALTH CENTER

2025 Q4 Claims Management

- No claims were reported or filed in 2025.

Claims Management							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
CM	# Claims submitted to HHS	NA	0	0	0	0	0
CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0


Questions?

2025 Annual Risk Management Report (ARMR)

Annual Risk Management Report (ARMR) to Governing Board for 2025

Title: 2025 Annual Risk Management Report to the Southern Nevada Community Health Center Governing Board

Date: January 1, 2025, to December 31, 2025

Submitted by: David Kahananui, MBA-HM, FQHC Administrative Manager/FQHC Risk Manager

Reviewed/approved by: Randy Smith, MBA, FQHC Chief Executive Officer

Date ARMR submitted to the board: Presentation scheduled for March 17, 2026

Date board approved the ARMR: Vote for approval scheduled for March 17, 2026

Date board approved the meeting minutes containing board approval of the ARMR: Approval of minutes scheduled for April 21, 2026.

Introduction

The purpose of this report is to provide an account of Southern Nevada Community Health Center's (SNCHC) annual performance, relative to the risk management plan, and to evaluate the effectiveness of risk management activities for the 2025 calendar year. SNCHC participates in risk management planning, reporting, and activities to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation. Topics presented include quarterly risk assessments, incidents, provider peer review reporting, risk management training, risk and patient safety activities, and claims management. Each topic includes:

- An introduction to explain the relevance of the topic
- A data summary to highlight performance relative to established goals
- A SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis to identify additional factors related to performance
- Follow-up actions to note activities aimed at maintaining or improving performance throughout the year
- A conclusion to summarize findings at year-end
- Proposed future activities to respond to identified areas of high organizational risk

See the attached Risk Management Dashboard for a complete data summary of all topics presented.

2025 Annual Risk Management Report (ARMR)

Quarterly Risk Assessments

Introduction

The Health Center Program Compliance Manual requires quarterly risk assessments focused on patient safety. A risk assessment is a structured process used to identify potential hazards within the organization's operations, departments, and services. Evidence-based risk assessment tools used by SNCHC are provided by the Emergency Care Research Institute (ECRI), which is the recommended risk management resource for the Health Resources and Services Administration (HRSA). Risk assessments are conducted when member(s) of leadership walk around the building, evaluate conditions, and ask employees about potential risks and concerns while observing processes in action. Collecting data on practices, policies, and safety cultures in various areas generates information that can be used to proactively target patient safety activities and prioritize risk prevention and reduction strategies. The purpose of conducting regular risk assessments is to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Quarterly risk assessments	• The health center conducts a minimum of one risk assessment quarterly/four per year. • When high risk issues are identified within the health center, quarterly risk assessments conducted correlate with identified areas of high-risk. • All four risk assessments have an emphasized focus on patient safety. • The findings and action plans that are produced as a part of the risk assessments are reviewed for opportunities for improvement by the Quality Work Group (QWG), leadership, and then presented to the governing board and the FQHC staff. • Areas of high concern are elevated to the medical director, senior leadership, QWG, and/or the board as appropriate. • Additional risk assessments may be conducted as new risks are identified. • In 2025, the names of the four quarterly risk assessment tools used were: the Managing Risks in Ambulatory Care - Clinical Management, the HIPAA Risk Assessment, the Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Services, and the Self-Assessment Tool for Bloodborne Pathogens. • Three common areas of improvement were identified throughout the assessments which included: developing and implementing policy and/or standard practices, appointing a responsible role for clinical oversight, and improving workflows to reduce risk to patients, staff, and organizational liability.

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≤75% Open action plans	Action plans are created from the results of the quarterly risk assessments, and other risk related activities. Each action plan is assigned a deadline upon creation. Action plans contain meaningful risk reduction strategies to improve overall patient safety and should be implemented in a timely manner. The health center's goal is to have no more than 75% of action plans open past their initial deadline. This allows for continued work from previous quarters to continue while new ones are discovered through subsequent assessments. Any action plan open past the deadline is elevated to senior leadership, including the Medical Director, and/or the board as appropriate for further discussion and intervention.

Data Summary - *See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.*

Risk Assessments							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	**3**
RM	# Completed quarterly assessments	Min 1/qtr.	**1**	**1**	**1**	**1**	**4**
RM	% Open action plans	≤75%	**0%**	**0%**	**20%**	**33%**	**22%**

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
• New medical director leading clinical growth and improvements. • Data integrity improvements.	• First time going through many of the standardized risk assessments has exposed areas not monitored before. • Policies specific to risk management need development, updating, and improvement.	• Improving reputable and reliable external resources to meet all compliance expectations. • Finding another training resource that enhances what is available on ECRI website. ECRI training cannot be repeated.	• New Executive orders and policy changes that impact operational workflows. • Las Vegas is a very litigious community. • Funding insecurities.

Follow-up Actions from Risk Assessments

2025 Annual Risk Management Report (ARMR)

Q1 Risk Assessment Findings & Action Plan: ECRI Managing Risks in Ambulatory Care - Clinical Management – Conducted by FQHC Medical Director on 3/26/2025. Score: 201/217 – 92.6%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up

Goal #1: Correct findings in the medication safety section of the risk assessment.	• Create, gain approval of, and train a new policy to address a drug-sample control program that includes inventory, periodic checks of expiration dates, and a recall system, and how drug samples are to be logged with the amount received from the pharmaceutical representative, expiration dates, and lot numbers.
	  ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025.
	• Create, gain approval of, and train a new policy to address the prohibition of the use of pre-signed and/or post-dated prescription forms, and training on how staff will adhere to this policy.
	  ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025.
	• Create, gain approval of, and train a new policy to require a "read back" of the complete order by the person taking verbal or telephone medication orders to confirm that they are correct.
	  ○ Dr. Carter and Dr. Bleak to lead, and Randy Smith, CEO, to approve and present to board for approval. Policy approval due date December 31, 2025.
		Completed in June of 2025.

		3 & 6 Month Follow Up

Goal #2: Correct findings in the health information management section of the risk assessment.	• Medical Director, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025:
	  • Documentation of treatment or procedures performed in the facility does not include patient condition at discharge.
	  ○ Dr. Carter has already provided training on this for the practitioners.
	  ○ Due June 30, 2025.
	  • The facility does not have a standardized set of abbreviations, acronyms, and symbols for use throughout the facility.
	  ○ Dr. Carter, Operations Managers, QMC, and CEO.
	  ○ Due August 31, 2025.
	  • The facility does not have a "do not use" list of abbreviations, acronyms, and symbols.
	  • The facility does not have a policy to document end-of-life discussions and decisions in the medical record.
		Completed in May of 2025.

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	• Regarding electronic medical records: computers in exam rooms are not positioned to avoid creating a barrier between the practitioner and the patient. • Assessment Item # 97.b: Regarding electronic medical records: computers in exam rooms do not have the computer screen shielded to protect confidentiality. • Assessment Item # 97.e: Missing policy addressing addendums, late entries, and corrections needing to be entered into the electronic record.	
		3 & 6 Month Follow Up
Goal #3: Correct findings in the health information management section of the quality improvement (QI) section.	• Medical Director, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: • At least one practitioner needs to be assigned to participate in the QI program. • Refine the formal policy to audit critical processes (e.g., follow up on diagnostic tests, test results, and communication of same.)	Completed in August of 2025
Goal #4: Correct findings in the health information management section of the Risk Management section.	• Medical Director, Risk Manager, QMC, Ops Managers, and Leadership will establish protocols and train and establish workflows to correct the following identified areas of improvement identified by the end of September 2025: • Develop and implement a documented definition of a near-miss or good-catch event. • Train and assess/verify that staff can recall the process to report a near-miss event.	Completed in May of 2025

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Q2 Risk Assessment Findings & Action Plan: SNHD HIPAA Risk Assessment Tool. – Conducted by FQHC Medical Director on 6/9/2025. Score: NA

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Goal #1: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Oral Communications.	• Operations Managers & Medical Director regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in oral communication regarding PHI. • Operations Managers & Medical Director cover expectations and risks at huddles regularly. • Operations Managers & Medical Director identify and define areas for verbally discussing PHI, so communication only occurs away from other patients. • Complete by October 2025.	Completed by operations managers in August of 2025.
		3 & 6 Month Follow Up
Goal #2: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Protecting Confidentiality of Electronic PHI.	• Operations Managers & Medical Director regularly walk through potential risk areas at the end of the day to ensure team members are signed out of their systems. • Operations Managers & Medical Director will walk through the clinic for continuous monitoring of team members signing out of their system as required. • Complete by October 2025.	Complete by operations managers and medical director in September of 2025.
		3 & 6 Month Follow Up
Goal #3: Close HIPAA Privacy gaps discovered in 2025 HIPAA Risk Assessment under category, Electronic Mail.	• Operations Managers & Medical Director cover the need for the confidentiality notices in their email signatures and have all team members send an email with their signature lines to verify. • Complete by October 2025.	Completed by operations managers and medical director in July of 2025.

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Q3 Risk Assessment Findings & Action Plan: HRSA ECRI Risk Assessment and Mitigation Tool: Safeguards for Behavioral Health Service – Conducted by FQHC Medical Director and Behavioral Health Manager on 9/15/2025. Score: 61/67 – 91%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Correct Criterion #1a – The health center conducts debriefing and safety huddles to support safe and effective behavioral health services.	• BH Manager & Medical Director consult on policy verbiage and workflow for huddles by January 2026. • Identify what constitutes a safety issue (consult with safety officer and security as needed) and what needs to be communicated to mitigate and prevent future safety incidents by January 2026. • Define workflow and procedure for huddles with ops teams and BH team. • Create a procedure in the proper SNHD/SNCHC format and have CEO review by January 2026. • Implement new debriefing and safety huddles process for all BH and Clinic operations teams by April 2026.	Completed by behavioral health manager and medical director in November 2025 and will be reviewed annually.
		3 & 6 Month Follow Up
Correct Criterion #2a – The health center utilizes patient navigators specific to behavioral health services.	• CEO, BH Manager, & Medical Director must decide what this role entails and if another FTE is required, or if these responsibilities can be shouldered by existing staff. Job descriptions need to be updated as determined by April 2026. • Once duties have been defined, and whether a new or existing FTE will assume those duties, a process must be developed for tracking the activities of this team member for reporting, transparency, and quality improvement by July of 2026.	Completed by behavioral health manager and medical director in December 2025. Workflow has corrected the gap here with CHW and PSR support.
		3 & 6 Month Follow Up
Correct Criterion #3a – The health center has a plan to identify and address behavioral health workforce shortages and burnout.	• BH Manager & Medical Director will define what burnout is and identify mitigation and planning tactics to minimize burnout. Cadence of review and first meeting will occur by July 2026. • BH Manager & Medical Director will regularly review staffing levels and patient demands and proactively plan access and service provision growth through new providers and operational efficiencies where, when, and how it is logistically possible.	January 2026 – This is still in process of development for identifying issues by the behavioral health manager. April 2026 – July 2026 –
		3 & 6 Month Follow Up
Correct Criterion #4a – The health center provides soothing music, toys, and comfortable furniture.	• BH Manager & Medical Director will work with Business Office on budget needs for ambiance in patient areas, which items to purchase. • BH Manager will work with AA to place a purchase order and get materials in and	Completed by behavioral health manager and medical director in January of 2026.

	activate or place all new supplies appropriately for the BH Center by April 2026.	Items budgeted and purchased have been implemented.
		3 & 6 Month Follow Up
Correct Criterion #4b – The health center counsels patients and their families about firearms and gun safety.	• BH Manager and Medical Director will work with the Safety Officer to post current SNHD policy compliant firearm and gun safety disclaimers in the BH waiting area by January 2026.	Completed by behavioral health manager in January of 2026 with support from the safety officer, security, and medical director, Signs are posted at the district.

Q4 Risk Assessment Findings & Action Plan: HRSA ECRI Self-Assessment Tool for Bloodborne Pathogens - Conducted by FQHC Medical Director and Behavioral Health Manager on 10/27/2025. Score: 111/120 – 92%

CY25 Goals	CY25 Activities (What, Who, When)	CY25 Performance
		3 & 6 Month Follow Up
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Exposure Determination and the Exposure Control Plan.	• Document annual consideration and implementation of safer medical devices, even if the decision is that no new medical devices are required. ○ Led by Medical Director to evaluate annually and implemented by June of 2026.	Completed in January of 2026. Maintenance of clinical devices has been reviewed, and no new devices are required.
		3 & 6 Month Follow Up
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Hygiene Practices.	• Revisit training of hand sanitizing at team huddles, and of lip balm not being used in clinic area ○ Medical Director and/or Operations Managers to provide training to team at huddles by April 2026.	Review and training provided in February of 2026.
		3 & 6 Month Follow Up
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Personal Protective Equipment.	• If an employee decides not to use PPE because its use would prevent healthcare delivery or pose an occupational safety hazard, is that incident investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future? ○ Medical Director to incorporate this language and protocol into the existing PPE policy by July 2026.	Jan 2026 – In process Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up

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Correct Criteria found to be out of compliance or in need of improvement for the section titled: Vaccination.	Exposure control plan (ECP) needs to be reviewed and revised to address all concerns identified through the risk assessment regarding employee vaccinations. o Medical Director reviews and revises the language of the ECP and then will present to operations managers and executives for approval and then have the board(s) approve by July 2026.	Jan 2026 – In process Apr 2026 – Jul 2026 –
		3 & 6 Month Follow Up
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Postexposure Evaluation, Follow-up, and Prophylaxis.	• Meet with clinical and executive leadership whether HBV & HCV rapid testing should be added for employees like HIV. o Medical Director conducts a review of current protocols, number of incidents in the last three years, and determination of whether SNHD should carry rapid testing for HBV & HCV, and have those rapid tests added to the CLIA lab license. • Currently, Concentra protocols are used to govern activities in this space. SNCHC leadership needs to evaluate the Concentra protocols and determine if updates are necessary and how to implement them. o Led by Medical Director and Quality Management Coordinator to present to leadership and potentially the Board(s) for approval by July 2026. • Conduct further education of the team regarding consultation after possible exposure to HIV according to the most recent U.S. Public Health Service recommendations, including: When the source virus is known or suspected to be resistant to antiretrovirals (although initiation of PEP should not be delayed awaiting results of resistance testing)? o Led by Medical Director and Operations Managers to educate the team and review at subsequent huddles.	Completed in February 2026 - All issues were reviewed with medical director and employee health nurse for revision. All protocols were found to follow standards of medicine and local, state, and federal law. Protocols were reviewed with team at huddles and through meetings..
		3 & 6 Month Follow Up
Correct Criteria found to be out of compliance or in need of improvement for the section titled: Housekeeping.	• Review general practices and SOP protocols for maintaining, cleaning, and disinfecting in patient care areas to control environmental contamination with agents of CJD, and Ebola disinfecting practices. o Led by Medical Director to review and revise protocols for changes needed by June 2026 o Training provided by Operational Managers once the Medical Director has decided which updates and training are needed from their review and revision of the protocols by July 2026.	Completed in January 2026 – protocols reviewed, training reviewed at huddles and meetings

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Conclusion

The number of quarterly risk assessments met the threshold. Three of the quarterly risk assessments completed were also high-risk assessments. The percentage of open action plans was 22% for the year, which was an improvement over the previous year's results. This means that there are only 22% of the action plan items that are not complete for the year with a threshold of 75% or less. 2/6 of the Q4 action plan items, and 1/5 Q3 action plan items were not corrected/completed, but all action items have been facilitated for correction/completion.

Proposed Future Activities

The number of quarterly risk assessments that were completed met the Health Center's goal. Due to the Health Center's aim to reduce the risk of adverse outcomes that could result in medical malpractice or other health or health-related litigation, all four risk assessments for 2026 are recommended to have a focus of patient safety in nature with support from the behavioral health manager, the clinical operations managers and the medical director for evaluation and recommended action items.

Three of the areas assessed for risk included high-risk categories: Risks in ambulatory care, HIPAA compliance, and Blood-borne pathogen risk.

- Medical Director is the clinical champion leading change and improvement in clinical execution with support from the Quality Management Coordinator, the Operations Managers, the Risk Manager, and the FQHC CEO as needed.

- Quarterly Risk Assessments are presented to the Quality Risk Management and Credentialing Committee and to the governing board.

2025 Annual Risk Management Report (ARMR)

Incident Reporting and Provider Peer Reviews

Introduction – Incident reporting is an essential component of the risk management program and is considered part of the performance and quality improvement process. Each provider, employee, or volunteer is responsible for reporting all incidents and near misses at the time they are discovered to his or her immediate supervisor and/or the risk manager. Provider Peer Reviews are chart audits conducted by a provider on patient charts that were documented by their peers in the health center. Both the incident reporting and provider peer review processes provide opportunities for a health center to identify potential issues, mitigate problems discovered, conduct root cause analysis, and implement proactive prevention strategies and mitigation tactics to enhance efficiency and reduce risk.

The "Risk Manager Informal Review" and the Risk Manager Formal Incident Review" forms are critical to determining the cause of the incident, who else needs to be alerted, what trainings need to be provided, analysis of the process, and outcomes.

2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Adverse Events/ Incident Reports							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
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Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	**95%**	**95%**	**98%**	**96%**	**96.00%**

- 59% of all incidents reported involved a medical issue where staff had to respond with the provision of medical care, monitoring, and follow-up, which is all documented, compared to 62% from last year.
  - 23 medical-event incidents that were reported involved staff responding to non-emergent medical issues.
  - 28 medical-event incidents that were reported involved staff responding to emergent medical issues that required a call to for EMS support.
- 20% of incidents reported involved a patient's behavior compared to 23% last year.
  - 6 incidents reported were for patients behaving aggressively but did not escalate to a level requiring the need for SNHD security support.
  - 1 incident reported was for a patient behaving aggressively and it did escalate to a level requiring the need for SNHD security support.

  - 7 incidents reported were for patient complaints regarding a poor experience.
- 4 medication errors were reported in 2025
  - 1 was due to the incorrect vaccine being administered.
  - 1 was due to a miscommunication between provider and clinical support staff.
  - 1 was due to due to a medication being administered before it was due to be administered.
  - 1 was due to a medication being administered because of an expired lab test.
- 1% of incidents reported were lab errors, which originated from incorrect lab orders.
- 21% of incidents reported were for a variety of reasons across multiple categories from injuries to power and water outages.
- 85.25% of all medical event incidents were reported as occurring in the FQHC division.
  - Of the medical-event incidents reported in the FQHC division, Fremont reported 44.26% of the medical event incidents in the FQHC division, demonstrating their commitment to reporting all incidents to support mitigation and prevention efforts.
  - Of the medical-event incidents reported in the FQHC division, Decatur's Sexual Health Clinic reported 11.48% of the medical event incidents in the FQHC division.
  - Of the medical-event incidents reported in the FQHC division, 29.51% of the incidents were in common areas of the FQHC division.
- 14.75% of all medical event incidents were reported as occurring in non-FQHC divisions.
- Root cause analysis was performed on 22.98% of incidents.
  - Most RCAs were performed on incidents that were high risk or medium risk incidents that could have escalated into becoming sentinel/high risk.
- Annual peer review scores averaged 96%, which is:
  - Improvement over previous year because of medical director and quality management coordinator involvement and leadership.
  - The "Ongoing Professional Practice Evaluation – Peer Review" policy and procedure being followed.

2025 Annual Risk Management Report (ARMR)

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
• Three consecutive years in a row, there has been an increase in the number of incidents being reported versus prior year. • A Peer Review process is being monitored. • A new medical director has been overseeing this process. • Staff are familiar with and execute the incident reporting process.	• Several iterations of incident reports and confusion about when to use each one • Some departments in the FQHC division are not reporting incidents commensurate with other departments who are sometimes less busy. • Interdepartmental priorities and processes.	• Technological systems or reporting templates are being explored to provide regular comprehensive reports to leadership, the QRMC Board Committee and the Governing Board. • ECRI/HRSA resources are being used to develop tools, reports, assessments, and dashboards.	• Monitoring executive orders and how they affect SNCHC's policies, procedures, and workflows.

Follow-up Actions

The incident tracking and communication process was made available to SNHD's legal and risk management leadership for consistency and cooperation across the district with the intent to collaborate on risk mitigation efforts. No peer review process in place and needs to be developed. Below is a snippet of the statistical data provided by the tracker for count, type, and severity of incidents.

Type of Incident Choose One and Type an "x" in Correct Category

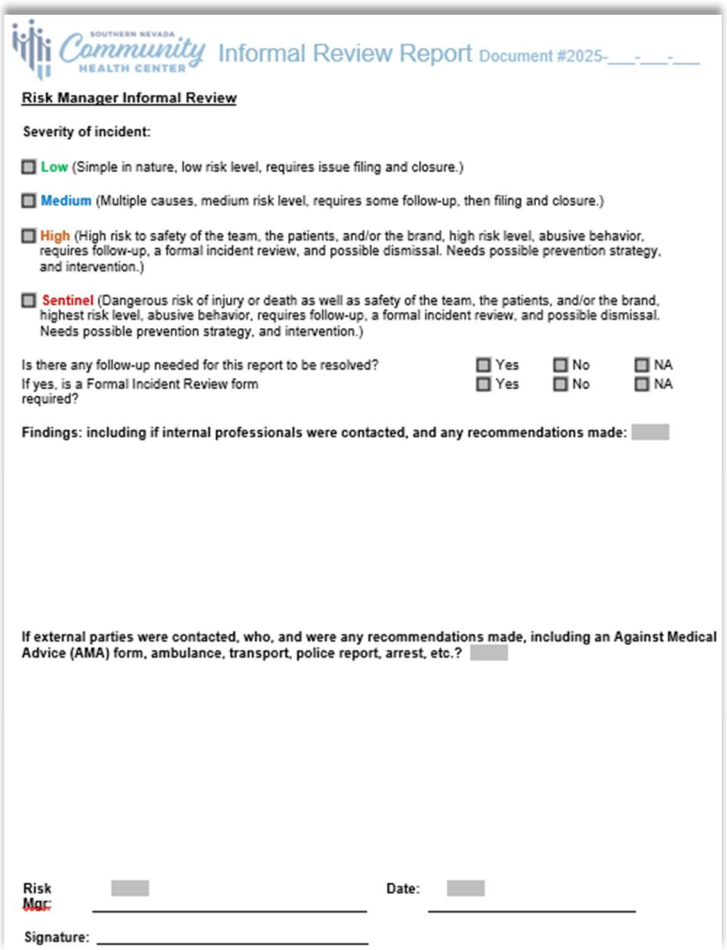
Assigned Incident #	Date of Incident	Time of Incident	Customer/Patient: Complaint	Injury	Security	Safety	Vehicle	Ethical	HIPAA	Critical Lab Result	Drug Seeking Behavior	Aggressive	Employee: Illness	Injury	Security	Vehicle	Ethical	HIPAA	Lab Issue	Aggressive
87			7	2	1	0	0	0	1	0	0	6	1	1	0	0	0	0	3	0
		% of Total	8%	2%	1%	0%	0%	0%	1%	0%	0%	7%	1%	1%	0%	0%	0%	0%	3%	0%

Assigned Incident #	Misc: District vehicle damage	District property loss	Personal property loss	Fire Hazard	Dr. Redbird	Dr. Bluebird	Non Bluebird Medical Event	Lab Order Error	Power Outage	Water Outage	EMR Outage	Cash Handling	Cybersecurity	Medication Error	Legal Threat	Aggressive Vendor	Alarm	Criminal	Other
87	0	0	1	0	0	23	28	1	1	2	0	1	0	4	0	0	0	0	4
% of Total	0%	0%	1%	0%	0%	26%	32%	1%	1%	2%	0%	1%	0%	5%	0%	0%	0%	0%	5%

Assigned Incident #	Severity - Type an "x": Low	Medium	High	Sentinel
87	9	66	12	0
% of Total	10%	76%	14%	0%

2025 Annual Risk Management Report (ARMR)

Incident Review Forms



Informal Review Report Document #2025-___-___-___

Risk Manager Informal Review

Severity of incident:

☐ Low (Simple in nature, low risk level, requires issue filing and closure.)

☐ Medium (Multiple causes, medium risk level, requires some follow-up, then filing and closure.)

☐ High (High risk to safety of the team, the patients, and/or the brand, high risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

☐ Sentinel (Dangerous risk of injury or death as well as safety of the team, the patients, and/or the brand, highest risk level, abusive behavior, requires follow-up, a formal incident review, and possible dismissal. Needs possible prevention strategy, and intervention.)

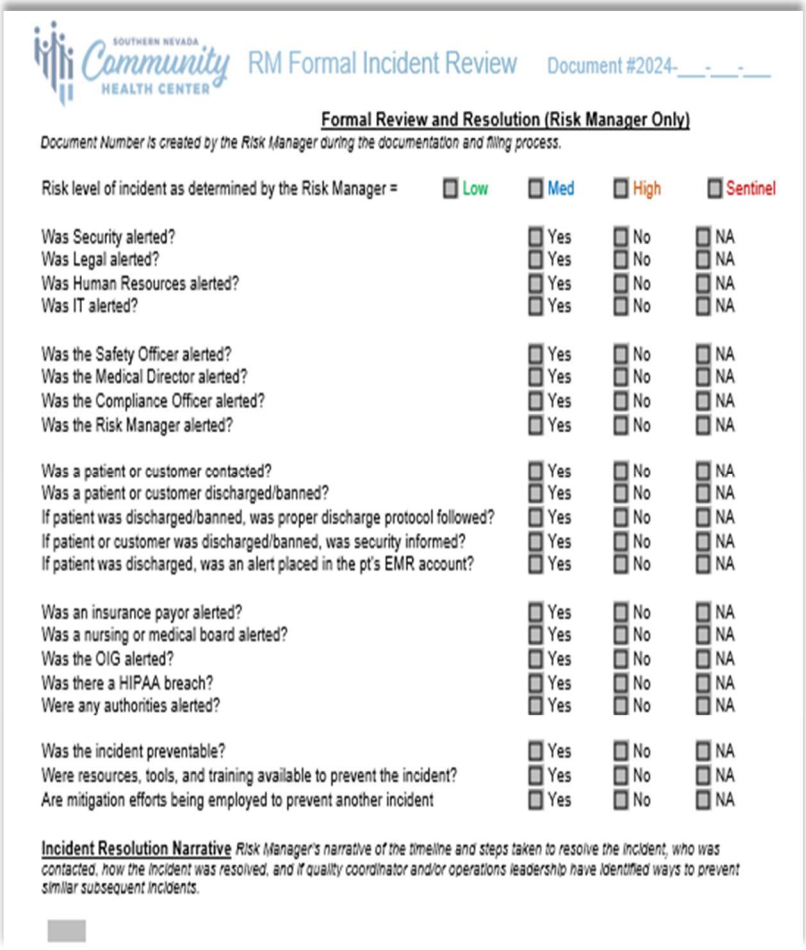
Is there any follow-up needed for this report to be resolved?	☐ Yes	☐ No	☐ NA
If yes, is a Formal Incident Review form required?	☐ Yes	☐ No	☐ NA

Findings: including if internal professionals were contacted, and any recommendations made:

If external parties were contacted, who, and were any recommendations made, including an Against Medical Advice (AMA) form, ambulance, transport, police report, arrest, etc.?

Risk Mgr: _____ **Date:** _____

Signature: _____



RM Formal Incident Review Document #2024-___-___-___

Formal Review and Resolution (Risk Manager Only)

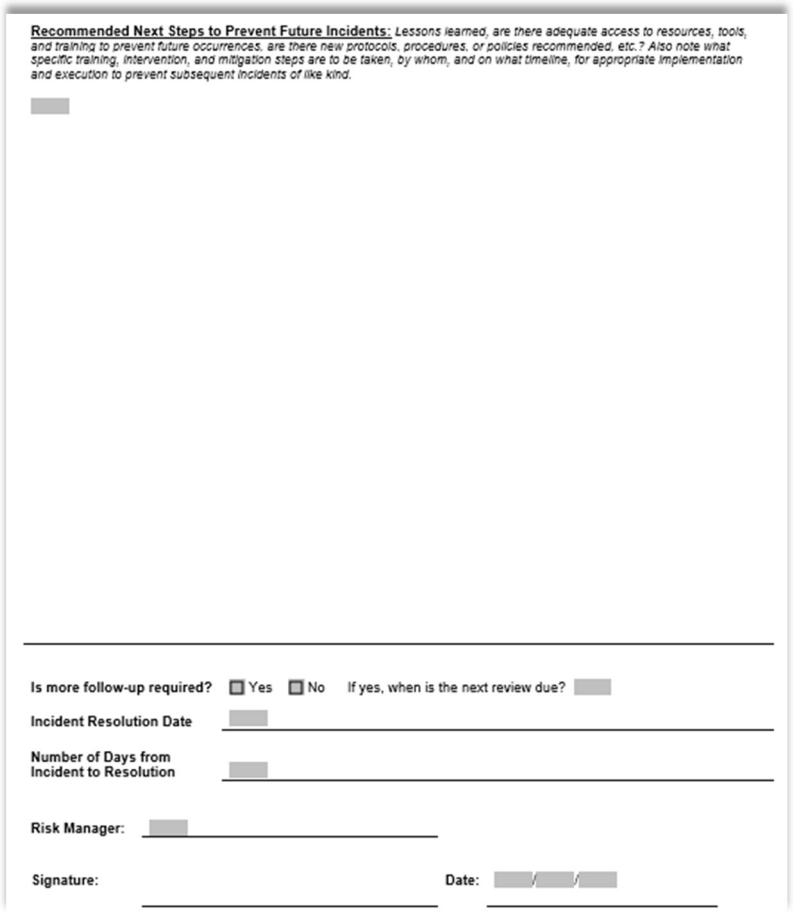
Document Number is created by the Risk Manager during the documentation and filing process.

Risk level of incident as determined by the Risk Manager = ☐ Low ☐ Med ☐ High ☐ Sentinel

Was Security alerted?	☐ Yes	☐ No	☐ NA
Was Legal alerted?	☐ Yes	☐ No	☐ NA
Was Human Resources alerted?	☐ Yes	☐ No	☐ NA
Was IT alerted?	☐ Yes	☐ No	☐ NA
Was the Safety Officer alerted?	☐ Yes	☐ No	☐ NA
Was the Medical Director alerted?	☐ Yes	☐ No	☐ NA
Was the Compliance Officer alerted?	☐ Yes	☐ No	☐ NA
Was the Risk Manager alerted?	☐ Yes	☐ No	☐ NA
Was a patient or customer contacted?	☐ Yes	☐ No	☐ NA
Was a patient or customer discharged/banned?	☐ Yes	☐ No	☐ NA
If patient was discharged/banned, was proper discharge protocol followed?	☐ Yes	☐ No	☐ NA
If patient or customer was discharged/banned, was security informed?	☐ Yes	☐ No	☐ NA
If patient was discharged, was an alert placed in the pt's EMR account?	☐ Yes	☐ No	☐ NA
Was an insurance payor alerted?	☐ Yes	☐ No	☐ NA
Was a nursing or medical board alerted?	☐ Yes	☐ No	☐ NA
Was the OIG alerted?	☐ Yes	☐ No	☐ NA
Was there a HIPAA breach?	☐ Yes	☐ No	☐ NA
Were any authorities alerted?	☐ Yes	☐ No	☐ NA
Was the incident preventable?	☐ Yes	☐ No	☐ NA
Were resources, tools, and training available to prevent the incident?	☐ Yes	☐ No	☐ NA
Are mitigation efforts being employed to prevent another incident	☐ Yes	☐ No	☐ NA

Incident Resolution Narrative *Risk Manager's narrative of the timeline and steps taken to resolve the incident, who was contacted, how the incident was resolved, and if quality coordinator and/or operations leadership have identified ways to prevent similar subsequent incidents.*

2025 Annual Risk Management Report (ARMR)



Recommended Next Steps to Prevent Future Incidents: *Lessons learned, are there adequate access to resources, tools, and training to prevent future occurrences, are there new protocols, procedures, or policies recommended, etc.? Also note what specific training, intervention, and mitigation steps are to be taken, by whom, and on what timeline, for appropriate implementation and execution to prevent subsequent incidents of like kind.*

Is more follow-up required? ☐ Yes ☐ No If yes, when is the next review due?

Incident Resolution Date

Number of Days from Incident to Resolution

Risk Manager:

Signature: **Date:**

- Efforts to improve the response time of the emergency response team to medical events were made this last year, improving response time. The efforts were led by the medical director, chief nursing director, and the operations managers.

2025 Annual Risk Management Report (ARMR)

- Although the peer review process was finalized and implemented the loss of the medical director left the process without clinical oversight. While a new medical director is being recruited the practice of peer review began. Incident reporting numbers are improving. The medical director has led the peer review process for 6 quarters now and the results are consistent and positive. The quality management coordinator monitors the data and trends produced by the peer reviews

Provider	Q1	Q2	Q3	Q4	Total Avg
1	99%	94%	99%	94%	**97%**
2	99%	94%	100%	93%	**97%**
3	87%	100%	98%	100%	**96%**
4	100%	95%	95%	98%	**97%**
5	93%	90%	99%	89%	**93%**
6	96%	96%	95%	TBD	**94%**
7	100%	100%	100%	TBD	**100%**
8	96%	96%	98%	91%	**95%**
9	100%	94%	95%	100%	**97%**
10	97%	92%	98%	80%	**92%**
11	99%	97%	91%	TBD	**96%**
12	94%	96%	96%	88%	**94%**

13	96%	97%	98%	100%	**98%**
14	95%	93%	100%	98%	**97%**
15	100%	100%	100%	93%	**98%**
16	100%	97%	91%	98%	**97%**
17	100%	92%	97%	100%	**97%**
18	94%	97%	100%	95%	**97%**
19	91%	95%	100%	100%	**97%**
20	n/a	100%	100%	96%	**99%**
21	n/a	88%	n/a	95%	**92%**

Conclusion

SNCHC's newly established risk management workflows, processes, policies, and operations have improved the quantity and quality of outcomes over the last two years.

Proposed Future Activities

A risk management refresher course still needs to be created and added to the annual training course bundle in the learning management system. A "good catch" program has been implemented, called an "On the Spot" award. This program encourages and rewards staff for identifying near-miss events and unsafe conditions through event reporting and mitigation tactics used when a risk presents itself.

Risk Management Training

2025 Annual Risk Management Report (ARMR)

Introduction

The Health Center Program Compliance Manual requires risk management training for all staff members and documentation that all appropriate staff complete training at least annually. Risk management education and training are critical for clinical and nonclinical staff to improve safety and mitigate risk related to patient care. Clinical risk training is required by all Licensed Independent Practitioners (LIPs), Other Licensed Clinical Practitioners (OLCPs), and Other Clinical Staff (OCS) that engage in patient care. Other staff may be assigned to participate in the training as SNHD policy/leadership requires. The risk manager collaborates with the medical director and the operations managers to identify areas of highest risk within the context of the health center's risk management plan and selects risk management training topics that will reduce risk to patient and staff safety.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
FQHC Leadership annually reviews the previous year's high-risk areas, and existing training programs to ensure FTCA compliance, best fit for Health Center, patient safety focused, reputable & evidence-based training programs.	The health center provides mandatory evidence-based virtual training to all health center clinical staff on the following risk related topics: Obstetrics: Safe, Equitable Care for All Women and Primary Care of the Postpartum Patient, Safe Injection Training, HIPAA Privacy Rule, Bloodborne Pathogens Awareness, and The Basics of Hand Hygiene for Healthcare Settings.
Obstetrics: Safe, Equitable Care for All Women and Primary Care of the Postpartum Patient Series	Threshold for this training is 90% of the relevant clinical staff having completed the required training annually. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training withing 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.
Safe Injection Training	Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training withing 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.

2025 Annual Risk Management Report (ARMR)

HIPAA Privacy Rule	Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training withing 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each staff team member. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.
Bloodborne Pathogens Awareness	Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training withing 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.
The Basics of Hand Hygiene for Healthcare Settings	Threshold for training is a 90% compliance rate. 100% is preferred, however the 90% threshold has been set to allow for newly hired team members to complete their training withing 90 days of hire per SNHD/SNCHC policy. Training must be completed annually by each clinical staff team member, which includes LIPs, OLCPs, and OCS staff. Certificates of completed training are then sent to the medical director, and the medical director updates the training tracker. The training tracker is then reviewed at FQHC Leadership meetings at least quarterly to ensure the required training gaps are being closed.

2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Training and Education							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total Completion Rate**
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High-Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	**100.00%**
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	**100.00%**
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	**100.00%**

SOUTHERN NEVADA Community HEALTH CENTER

2025 Annual Risk Management Report (ARMR)

Training Tracker:

Department	Job Title	Clinical/ Non-Clinical	Manager	Obstetrics: Safe, Equitable Care for All Women and Primary of the Postpartum Patient (CLINICAL STAFF) (ECRI)	Safe Injection Training (CLINICAL STAFF)	HIPAA Privacy Rule (ALL)	Bloodborne Pathogens Awareness (Annual/ NEOGOV (CLINICAL STAFF)	The Basics of Hand Hygiene for Healthcare Settings https://www.ctrain.org/main/course/1084875/details (CLINICAL STAFF)
Primary Care Center	Medical Assistant	Clinical	Bernadette Meily	03/19/25	03/19/25	03/21/25	03/21/25	03/21/25
Family Planning	Adv Prctcl Registered Nurse I	Clinical	Bernadette Meily	03/13/25	03/19/25	03/18/25	03/19/25	03/18/25
Primary Care Center	Laboratory Assistant	Non Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Pharmacy	Pharmacy Technician	Clinical	Todd Bleak	N/A	03/13/25	03/13/25	03/13/25	03/13/25
Family Planning	Medical Assistant	Clinical	Merylyn Yegon	03/13/25	03/24/25	04/01/25	03/31/25	03/31/25
Family Planning	Adv Prctcl Registered Nurse I	Clinical	Merylyn Yegon	03/18/25	03/18/25	02/04/25	04/07/25	04/08/25
Ryan White	Community Health Worker I	Non Clinical	Merylyn Yegon	N/A	N/A	03/18/25	N/A	03/18/25
Family Planning	Community Health Nurse I	Clinical	Bernadette Meily	03/18/25	03/27/25	03/18/25	03/28/25	03/18/25
Primary Care Center	Patient Services Representative	Non Clinical	Cassandra Major	N/A	N/A	03/17/25	N/A	03/13/25
	Medical Assistant	Clinical	Merylyn Yegon	03/18/25	03/17/25	03/17/25	03/18/25	03/18/25
Administration	Senior Administrative Specialist	Non Clinical	Randy Smith	N/A	N/A	04/16/25	N/A	N/A
Family Planning	Community Health Nurse II	Clinical	Bernadette Meily	03/18/25	04/01/25	04/01/25	04/01/25	04/01/25
Pharmacy	Pharmacy Manager	Clinical	Randy Smith	03/18/25	03/13/25	03/13/25	03/13/25	03/13/25
Family Planning	Mobile Unit Operator	Non Clinical	Bernadette Meily	N/A	N/A	N/A	N/A	N/A
Sexual Health Clinic	Administrative Assistant II	Non Clinical	Cassandra Major	N/A	N/A	03/18/25	N/A	03/24/25
Sexual Health Clinic	Medical Assistant	Clinical	Bernadette Meily	03/18/25	03/18/25	04/01/25	04/01/25	03/18/25
Family Planning	Administrative Assistant II	Non Clinical	Bernadette Meily	N/A	N/A	03/13/25	N/A	03/19/25
Ryan White	Community Health Nurse I/Certified C	Clinical	Merylyn Yegon	03/26/25	03/27/25	03/27/25	03/27/25	03/27/25
Sexual Health Clinic	Community Health Nurse I	Clinical	Karin Dinda	03/12/25	03/12/25	03/13/25	03/13/25	03/13/25
Family Planning	Administrative Assistant II	Non Clinical	Cassandra Major	N/A	N/A	03/18/25	N/A	03/18/25
Administration	CMO/Medical Director	Clinical	Randy Smith	03/12/25	03/11/25	02/03/25	03/13/25	03/13/25
Family Planning	Patient Services Representative	Non Clinical	Cassandra Major	N/A	N/A	04/01/25	N/A	04/03/25
Ryan White	Care Coordinator	Non Clinical	Merylyn Yegon	N/A	N/A	03/18/25	N/A	03/18/25
Ryan White	Community Health Worker I	Non Clinical	Cassandra Major	N/A	N/A	03/13/25	N/A	03/18/25
Ryan White	Community Health Nurse II	Clinical	Merylyn Yegon	03/18/25	03/31/25	03/31/25	03/31/25	03/31/25
Ryan White	Community Health Nurse II	Clinical	Merylyn Yegon	03/18/25	03/12/25	03/17/25	03/12/25	03/13/25
Ryan White	Sr Community Health Nurse	Clinical	Merylyn Yegon	03/12/25	03/13/25	03/13/25	03/13/25	03/13/25
Primary Care Center	Laboratory Assistant	Non Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Sexual Health Clinic	Administrative Assistant	Non Clinical	Cassandra Major	N/A	N/A	03/31/25	N/A	03/18/25
Family Planning	Community Health Nurse II	Clinical	Merylyn Yegon	03/14/25	03/14/25	03/14/25	03/13/25	03/13/25
Primary Care Center	Medical Assistant	Clinical	Bernadette Meily	04/08/25	04/08/25	04/08/25	04/08/25	04/08/25
Ryan White	Medical Assistant	Clinical	Merylyn Yegon	03/25/25	03/12/25	04/01/25	03/26/25	03/26/25
Family Planning	Community Health Nurse I	Clinical	Bernadette Meily	04/01/25	03/13/25	03/13/25	03/13/25	03/13/25
Sexual Health Clinic	CHN Supervisor	Clinical	Merylyn Yegon	03/17/25	03/13/25	03/13/25	03/13/25	03/13/25
Primary Care Center	Medical Assistant	Clinical	Merylyn Yegon	03/12/25	03/12/25	03/12/25	03/12/25	03/12/25
Sexual Health Clinic	Physician's Assistant II	Clinical	Karin Dinda	03/12/25	03/18/25	04/07/25	04/07/25	04/08/25
Primary Care Center	Info & Referral Specialist	Non Clinical	Cassandra Major	N/A	N/A	03/17/25	N/A	03/13/25
Primary Care Center	Medical Assistant	Clinical	Merylyn Yegon	03/17/25	03/18/25	03/18/25	03/18/25	03/18/25
Family Planning	Community Health Worker I	Non Clinical	Bernadette Meily	N/A	03/19/25	03/19/25	03/19/25	03/19/25
Sexual Health Clinic	Sr Community Health Nurse	Clinical	Karin Dinda	03/12/25	03/18/25	01/16/25	03/18/25	03/18/25
Sexual Health Clinic	Community Health Nurse I	Clinical	Karin Dinda	03/25/25	03/27/25	03/25/25	03/25/25	03/27/25
Family Planning	Medical Assistant	Clinical or Non	Bernadette Meily	03/18/25	03/18/25	03/18/25	03/19/25	04/01/25
Primary Care Center	Adv Prctcl Registered Nurse I	Clinical	Bernadette Meily	03/20/25	03/20/25	04/01/25	03/31/25	04/01/25
Primary Care Center	Community Health Worker I	Non Clinical	Cassandra Major	N/A	N/A	03/13/25	N/A	03/17/25
	Medical Assistant	Clinical	Merylyn Yegon	03/18/25	03/18/25	03/18/25	03/18/25	03/18/25
Ryan White	Adv Prctcl Registered Nurse II	Clinical	Merylyn Yegon	03/19/25	03/19/25	04/07/25	04/07/25	04/08/25
Behavioral Health	Behavioral Health Manager	Non Clinical	Randy Smith	03/11/25	03/13/25	01/02/25	03/11/25	03/13/25
Refugee Program	Medical Assistant	Clinical	Bernadette Meily	03/18/25	03/18/25	04/08/25	04/01/25	04/03/25

2025 Annual Risk Management Report (ARMR)

Stats from Training Tracker:

Clinical or Non-Clinical	Manager	Obstetrics: Safe, Equitable Care for All Women and Primary Ca of the Postpartum Patient (CLINICAL STAFF) (ECRI)	Safe Injection Training (CLINICAL STAFF)	HIPAA Privacy Rule (ALL)	Bloodborne Pathogens Awareness (Annual) NEOGOV (CLINICAL STAFF)	The Basics of Hand Hygiene for Healthcare Settings https://www.train.org/main/course/1084875/details (CLINICAL STAFF)
# of rows		111	111	111	111	111
# of blank cells		0	0	0	0	0
# of N/A		43	42	1	36	8
# of trainings compliant		68	69	110	75	103
# of late trainings		0	0	0	0	0
# of expired trainings		0	0	0	0	0
% of non compliant & blank		0.00%	0.00%	0.00%	0.00%	0.00%
% of compliant		100.00%	100.00%	100.00%	100.00%	100.00%

Risk Manager Annual Training:

2025 Annual Risk Management Report (ARMR)

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Virtual, evidence-based, patient-safety focused, reputable, readily available training. New medical director. Regular monitoring is occurring.	Available virtual trainings.	Other training resources can be researched for supplemental relevant training courses that enhance existing training.	Training from virtual organizations depends on those organizations to maintain relevance, accessibility, and compliance with medical standards, and relies on them to continue to provide new training. Some current training is not allowed to be taken more than once.

Follow-up Actions

Training plan updated and approved by the Board in 2025. Training tracker is updated in real time when a team member sends their certificate to the medical director and results are reviewed at quarterly leadership meetings for progress.

Conclusion

During 2025, SNCHC staff were 100% compliant with FTCA training expectations by the end of Q2. This is a significantly improved outcome compared to 2024. Training was still monitored quarterly to ensure new hires were also compliant. Training selected by the leadership team and Risk Manager were focused on risks to patients' safety in a primary care setting.

Proposed Future Activities

Searching for additional training that can be provided to staff in 2026, because some of the available trainings in ECRI are not accessible once the training has been taken. New training courses are needed to remain compliant. SNCHC reached out to BPHC inquiring about what other trainings may be recommended for obstetric training because their Obstetric training series are no longer available since everyone has already taken those trainings. Their guidance in response was: "In response to your inquiry, Health centers may choose from various training sources, such as HRSA trainings, ECRI trainings, in-house trainings, or other public or private training resources.

Health centers have the flexibility to choose the delivery method and format of the OB training. Options may include in-person, virtual, or hybrid training. Additionally, health centers may utilize different training formats, such as lectures, videos, presentations, labs or online modules.

Content covered during OB training: Health centers can determine the specific content covered during each OB training session based on health center data, assessments, and other available information. For example, a health center may require applicable staff members to complete OB training focused on topics such as maternal mortality, post-partum depression, shoulder dystocia, pregnancy and diabetes, or pregnancy and obesity.

By considering these factors, health centers can tailor their OB training programs to effectively address the needs of their staff and meet the requirements for FTCA deemed status." Guidance will be followed as SNCHC moves forward and continues to provide required training for FTCA compliance.

2025 Annual Risk Management Report (ARMR)

Risk and Patient Safety Activities

Introduction

The objective of the health center's patient safety and risk management program is to continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Patient Satisfaction Scores	Patient satisfaction scores are expected to be at or above 90%. Surveys are offered to every patient that visits SNCHC. Surveys are available by a link provided to the patient or by QR code. Scores are monitored and reported to leadership monthly, and mitigation tactics are deployed immediately for areas of opportunity identified. Patient feedback is critical to SNCHC's ability to adapt, innovate, correct, and improve.
# of Patient Grievances	A patient grievance is a formal written or verbal complaint filed by a patient that cannot be resolved promptly by staff present. All grievances are investigated and reviewed for opportunities for improvement. The health center monitors the number of grievances opened per quarter. No minimum nor maximum threshold is set.
% of Patient Grievances Resolved	The health center responds to and resolves grievances in a timely manner. To resolve the grievance, the health center calls and speaks with the patient to gain greater understanding and when appropriate, provides the patient with written notice that the health center is in reception of their grievance. The Health Center representative contacting the complainant takes steps to correct the causes of the grievance and communicates the root causes to the Health Center's leadership team for dissemination to the team and improvement of process. An incident report is completed for the grievances, and the Health Center documents steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. The health center's goal is to resolve a grievance within 10 business days from initial receipt of notification, and to have fixes in place to improve process and personnel to prevent further grievances within 60 days.

Pharmacy packaging and error rate	The rate of pharmacy packaging errors that caused a medication dispensing error, or an incident where a patient took incorrect medication because of a packaging error. Ideally this number is 0% but the target is set to be less than 5%.
# of HIPAA breaches	The health center encourages all staff to report suspected HIPAA breaches. This year the health center continues to work on process improvements as identified that are associated with these types of breaches. The health center monitors the number of HIPAA breaches involving visit handouts per quarter. No minimum nor maximum is set, although the ideal number of HIPAA breaches is 0.

2025 Annual Risk Management Report (ARMR)

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Referral completion rate	The percentage of referrals ordered by an SNCHC provider that were processed and sent to the referred provider, changing the status of the referral in the EMR from "open" to "completed". Many factors can impede this process, especially referred provider accessibility and insurance authorizations, so the target is set to be 90%.
% of Pts Screened for Pregnancy Intention	The percentage of health center patients that have a visit with a health center provider, and are eligible to be screened for pregnancy intention, and are screened using a PISQ tool. This is UDS required data.
# of Pts Screened for Pregnancy Intention	The number of female patients who are of reproductive age that are seen at the health center, who *were* screened for their intent to become pregnant in the next 12 months using a standardized pregnancy intention screening questionnaire (PISQ) tool. This is a new UDS measurement required by HRSA.
# of Pts eligible for Pregnancy Intention Screening	The number of female patients who are of reproductive age that are seen at the health center, who are eligible to be screened for their intent to become pregnant in the next 12 months. This is a new UDS measurement required by HRSA.
# of Pregnant Pts seen	The number of female health center patients that are seen, who report to be pregnant during the health center appointment.
# of Pregnant pts referred out for prenatal care	The number of female health center patients that are seen, who report to be pregnant during the health center appointment and are referred to an OB who has an active MOU/MOA with SNCHC not receive prenatal care. This is UDS required data. Target depends on how many pregnant health center patients are seen and if a referral to a contracted OB provider is documented in the EMR.
# of Pregnant Pts w Documented Trimester of Pregnancy When First Seen	The number of female health center patients that are seen, who report to be pregnant during the health center appointment. The age of the pregnant patient, and the trimester in which the patient's pregnancy is at the time of the visit. This is UDS required data. Target depends on how many pregnant health center patients are seen and if the trimester in which they are pregnant has been documented in the EMR.
% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	% of female pregnant patients who had a visit with a Health Center provider whose age and trimester of pregnancy was documented. Target is to have this data documented in the EMR 75% of the time.
# of Birthweights by Race Captured	The number of babies born, who have documented race and birthweight data documented in the EMR, who were born to health center patients that reported being pregnant at the time the pregnant patient had a health center visit. Target depends on how many babies are born to health center patients during the calendar year.
Credentialing and privileging file review rate	The health center maintains files for all clinical staff that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with the health center's operating procedures as required by the Health Center Program Compliance Manual. The health center monitors for timely renewal of privileges. The goal is to complete all renewals within the month they are due 100% of the time. The credentialing and privileging information of each provider must be reviewed and updated as necessary at least every two years.

2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Risk and Patient Safety Activities							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%
QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	**0%**
Compliance/RM	HIPAA breaches	Total # of breaches	0	0	0	0	**0**
QI/MD/Ops Mgrs/RM	Referral completion rate	>90%	96%	97%	98%	97%	**97%**
QI/MD/Ops Mgrs/RM	% of Pts Screened for Pregnancy Intention	>75%	**37.6%**	**45.2%**	**54.8%**	**56.0%**	**47.8%**
QI/MD/Ops Mgrs/RM	# of Pts Screened for Pregnancy Intention	Total Screened	527	588	643	646	2404
QI/MD/Ops Mgrs/RM	# of Pts eligible for Pregnancy Intention Screening	Total Eligible	1403	1301	1174	1154	5032
QI/MD/Ops Mgrs/RM	# of Pregnant Pts Seen	Total #	22	25	19	0	66
QI/MD/Ops Mgrs/RM	# of Prenatal pts referred out for prenatal care	# of Prenatal Pts Referred	4	2	6	5	17

2025 Annual Risk Management Report (ARMR)

QI/MD/Ops Mgrs/RM	# of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	# of Prenatal Pts Referred	0	0	0	0	0
QI/MD/Ops Mgrs/RM	% of Prenatal Pts w Documented Trimester of Pregnancy When First Seen	>75%	0%	0%	0%	0%	0%
QI/MD/Ops Mgrs/RM	# of Birthweights by Race Captured	Total #	0	0	1	0	1
RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*

2025 Annual Risk Management Report (ARMR)

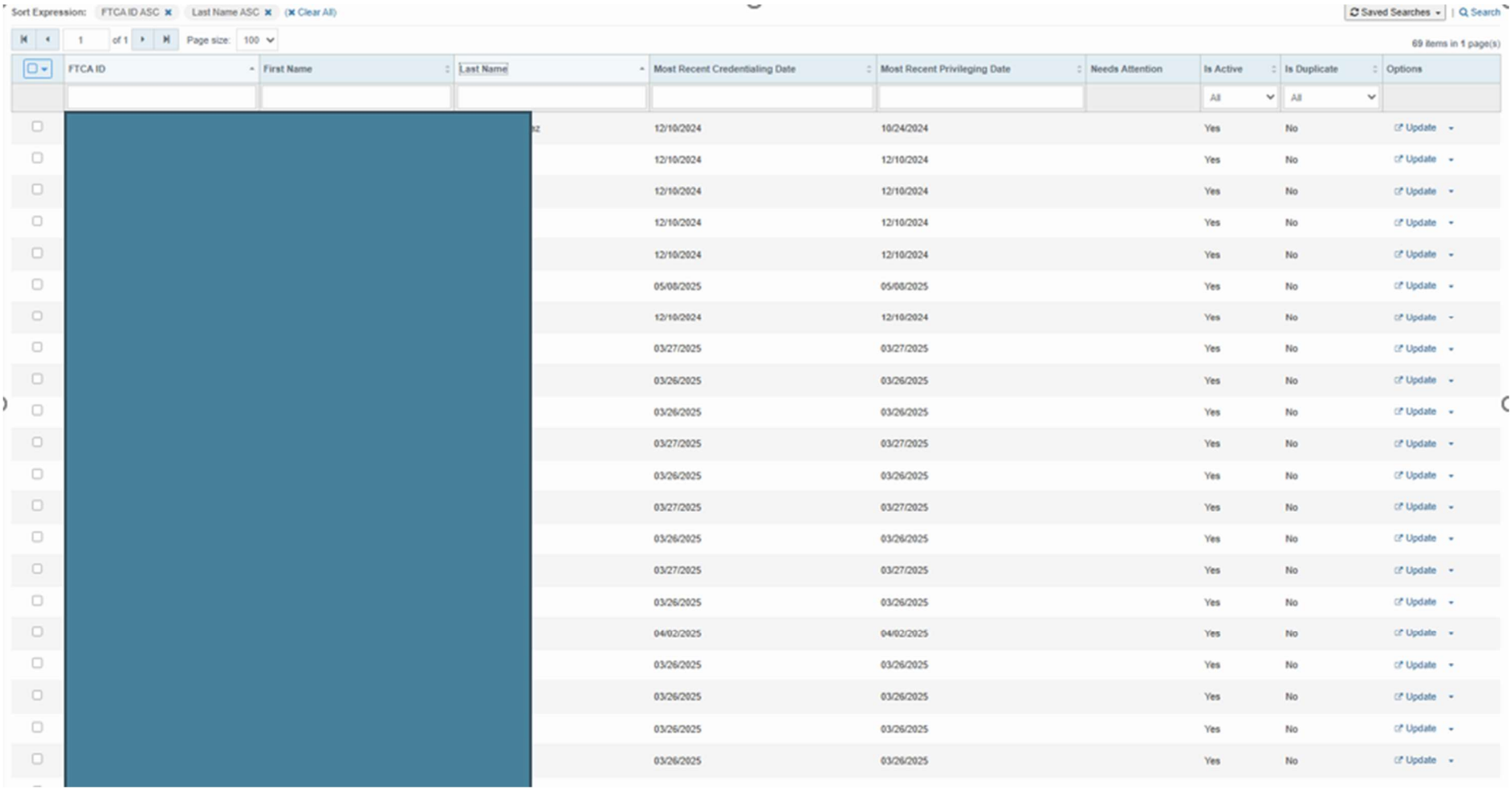
2025 Patient Satisfaction Scores:

Month	Overall Monthly Score	Overall Quarterly Score	Overall Annual Score
Jan	98.77%	98.42%	98.19%
Feb	98.39%		
Mar	98.11%		
Apr	98.16%	97.81%	
May	97.84%		
Jun	97.43%		
Jul	98.50%	98.79%	
Aug	99.09%		
Sep	98.79%		
Oct	97.09%	97.72%	
Nov	97.38%		
Dec	98.68%		

Question	Ave Annual Score
Was the recent visit as soon as you needed?	94.69%
Providers explain well?	98.86%
Providers listen well?	98.57%
Providers respect you?	98.83%
Providers spend enough time with you?	97.99%
Staff helpful?	98.43%
Staff courteous and respectful?	99.26%
Easy to schedule appt?	98.20%
Cleanliness and appearance of facility?	99.45%
Overall Care	97.58%

2025 Annual Risk Management Report (ARMR)

Credentialing and Privileging Tracker from the EHB – 100% updated with valid credentialing and privileging renewal dates within a two-year period as of 12/31/2025.



2025 Annual Risk Management Report (ARMR)

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Grievance responses to patients were immediately upon incidents being reported No HIPAA breaches were reported for 2025.	Data for pregnant patients, the trimesters of pregnancy when first presenting are being captured, but not in a structured reportable manner. Manual work is currently providing these data. This is an ongoing challenge because the workflows are not supported well with technology yet. PDSA cycles for these measures are still underway and being tested. Outreach follow up efforts are currently being made to attempt to capture race and birthweight data of the babies born to health center patients who reported being pregnant. Outreach has not been very successful. Patients report being uneasy about reporting this data.	Outreach process for connecting with patients who were pregnant was underway, and manual tracking has been tested and is working. Monthly meetings with Informatics to review system limitations are under way. Meetings are continuing, slowly and steadily improving process and results.	AZARA mapping has been a big challenge for these criteria. Work is being done to test where clinical staff are entering data, and whether it is being mapped into a report or not, and if the data is not displaying correctly, more trial-and-error attempts are being made. In the meantime, data is being tracked manually, so SNCHC has correct data to report for UDS

Follow-up Actions

Monthly UDS Data Integrity meetings occur on the second Thursday of each month to review manually tracked and automated data in AZARA, eCW, and other reports, so the quality of data being reported is as accurate as possible. The Quality Work Group (QWG) consists of the medical director, the FQHC administrative manager, IT, Informatics, operations managers, clinical office supervisor, and is led by the quality management coordinator. The QWG plans, implements, executes, monitors, and reports on strategies to improve all areas in which there are deficiencies. If desired results are not achieved according to monthly reports, efforts made are then analyzed and adjusted. Revisions to the mitigation tactics are then deployed to see if results can be improved. The QWG will continue to meet monthly in 2026 to further progress made in 2025.

2025 Annual Risk Management Report (ARMR)

Conclusions

Progress has been made in several areas of this report, and many tactics to reduce risk have been expanded beyond the responsibilities of the risk manager. The medical director is overseeing much of the clinical impact and training needed to improve outcomes. The operations managers are improving workflows and efficiencies in day-to-day operations to maximize patient access to services while balanced with a safe and conscientious environment. More work is needed to filter out the cause of the data issues for pregnant health center patients, and to overcome patient hesitancy to provide data.

Proposed Future Activities

Reaching out to other health centers that have similar populations as SNHD and to national and state resource organizations may allow SNCHC to find best practices or policies that may help improve the overall automation of data being captured and reported more accurately.

2025 Annual Risk Management Report (ARMR)

Claims Management

Introduction

The Health Center Program Compliance Manual requires health centers to have a claims management process for addressing any potential or actual health or health-related claims. The health center identifies risk areas most likely to lead to claims based on previous claims activity, claims prevention guidance from professional organizations, and published research.

Claims Management Focus Area/ Measure	Summary Description of Assessment/Methodology/Indicators
# Claims submitted to HHS	The health center immediately sends court complaints or notices of intent to the HHS Office of the General Counsel. The health center monitors the number of claims sent per quarter. No minimum nor maximum threshold is set.
# Claims settled or closed	The health center monitors the number of claims settled or closed per quarter. No minimum nor maximum threshold is set.
# Claims open	The health center monitors the number of claims opened per quarter. No minimum nor maximum threshold is set.
# Lawsuits filed	The health center monitors the number of lawsuits resulting from a claim are filed per quarter. No minimum nor maximum threshold is set.
# Lawsuits settled	The health center monitors the number of lawsuits settled per quarter. No minimum nor maximum threshold is set.
# Lawsuits litigated	The health center monitors the number of lawsuits litigated per quarter. No minimum nor maximum threshold is set.

2025 Annual Risk Management Report (ARMR)

Data Summary

See the dashboard below for completed risk management activities and status of the health center's performance relative to established risk management goals.

Claims Management							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
CM	# Claims submitted to HHS	NA	0	0	0	0	0
CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
N/A	N/A	N/A	N/A

Follow-up Actions

No claims activities occurred in 2025. Continued prevention strategies are being deployed to keep this statistic as low as possible.

Conclusion

No claims activities occurred in 2025. Continued prevention strategies are being deployed to keep this statistic as low as possible.

Proposed Future Activities

Continue current claims management processes that include monitoring for emerging concerns, preserving claims-related documentation, and promptly communicating with HHS Office of the General Counsel, General Law Division regarding any actual or potential claim or complaint.

Report Submission

The 2025 Annual Risk Management Report to the Southern Nevada Community Health Center Governing Board is respectfully submitted to demonstrate the ongoing risk management program to reduce the risk of adverse outcomes and provide safe, efficient, and effective care and services.

Risk Management Dashboard

Components of this report are provided according to standards that must be met to meet FTCA deeming requirements related to risk management. Such guidance can be found using the following resources: Chapter 21: Federal Tort Claims Act (FTCA) Deeming Requirements, Chapter 10: Quality Improvement/Assurance, and Health Center Program Compliance Manual.

Risk Assessments							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
RM	# Completed annual high-risk assessments	≥ 2/yr	1	1	-	1	**3**
RM	# Completed quarterly assessments	Min 1/qtr.	**1**	**1**	**1**	**1**	**4**
RM	% Open action plans	≤75%	**0%**	**0%**	**20%**	**33%**	**22%**

Adverse Events/ Incident Reports							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
Center staff	# Sentinel Incidents	Total /qtr.	0	0	0	0	**0**
Center staff	# High Risk Incidents	Total /qtr.	1	5	2	4	**12**
Center staff	# Medium Risk Incidents	Total /qtr.	15	18	23	10	**66**
Center staff	# Low Risk Incidents/Near Misses	Total /qtr.	2	2	0	5	**9**
Quarterly Incident Totals		Prior Year - 70	18	25	25	19	87
RM	# Root Cause Analyses (RCA) completed per qtr.	Total /qtr.	5	1	8	6	20
Quarterly Peer Review Audit							
Medical Director	# Peer review audits completed (5/provider/qtr.)	80%	**95%**	**95%**	**98%**	**96%**	**96.00%**

Training and Education

2025 Annual Risk Management Report (ARMR)

Person responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total Completion Rate
FQHC Leadership	Planning, review and completion of annual OB training.	≥90% by year-end	97.30%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High Risk Area (Safe Injection) training.	≥90% by year-end	89.33%	100.00%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High Risk Area (HIPAA Privacy) training.	≥90% by year-end	84.26%	99.07%	99.02%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual Infection Prevention (BBP) training.	≥90% by year-end	81.51%	99.13%	100.00%	100.00%	**100.00%**
FQHC Leadership	Planning, review and completion of annual High Risk Area (Basics of Hand Hygiene for Healthcare Settings) training.	≥90% by year-end	86.90%	100.00%	100.00%	100.00%	**100.00%**
Average Completion Rate of Mandatory FTCA Trainings							
RM	Annual Training Completion Rate Goal of 90%	≥90% by year-end	88.10%	99.64%	99.76%	100.00%	**100.00%**
Risk Manager Annual Training Requirement							
RM	Required Risk Manager Annual Training	2 Required FTCA trainings by End of Year	100.00%	100.00%	100.00%	100.00%	**100.00%**

Risk and Patient Safety Activities							
Person responsible	**Measure/ Key Performance Indicator**	**Threshold**	**Q1**	**Q2**	**Q3**	**Q4**	**Annual Total**
QI/MD/Ops Mgrs/RM	Patient satisfaction score	90%	98.4%	97.8%	98.3%	97%	98%

2025 Annual Risk Management Report (ARMR)

QI/MD/Ops Mgrs/RM	# Grievances	Avg/qtr	2	1	0	0	3
QI/MD/Ops Mgrs/RM	# Grievances resolved	100%	100%	100%	100%	100	100%
QI/Phar Mgr	Pharmacy packaging and labeling error rate	<5%	0%	0%	0%	0%	**0%**
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RM/HR	Credentialing and privileging file review rate	100%	97%	100%	100%	100%	100%*

2025 Annual Risk Management Report (ARMR)

Claims Management							
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CM	# Claims settled or closed	NA	0	0	0	0	0
CM	# Claims open	NA	0	0	0	0	0
CM	# Lawsuits filed	NA	0	0	0	0	0
CM	# Lawsuits settled	NA	0	0	0	0	0
CM	# Lawsuits litigated	NA	0	0	0	0	0