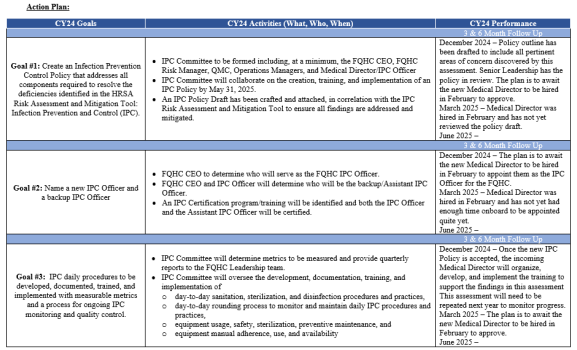
# 2024 Annual Risk Management Report

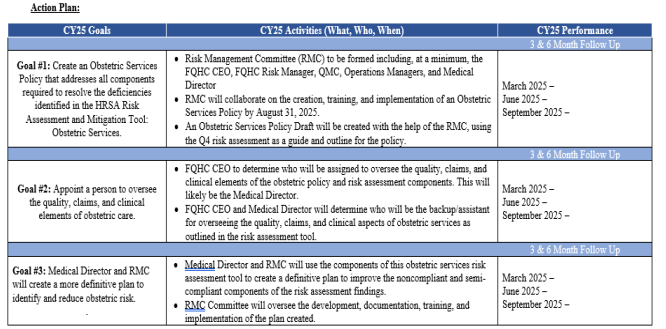
# 2024 Quarterly Risk Assessments

- Q1 Risk Assessment - Ambulatory Medical and Dental Risk Management Assessment (ECRI Tool)
- Q2 Risk Assessment – HIPAA Risk Assessment (SNHD Compliance Tool)
- Q3 Risk Assessment – Infection Prevention and Control (ECRI Tool)
- Q4 Risk Assessment – Obstetric Services Risk Assessment (ECRI Tool)



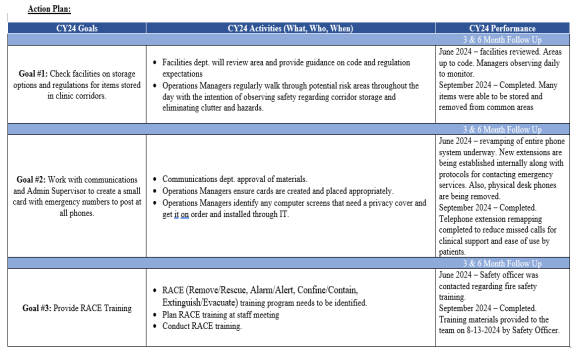
**Action Plan:**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Create an Infection Prevention Control Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC). | • IPC Committee to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director/IPC Officer<br>• IPC Committee will collaborate on the creation, training, and implementation of an IPC Policy by May 31, 2025.<br>• An IPC Policy Draft has been crafted and attached, in correlation with the IPC Risk Assessment and Mitigation Tool to ensure all findings are addressed and mitigated. | December 2024 – Policy outline has been drafted to include all pertinent areas of concern discovered by this assessment. Senior Leadership has the policy in review. The plan is to await the new Medical Director to be hired in February to approve.<br>March 2025 – Medical Director was hired in February and has not yet reviewed the policy draft.<br>June 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Name a new IPC Officer and a backup IPC Officer | • FQHC CEO to determine who will serve as the FQHC IPC Officer.<br>• FQHC CEO and IPC Officer will determine who will be the backup/Assistant IPC Officer.<br>• An IPC Certification program/training will be identified and both the IPC Officer and the Assistant IPC Officer will be certified. | December 2024 – The plan is to await the new Medical Director to be hired in February to appoint them as the IPC Officer for the FQHC.<br>March 2025 – Medical Director was hired in February and has not yet had enough time onboard to be appointed quite yet.<br>June 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control. | • IPC Committee will determine metrics to be measured and provide quarterly reports to the FQHC Leadership team.<br>• IPC Committee will oversee the development, documentation, training, and implementation of<br>○ day-to-day sanitation, sterilization, and disinfection procedures and practices,<br>○ day-to-day rounding process to monitor and maintain daily IPC procedures and practices,<br>○ equipment usage, safety, sterilization, preventive maintenance, and<br>○ equipment manual adherence, use, and availability | December 2024 – Once the new IPC Policy is accepted, the incoming Medical Director will organize, develop, and implement the training to support the findings in this assessment This assessment will need to be repeated next year to monitor progress.<br>March 2025 – The plan is to await the new Medical Director to be hired in February to approve.<br>June 2025 – |



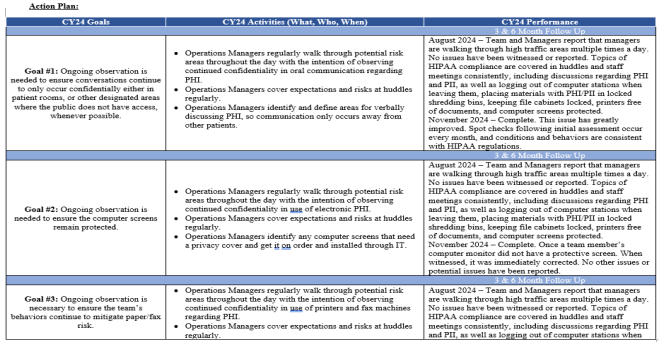
**Action Plan:**

| CY25 Goals | CY25 Activities (What, Who, When) | CY25 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Create an Obstetric Services Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Obstetric Services. | • Risk Management Committee (RMC) to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director<br>• RMC will collaborate on the creation, training, and implementation of an Obstetric Services Policy by August 31, 2025.<br>• An Obstetric Services Policy Draft will be created with the help of the RMC, using the Q4 risk assessment as a guide and outline for the policy. | March 2025 –<br>June 2025 –<br>September 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Appoint a person to oversee the quality, claims, and clinical elements of obstetric care. | • FQHC CEO to determine who will be assigned to oversee the quality, claims, and clinical elements of the obstetric policy and risk assessment components. This will likely be the Medical Director.<br>• FQHC CEO and Medical Director will determine who will be the backup/assistant for overseeing the quality, claims, and clinical aspects of obstetric services as outlined in the risk assessment tool. | March 2025 –<br>June 2025 –<br>September 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Medical Director and RMC will create a more definitive plan to identify and reduce obstetric risk. | • Medical Director and RMC will use the components of this obstetric services risk assessment tool to create a definitive plan to improve the noncompliant and semi-compliant components of the risk assessment findings.<br>• RMC Committee will oversee the development, documentation, training, and implementation of the plan created. | March 2025 –<br>June 2025 –<br>September 2025 – |



**Action Plan:**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Check facilities on storage options and regulations for items stored in clinic corridors. | • Facilities dept. will review area and provide guidance on code and regulation expectations<br>• Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing safety regarding corridor storage and eliminating clutter and hazards. | June 2024 – facilities reviewed. Areas up to code. Managers observing daily to monitor.<br>September 2024 – Completed. Many items were able to be stored and removed from common areas |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Work with communications and Admin Supervisor to create a small card with emergency numbers to post at all phones. | • Communications dept. approval of materials.<br>• Operations Managers ensure cards are created and placed appropriately.<br>• Operations Managers identify any computer screens that need a privacy cover and get it on order and installed through IT. | June 2024 – revampung of entire phone system underway. New extensions are being established internally along with protocols for contacting emergency services. Also, physical desk phones are being removed.<br>September 2024 – Completed. Telephone extension remapping completed to reduce missed calls for clinical support and ease of use by patients. |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Provide RACE Training | • RACE (Remove/Rescue, Alarm/Alert, Confine/Contain, Extinguish/Evacuate) training program needs to be identified.<br>• Plan RACE training at staff meeting<br>• Conduct RACE training. | June 2024 – Safety officer was contacted regarding fire safety training.<br>September 2024 – Completed. Training materials provided to the team on 8-13-2024 by Safety Officer. |



**Action Plan:**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Ongoing observation is needed to ensure conversations continue to only occur confidentially either in patient rooms, or other designated areas where the public does not have access, whenever possible. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in oral communication regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify and define areas for verbally discussing PHI, so communication only occurs away from other patients. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected.<br>November 2024 – Complete. This issue has greatly improved. Spot checks following initial assessment occur every month, and conditions and behaviors are consistent with HIPAA regulations. |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Ongoing observation is needed to ensure the computer screens remain protected. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of electronic PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify any computer screens that need a privacy cover and get it on order and installed through IT. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected.<br>November 2024 – Complete. Once a team member's computer monitor did not have a protective screen. When witnessed, it was immediately corrected. No other issues or potential issues have been reported. |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Ongoing observation is necessary to ensure the team's behaviors continue to mitigate paper/fax risk. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of printers and fax machines regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when |

| Risk Assessments | | | | | | | |
|---|---|---|---|---|---|---|---|
| Person responsible | Measure/ Key Performance Indicator | Threshold | Q1 | Q2 | Q3 | Q4 | Annual Total |
| RM | # Completed annual high-risk assessments | ≥ 2/yr | | | Infection Prevention and Control | Obstetrics | 2 |
| RM | # Completed quarterly assessments | Min 1/qtr | 1 | 1 | 1 | 1 | 4 |
| RM | % Open action plans | ≤75% | 0% | 0% | 75% | 100% | 44% |

# 2024 Incident Reporting and Peer Reviews

| Adverse Events/ Incident Reports | | | | | | | |
|---|---|---|---|---|---|---|---|
| Person responsible | Measure/ Key Performance | Threshold | Q1 | Q2 | Q3 | Q4 | Annual Total |
| Center staff | # Sentinel Incidents | Total /qtr. | 1 | 0 | 0 | 0 | 1 |
| Center staff | # High Risk Incidents | Total /qtr. | 2 | 4 | 6 | 3 | 15 |
| Center staff | # Medium Risk Incidents | Total /qtr. | 12 | 8 | 18 | 14 | 52 |
| Center staff | # Low Risk Incidents/Near Misses | Total /qtr. | 2 | 0 | 0 | 0 | 2 |
| Quarterly Incident Totals | | Prior Year - 66 | 17 | 12 | 24 | 17 | 70 |
| RM | # Root Cause Analyses (RCA) completed per qtr. | Total /qtr. | 5 | 5 | 8 | 3 | 21 |
| Medical Director | # Peer review audits completed (5/provider/qtr) | 80% | 0% | 0% | 94% | 96% | 47.50% |

| Q3 Peer Review Scores | | | |
|---|---|---|---|
| Location | Program | Provider Name | Total Avg Score |
| Fremont | BH | [redacted] | 100% |
| Fremont | FP | | 100% |
| Decatur | SHC | | 97% |
| Fremont | FH | | 97% |
| Decatur | FP | | 96% |
| Fremont | FH | | 96% |
| Decatur | FH | | 96% |
| Decatur | RW | | 96% |
| Decatur | SHC | | 95% |
| Decatur | FH | | 95% |
| Decatur | RW | | 94% |
| Decatur | BH | | 91% |
| Decatur | BH | | 90% |
| Fremont | BH | | 90% |
| Decatur | RW | | 89% |
| Fremont | BH/SHC | | 88% |
| Decatur | SHC | | 87% |
| Decatur | FH | | 87% |

| Q4 Peer Review Scores | | | |
|---|---|---|---|
| Location | Program | Provider Name | Total Avg Score |
| Decatur | SHC | [redacted] | 100% |
| Decatur | BH | | 100% |
| Decatur | FH | | 99% |
| Fremont | BH | | 98% |
| Fremont | FH | | 97% |
| Decatur | SHC | | 97% |
| Fremont | BH | | 97% |
| Fremont | FH | | 97% |
| Decatur | FP | | 96% |
| Decatur | FH | | 96% |
| Decatur | BH | | 96% |
| Fremont | BH/SHC | | 95% |
| Decatur | RW | | 94% |
| Decatur | RW | | 94% |
| Decatur | FH | | 94% |
| Fremont | FP | | 94% |
| Decatur | RW | | 93% |
| Decatur | SHC | | 90% |

# 2024 FTCA Required Annual Training Compliance

| 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 | 9.23% | 9.23% | 9.23% | 9.23% | 9.23% |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Safe Injection) training. | ≥90% by year-end | 0.00% | 19.05% | 19.05% | 19.05% | 19.05% |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Hand Hygiene) training. | ≥90% by year-end | 0.00% | 80.77% | 80.77% | 80.77% | 80.77% |
| FQHC Leadership | Planning , review and completion of annual HIPAA training. | ≥90% by year-end | 0.00% | 89.47% | 89.47% | 89.47% | 89.47% |
| FQHC Leadership | Planning , review and completion of annual Infection Prevention (BBP) training. | ≥90% by year-end | 0.00% | 58.09% | 58.09% | 58.09% | 58.09% |
| FQHC Leadership | Annual Training Completion Rate Goal of 90% | ≥90% by year-end | 1.85% | 51.32% | 51.32% | 51.32% | 51.32% |

- Annual Risk Training was not conducted in 2024.
- Discovery of this gap happened during a HRSA FTCA clinic training.
- Risk Training Plan  was amended to include a regular cadence for the FQHC Leadership to review the training trackers and prevent this gap.
- Required FTCA training was immediately provided in March of 2025 when the gap was discovered to ensure the team had the training.

# 2024 Risk and Patient Safety Activities

| Risk and Patient Safety Activities | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual Total** |
| QI/MD/Ops Mgrs./RM | # Grievances | Avg/qtr | 2 | 0 | 0 | 2 | 4 |
| QI/MD/Ops Mgrs./RM | # Grievances resolved | 100% | 2 | 0 | 0 | 2 | 100% |
| QI/MD/Ops Mgrs./RM | Patient Satisfaction Scores | ≥90% | 97.8% | 97.7% | 97.8% | 98.3% | 97.9% |
| Compliance/RM | HIPAA breaches - wrong visit handouts | Total # of breaches | 0 | 0 | 0 | 0 | 0 |
| QI/MD/Ops Mgrs./RM | # of Pts eligible for Pregnancy Intention Screening | Total # | 1325 | 897 | 1419 | 586 | 4227 |
| QI/MD/Ops Mgrs./RM | # of Pts Screened for Pregnancy Intention | Total # | 550 | 363 | 589 | 421 | 1923 |
| QI/MD/Ops Mgrs./RM | % of Pts Screened for Pregnancy Intention | >75% | 41.51% | 40.47% | 41.51% | 71.84% | 45.49% |
| QI/MD/Ops Mgrs./RM | # of Pregnant Pts Seen | Total # | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Pregnant pts referred out for prenatal care | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Prenatal Pts w Documented Trimester of Pregnancy When First | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | % of Prenatal Pts w Documented Trimester of Pregnancy When First | >75% | 100% | 100% | 100% | 100% | 100% |
| QI/MD/Ops Mgrs./RM | # of Birthweights by Race Captured | Total # | 0 | 0 | 0 | 0 | 0 |
| RM/HR | Credentialing and privileging file review rate | 100% | 100% | 100% | 100% | 100% | 100%* |

- Improvement needed with processes revolving around capturing pregnant patient data, and their referrals for prenatal care
- Improvement needed to capture data of babies when they are born for UDS.

# 2024 Credentialing and Privileging Tracker

| Loc | Employee | Job Title | Hire Date | Bilingual Pay | FTE | JD | Gov. ID | Lic. Type | State License | CPR/BLS | Edu Verif. | NPDB | OIG | Priv Appr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 337 | Alfaro, Stacey | Medical Assistant | 5/28/2024 | N/A | 1.00 | 5/7/2024 | 8/14/2028 | N/A | N/A | N/A | 5/15/2024 | 6/12/2024 | 5/15/2024 | 5/7/2024 |
| 309 | Andrade, Daysi | Medical Assistant | 1/3/2022 | Spanish | 1.00 | 3/26/2025 | 11/26/2024 | N/A | N/A | N/A | 12/5/2021 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Basa, Doris | Medical Assistant | 11/12/2024 | N/A | 1.00 | 10/24/2024 | 9/8/2027 | N/A | N/A | N/A | 11/4/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 350 | Calito, Maria | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 8/27/2030 | N/A | N/A | N/A | 8/21/2024 | 1/30/2025 | 8/21/2024 | 8/6/2024 |
| 338 | Diaz Villa, Banessa | Medical Assistant | 1/28/2019 | Spanish | 1.00 | 3/26/2025 | 8/12/2031 | MA | 6/18/2025 | N/A | 1/31/2019 | 6/30/2024 | 5/29/2024 | 3/26/2025 |
| 309 | Diaz, Michelle | Medical Assistant | 3/26/2018 | Spanish | 1.00 | 3/27/2025 | 6/27/2031 | LA | 5/27/2025 | N/A | 3/15/2018 | 7/25/2024 | 5/29/2024 | 3/27/2025 |
| 337 | Dominguez, Liliana | Medical Assistant | 7/10/2017 | Spanish | 1.00 | 3/27/2025 | 8/17/2030 | N/A | N/A | N/A | 6/8/2017 | 7/25/2024 | 5/29/2024 | 3/27/2025 |
| 337 | Fajardo, Claudette | Medical Assistant | 5/13/2019 | Spanish | 1.00 | 3/26/2025 | 4/15/2029 | N/A | N/A | N/A | 5/6/2019 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Iniguez Barrera, Ricardo | Medical Assistant | 11/12/2024 | Spanish | 1.00 | 10/22/2024 | 9/13/2027 | N/A | N/A | N/A | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/22/2024 |
| 350 | Martinez, Monica | Medical Assistant | 4/10/2023 | Spanish | 1.00 | 4/3/2025 | 2/29/2031 | N/A | N/A | N/A | 4/4/2023 | 7/13/2024 | 5/29/2024 | 4/3/2025 |
| 338 | Miller, Tanisha | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 9/10/2031 | N/A | N/A | N/A | 8/15/2024 | 1/30/2025 | 8/15/2024 | 8/6/2024 |
| 337 | Nyberg, Chantel | Medical Assistant | 8/21/2023 | N/A | 1.00 | 6/29/2023 | 7/7/2025 | N/A | N/A | N/A | 8/15/2023 | 3/19/2024 | 5/29/2024 | 6/29/2023 |
| 337 | Orea-Valencia, Mirelly | Medical Assistant | 6/4/2018 | Spanish | 1.00 | 3/26/2025 | 8/23/2028 | N/A | N/A | N/A | 5/29/2018 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Ortega Martinez, Itzel | Medical Assistant | 11/30/2020 | Spanish | 1.00 | 3/26/2025 | 7/23/2026 | N/A | N/A | N/A | 11/5/2020 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 353 | Ortega Martinez, Leydi | Medical Assistant | 11/12/2024 | Spanish | 1.00 | 10/24/2024 | 10/15/2026 | N/A | N/A | 11/1/2026 | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 350 | Perez, Jose | Medical Assistant | 7/15/2019 | Spanish | 1.00 | 10/24/2023 | 12/10/2026 | N/A | N/A | N/A | 6/18/2019 | 1/30/2025 | 5/29/2024 | 10/24/2023 |
| 338 | Quiroz, Patricia | Medical Assistant | 5/13/2019 | Spanish | 1.00 | 3/26/2025 | 11/21/2029 | N/A | N/A | N/A | 5/10/2019 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Royval, Yvonne | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 8/29/2026 | N/A | N/A | N/A | 8/13/2024 | 1/30/2025 | 8/13/2024 | 8/6/2024 |
| 350 | Santillan, Myra | Medical Assistant | 10/29/2018 | Spanish | 1.00 | 10/24/2023 | 4/29/2026 | N/A | N/A | N/A | 10/15/2018 | 7/25/2024 | 5/29/2024 | 10/24/2023 |
| 309 | Valdes Ayala, Beatriz | Medical Assistant | 11/5/2018 | Spanish | 1.00 | 3/26/2025 | 3/19/2027 | N/A | N/A | N/A | 10/23/2018 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 309 | Villalobos, Yolanda | Medical Assistant | 9/3/2019 | Spanish | 1.00 | 10/23/2023 | 1/11/2030 | N/A | N/A | N/A | 8/16/2019 | 7/25/2024 | 5/29/2024 | 10/23/2023 |
| 337 | Basa, Doris | Medical Assistant | 11/12/2024 | N/A | 1.00 | 10/24/2024 | 9/8/2027 | N/A | N/A | N/A | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 337 | Guerrero, Jocelyne | Medical Assistant | 3/17/2025 | Spanish | 1.00 | 2/19/2025 | 1/2/2026 | N/A | N/A | N/A | 2/18/2025 | 3/17/2025 | 2/18/2025 | 2/19/2025 |

- Credentialing and Privileging Data in 2024 remained current.

# 2024 Claims Management

| 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 |

- No lawsuits or other claims were received or processed in 2024.


Questions?

# 2025 Risk Management GOALS

# 2025 Risk Management Goal Dashboard

| Risk Assessments | | |
|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** |
| RM | # Completed annual high-risk assessments | ≥ 2/yr |
| RM | # Completed quarterly assessments | Min 1/qtr |
| RM | % Open action plans | ≤75% |

| Training and Education | | |
|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** |
| FQHC Leadership | Planning , review and completion of annual OB training. | ≥90% by year-end |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Safe Injection) training. | ≥90% by year-end |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Hand Hygiene) training. | ≥90% by year-end |
| FQHC Leadership | Planning , review and completion of annual HIPAA training. | ≥90% by year-end |
| FQHC Leadership | Planning , review and completion of annual Infection Prevention (BBP) training. | ≥90% by year-end |
| RM | Annual Training Completion Rate Goal of 90% | ≥90% by year-end |

| Adverse Events/ Incident Reports | | |
|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** |
| Center staff | # Sentinel Incidents | Total /qtr. |
| Center staff | # High Risk Incidents | Total /qtr. |
| Center staff | # Medium Risk Incidents | Total /qtr. |
| Center staff | # Low Risk Incidents/Near Misses | Total /qtr. |
| Quarterly Incident Totals | | Prior Year - 65 |
| RM | # Root Cause Analyses (RCA) completed per qtr. | Total /qtr. |
| Medical Director | # Peer review audits completed (5/provider/qtr) | 80% |

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


Questions?

# 2024 Annual Risk Management Report (ARMR)

# Annual Risk Management Report (ARMR) to Governing Board for 2024

**Title:** 2024 Annual Risk Management Report to the Southern Nevada Community Health Center Governing Board

**Date:** January 1, 2024, to December 31, 2024

**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:** April 15, 2025

**Date board approved the ARMR:**

**Date board approved the meeting minutes containing board approval of the ARMR:**

## 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 2024 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, incident an 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 to maintain or improve 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.

# 2024 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.<br>• At minimum, two quarterly risk assessments conducted during the year must correlate with identified areas of high-risk within the health center.<br>• All four risk assessments have a emphasized focus on patient safety<br>• 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.<br>• Areas of high concern are elevated to the medical director, senior leadership, QWG, and/or the board as appropriate.<br>• Additional risk assessments may be conducted as new risks are identified.<br>• In 2024, the names of the four quarterly risk assessment tools used were: the ECRI Ambulatory Medical and Dental Risk Management Assessment Tool, the SNHD HIPAA Risk Assessment Tool assessment, the HRSA ECRI Risk Assessment and Mitigation Tool: Infection Prevention and Control, and the HRSA ECRI Risk Assessment and Mitigation Tool: Obstetric Services.<br>• 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. |
| 50% 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.<br><br>The health center's goal is to have no more than 75% of action plans open past their initial deadline. 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. |

# 2024 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 Assessments | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual Total** |
| RM | # Completed annual high-risk assessments | ≥ 2/yr | | | Infection Prevention and Control | Obstetrics | **2** |
| RM | # Completed quarterly assessments | Min 1/qtr | **1** | **1** | **1** | **1** | **4** |
| RM | % Open action plans | ≤75% | **0%** | **0%** | **75%** | **100%** | **44%** |

## SWOT Analysis

| Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|
| • Managers have been working with the new Quality Management Coordinator to improve workflows, service integration, training, and PDSA cycles for quality metrics.<br>• New tracking metrics were created to follow statistics of incident reporting and mitigation.<br>• The new Medical Director has been hired and will help steer the clinical practice in ways that support risk mitigation and improve outcomes. | • Not having a Medical Director for most of the year also took a toll on operational and policy improvement.<br>• Policies specific to risk management need development, updating, and improvement. | • Possibility of collaborating with other Health Centers and NVPCA on Risk Management Practices, Tools, and Training.<br>• Better utilization of ECRI membership and training available. | • New Executive orders and policy changes that impact operational workflows.<br>• Las Vegas is a very litigious community. |

# 2024 Annual Risk Management Report (ARMR)

## *Follow-up Actions*

**ECRI Ambulatory Medical and Dental Risk Management Assessment Tool**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Check with facilities on storage options and regulations for items stored in clinic corridors. | • Facilities dept. will review area and provide guidance on code and regulation expectations<br>• Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing safety regarding corridor storage and eliminating clutter and hazards. | June 2024 – facilities reviewed. Areas up to code. Managers observing daily to monitor.<br>September 2024 – Completed. Many items were able to be stored and removed from common areas |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Work with communications and Admin Supervisor to create a small card with emergency numbers to post at all phones. | • Communications dept. approval of materials.<br>• Operations Managers ensure cards are created and placed appropriately.<br>• Operations Managers identify any computer screens that need a privacy cover and get it on order and installed through IT. | June 2024 – revamping of entire phone system underway. New extensions are being established internally along with protocols for contacting emergency services. Also, physical desk phones are being removed.<br>September 2024 – Completed. Telephone extension remapping completed to reduce missed calls for clinical support and ease of use by patients. |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Provide RACE Training | • RACE (Remove/Rescue, Alarm/Alert, Confine/Contain, Extinguish/Evacuate) training program needs to be identified.<br>• Plan RACE training at staff meeting<br>• Conduct RACE training. | June 2024 – Safety officer was contacted regarding fire safety training.<br>September 2024 – Completed. Training materials provided to the team on 8-13-2024 by Safety Officer. |

**SNHD HIPAA Risk Assessment Tool assessment.**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Ongoing observation is needed to ensure conversations continue to only occur confidentially either in patient rooms, or other designated areas where the public does not have access, whenever possible. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in oral communication regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify and define areas for verbally discussing PHI, so communication only occurs away from other patients. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected. November 2024 – Complete but ongoing. This issue has greatly improved. Spot checks following initial assessment occur every month, and conditions and behaviors are consistent with HIPAA regulations. |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Ongoing observation is needed to ensure the computer screens remain protected. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of electronic PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify any computer screens that need a privacy cover and get it on order and installed through IT. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected. November 2024 – Complete but ongoing. Once a team member's computer monitor did not have a protective screen. When witnessed, it was immediately corrected. No other issues or potential issues have been reported. |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Ongoing observation is necessary to ensure the team's behaviors continue to mitigate paper/fax risk. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of printers and fax machines regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected. |

| | | |
|---|---|---|
| | | November 2024 – Complete but ongoing. This issue is an ongoing area of risk, however, the workflows and protocols in place are effectively and consistently mitigating any potential risk. |

**HRSA ECRI Risk Assessment and Mitigation Tool: Infection Prevention and Control**

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Create an Infection Prevention Control Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Infection Prevention and Control (IPC). | • IPC Committee to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director/IPC Officer<br>• IPC Committee will collaborate on the creation, training, and implementation of an IPC Policy by May 31, 2025.<br>• An IPC Policy Draft has been crafted and attached, in correlation with the IPC Risk Assessment and Mitigation Tool to ensure all findings are addressed and mitigated. | December 2024 – Policy outline has been drafted to include all pertinent areas of concern discovered by this assessment. Senior Leadership has the policy in review. The plan is to await the new Medical Director to be hired in February to approve.<br>March 2025 – Medical Director was hired in February and has not yet reviewed the policy draft.<br>June 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Name a new IPC Officer and a backup IPC Officer | • FQHC CEO to determine who will serve as the FQHC IPC Officer.<br>• FQHC CEO and IPC Officer will determine who will be the backup/Assistant IPC Officer.<br>• An IPC Certification program/training will be identified and both the IPC Officer and the Assistant IPC Officer will be certified. | December 2024 – The plan is to await the new Medical Director to be hired in February to appoint them as the IPC Officer for the FQHC.<br>March 2025 – Medical Director was hired in February and has not yet had enough time onboard to be appointed quite yet.<br>June 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** IPC daily procedures to be developed, documented, trained, and implemented with measurable metrics and a process for ongoing IPC monitoring and quality control. | • IPC Committee will determine metrics to be measured and provide quarterly reports to the FQHC Leadership team.<br>• IPC Committee will oversee the development, documentation, training, and implementation of<br>  ○ day-to-day sanitation, sterilization, and disinfection procedures and practices,<br>  ○ day-to-day rounding process to monitor and maintain daily IPC procedures and practices,<br>  ○ equipment usage, safety, sterilization, preventive maintenance, and | December 2024 – Once the new IPC Policy is accepted, the incoming Medical Director will organize, develop, and implement the training to support the findings in this assessment This assessment will need to be repeated next year to monitor progress.<br>March 2025 – The plan is to await the new Medical Director to be hired in February to approve.<br>June 2025 – |

| | | |
|---|---|---|
| | ○ equipment manual adherence, use, and availability | |

**HRSA ECRI Risk Assessment and Mitigation Tool: Obstetric Services.**

| CY25 Goals | CY25 Activities (What, Who, When) | CY25 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Create an Obstetric Services Policy that addresses all components required to resolve the deficiencies identified in the HRSA Risk Assessment and Mitigation Tool: Obstetric Services. | • Risk Management Committee (RMC) to be formed including, at a minimum, the FQHC CEO, FQHC Risk Manager, QMC, Operations Managers, and Medical Director<br>• RMC will collaborate on the creation, training, and implementation of an Obstetric Services Policy by August 31, 2025.<br>• An Obstetric Services Policy Draft will be created with the help of the RMC, using the Q4 risk assessment as a guide and outline for the policy. | March 2025 –<br>June 2025 –<br>September 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #2:** Appoint a person to oversee the quality, claims, and clinical elements of obstetric care. | • FQHC CEO to determine who will be assigned to oversee the quality, claims, and clinical elements of the obstetric policy and risk assessment components. This will likely be the Medical Director.<br>• FQHC CEO and Medical Director will determine who will be the backup/assistant for overseeing the quality, claims, and clinical aspects of obstetric services as outlined in the risk assessment tool. | March 2025 –<br>June 2025 –<br>September 2025 – |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Medical Director and RMC will create a more definitive plan to identify and reduce obstetric risk.<br>. | • Medical Director and RMC will use the components of this obstetric services risk assessment tool to create a definitive plan to improve the noncompliant and semi-compliant components of the risk assessment findings.<br>• RMC Committee will oversee the development, documentation, training, and implementation of the plan created. | March 2025 –<br>June 2025 –<br>September 2025 – |

## Conclusion

The number of quarterly risk assessments met the threshold. Two of the quarterly risk assessments completed were also high-risk assessments. The percentage of open action plans was 44% for the year, meaning that there is only 44% of the action plan items that are not complete for the year with a threshold of 75% or less. The Q4 action plan items were not completed, as the risk assessment was conducted in December with little time to respond to the findings.

## 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 2025 are recommended to have a focus of patient safety in nature with support from the clinical operations managers and the medical director for evaluation and recommended action items.

Two of the areas assessed for risk included high-risk categories: infection prevention and control, and obstetric care.

- Medical Director to be 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.

# 2024 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.

### 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** |
| Center staff | # Sentinel Incidents | Total /qtr. | 1 | 0 | 0 | 0 | **1** |
| Center staff | # High Risk Incidents | Total /qtr. | 2 | 4 | 6 | 3 | **15** |
| Center staff | # Medium Risk Incidents | Total /qtr. | 12 | 8 | 18 | 14 | **52** |
| Center staff | # Low Risk Incidents/Near Misses | Total /qtr. | 2 | 0 | 0 | 0 | **2** |
| Quarterly Incident Totals | | Prior Year - 65 | 17 | 12 | 24 | 17 | 70 |
| RM | # Root Cause Analyses (RCA) completed per qtr. | Total /qtr. | 5 | 5 | 8 | 3 | 21 |
| Medical Director | # Peer review audits completed (5/provider/qtr) | 80% | **0%** | **0%** | **94%** | **96%** | **47.50%** |

- 62% 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.
    - 22 medical-event incidents that were reported involved staff responding to non-emergent medical issues.
    - 22 medical-event incidents that were reported involved staff responding to emergent medical issues that required a call to for EMS support.
- 23% of incidents reported involved a patient's behavior.
    - 8 incidents reported were for patients behaving aggressively, but did not escalate to a level requiring the need for SNHD security support.
    - 4 incidents reported were for patients behaving aggressively, and did escalate to a level requiring the need for SNHD security support, including the only sentinel event of the year.
    - 4 incidents reported were for patient complaints regarding a poor experience.

- 6% of incidents reported involved lab errors, which originated from incorrect lab orders.
- 9% of incidents reported were for a variety of reasons across six other categories.
- 68.75% 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 60.6% 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 30.3% of the medical event incidents in the FQHC division.
    - Of the medical-event incidents reported in the FQHC division, 9.1% of the incidents were in common areas of the FQHC division.
- 31.25% of all medical event incidents were reported as occurring in non-FQHC divisions.
- Root cause analysis was performed on 30% of incidents.
    - Most RCAs were performed on incidents that were sentinel or high risk or medium risk incidents that could have escalated into becoming high risk.
- 47.5% annual peer review score reflects:
    - No peer review data recorded in Q1 or Q2, despite some peer review activity occurring.
        - No medical director to oversee.
        - FQHC CEO, Quality Management Coordinator, and Operation Managers developed the policy and procedure to correct the unstructured peer review process.
    - The "Ongoing Professional Practice Evaluation – Peer Review" policy and procedure was presented, approved, and implemented during Q2.
    - The 19 SNCHC providers had an average quality score of 94% in Q3.
    - The 19 SNCHC providers had an average quality score of 96% in Q4.

## *SWOT Analysis*

| Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|
| • Two consecutive years in a row, there has been an increase in the number of incidents being reported versus prior year.<br>• An incident reporting and root cause analysis process has been developed and implemented.<br>• A Peer Review process has been developed, approved, and implemented.<br>• A new medical director has been onboarded to oversee this process. | • Several iterations of incident reports and confusion about when to use each one<br>• Some departments in the FQHC division are not reporting incidents commensurate with other departments who are sometimes less busy.<br>• More training for staff on the incident reporting process and expectations is needed.<br>• Peer review audit policy has lacked oversight with no medical director to review and take action. | • Technological systems or reporting templates are being explored to provide regular comprehensive reports to leadership, the QRMC Board Committee and the Governing Board.<br>• 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. |

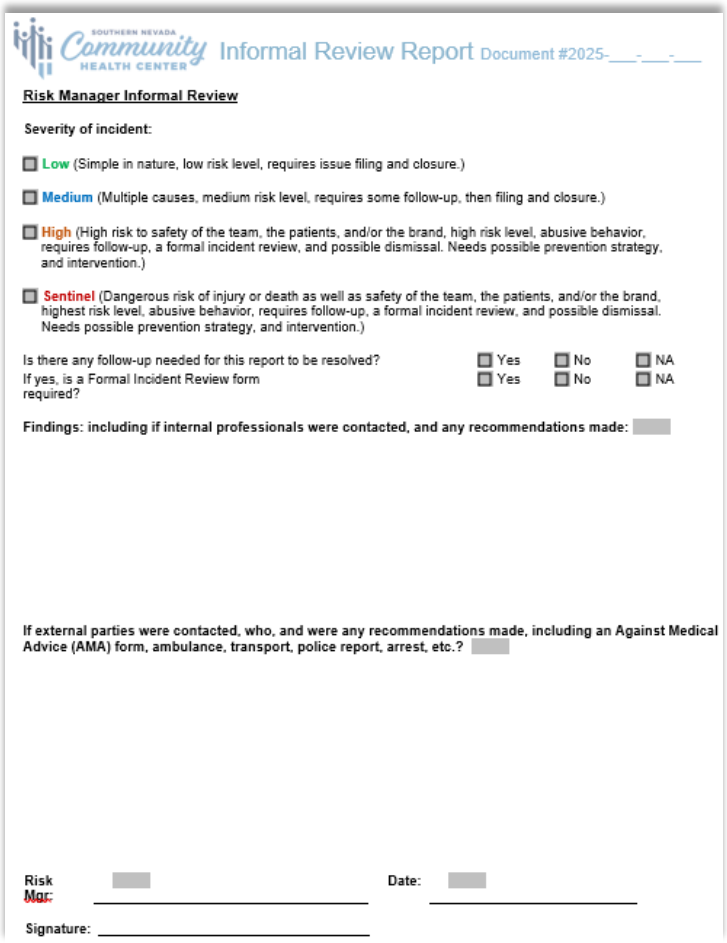
# 2024 Annual Risk Management Report (ARMR)

## *Follow-up Actions*

- New incident review and tracking process was developed and led by the Risk Manager. Approval was needed and acquired from FQHC leadership. 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.

| | Type of Incident Choose One and Type an "x" in Correct Category | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Severity - Type an "x" | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Customer/Patient | | | | | | | | | | Employee | | | | | | | | Misc | | | | | | | | | | | | | | | | | | | | | | |
| Assigned Incident # | Complaint | Injury | Security | Safety | Vehicle | Ethical | HIPAA | Critical Lab Result | Drug Seeking Behavior | Aggressive | Illness | Injury | Security | Vehicle | Ethical | HIPAA | Lab issue | Aggressive | District vehicle damage | District property loss | Personal property loss | Fire Hazard | Dr. Redbird | Dr. Bluebird | Other Medical | Lab Order Error | Cybersecurity | Medication Error | Legal Threat | Aggressive Vendor | Alarm | Criminal | Other | Low | Medium | High | Sentinel |
| 2024-12-19-001 | | | | | | | | | | | | | | | | | | | | | | | | | x | | | | | | | | | x | | |
| 2024-12-26-001 | | | | | | | | | | | | | | | | | | | | | | | | | x | | | | | | | | | x | | |
| 70 | 4 | 0 | 4 | 0 | 0 | 0 | 0 | 1 | 0 | 8 | 1 | 0 | 0 | 0 | 0 | 0 | 4 | 0 | 0 | 0 | 0 | 0 | 1 | 22 | 22 | 0 | 0 | 1 | 1 | 0 | 0 | 1 | 0 | 2 | 52 | 15 | 1 |
| | 6% | 0% | 6% | 0% | 0% | 0% | 0% | 1% | 0% | 11% | 1% | 0% | 0% | 0% | 0% | 0% | 6% | 0% | 0% | 0% | 0% | 0% | 1% | 31% | 31% | 0% | 0% | 1% | 1% | 0% | 0% | 1% | 0% | 3% | 74% | 21% | 1% |
| | % of Total | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | % of Total | | | |

**Incident Review Forms**



Southern Nevada Community Health Center 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

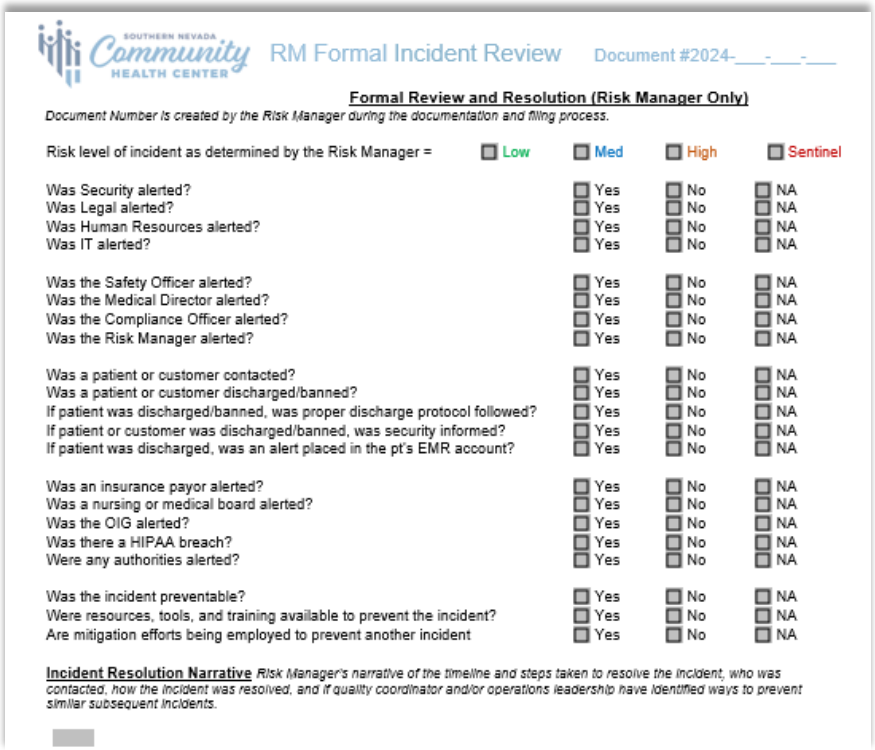
**Findings: including if internal professionals were contacted, and any recommendations made:**

**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:** _____

# 2024 Annual Risk Management Report (ARMR)



SOUTHERN NEVADA Community HEALTH CENTER

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.*

**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:** ___/___/___

# 2024 Annual Risk Management Report (ARMR)

| | | | # of Incident Reports Completed |
|---|---|---|---|
| **Goal #4:** Improve the reporting of actual or potential incidents. | 15 total incidents reported in CY22<br>65 total incidents reported in CY23 | • FQHC Administrative Manager to create, implement, and monitor the new Incident Reporting process.<br>• FQHC Administrative Manager to create, implement, and monitor the new incident reporting forms.<br>• FQHC Administrative Manager to keep statistics of types of incidents being reported, severity of incidents, and the number of incidents.<br>• FQHC Administrative Manager to review the findings with the Quarterly Quality, Risk Management, and Credentialing Committee. | 2024 2023<br>Q1: 15 16<br>Q2: 12 9<br>Q3: 25 18<br>Q4: 18 22<br>**CY24 Result: 70 incident reports submitted through Q4 of 2024** compared to 65 incident reports submitted through Q4 of CY23, **a 7.7% increase in the number of incidents reported YOY.**<br><br>Dr. Bluebird Medical Event Breakdown:<br>• 13/24 (54.17%) were in FQHC<br>  ○ 9/13 (69.23%) reported from Fremont FQHC<br>  ○ 4/13 (30.77%) reported from Decatur FQHC<br>• 11/24 (45.83%) reported from non FQHC<br><br>Non-Bluebird Medical Event Breakdown:<br>• 20/24 reported in the FQHC (81.82%)<br>  ○ 11/20 (55%) reported from Fremont FQHC<br>  ○ 9/20 (45%) reported from Decatur FQHC<br>  ▪ 8/9 (88.89%) Decatur FQHC reported from SHC<br>• 4/24 (18.18%) reported from non-FQHC |

- Efforts to improve the response time of the emergency response team to medical events is a focus led by the medical director, chief nursing director, and the operations managers.

| | | |
|---|---|---|
| **Goal #2:** Reduce delayed response time for Dr. Bluebird events by 50% year over year. | CY22 – 25% of bluebird incidents w/response time at or longer than 2 min<br>CY23 – 4% bluebird incidents w/response time at or longer than 2 min | • Clinical staff and Chief Nurse are working to revise the current policy for medical events, that will include training for staff responding to medical events. This is currently in process and should be ready for presentation in Q3.<br>• Inspect and verify the crash carts are labeled and stocked with supplies.<br>• Mapping of AEDs and provide biannual training for use of AEDs when BLS licenses are renewed. |

- 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.

# 2024 Annual Risk Management Report (ARMR)

| Q3 Peer Review Scores | | | |
|---|---|---|---|
| Location | Program | Provider Name | Total Avg Score |
| Fremont | BH | [redacted] | 100% |
| Fremont | FP | | 100% |
| Decatur | SHC | | 97% |
| Fremont | FH | | 97% |
| Decatur | FP | | 96% |
| Fremont | FH | | 96% |
| Decatur | FH | | 96% |
| Decatur | RW | | 96% |
| Decatur | SHC | | 95% |
| Decatur | FH | | 95% |
| Decatur | RW | | 94% |
| Decatur | BH | | 91% |
| Decatur | BH | | 90% |
| Fremont | BH | | 90% |
| Decatur | RW | | 89% |
| Fremont | BH/SHC | | 88% |
| Decatur | SHC | | 87% |
| Decatur | FH | | 87% |

| Q4 Peer Review Scores | | | |
|---|---|---|---|
| Location | Program | Provider Name | Total Avg Score |
| Decatur | SHC | [redacted] | 100% |
| Decatur | BH | | 100% |
| Decatur | FH | | 99% |
| Fremont | BH | | 98% |
| Fremont | FH | | 97% |
| Decatur | SHC | | 97% |
| Fremont | BH | | 97% |
| Fremont | FH | | 97% |
| Decatur | FP | | 96% |
| Decatur | FH | | 96% |
| Decatur | BH | | 96% |
| Fremont | BH/SHC | | 95% |
| Decatur | RW | | 94% |
| Decatur | RW | | 94% |
| Decatur | FH | | 94% |
| Fremont | FP | | 94% |
| Decatur | RW | | 93% |
| Decatur | SHC | | 90% |

- New medical director accepted an offer and will start during Q1 of 2025. Peer review process implemented and has some clinical oversight through other clinicians, but needs more focused oversight and feedback from the incoming medical director. Incident reporting improved among Fremont and SHC at Decatur, but other departments in Decatur are not reporting nearly as many incidents or near misses as other departments. This needs investigating. Also, medication errors are a focus of improvement, led by the medical director, pharmacy manager, and the operations managers.

| | | |
|---|---|---|
| **Goal #1:** Reduce medication errors to 0. | CY22 – 7 errors<br>CY23 – 3 errors | • Implementation of the vaccine administration training and competency checklist, which is reviewed one by one during employee evaluation, and updated by the supervisor annually.<br>• Annual vaccine administration training every September organized and facilitated by the Vaccine Coordinator. |

## *Conclusion*

Adverse event reporting has been stable during the year. There was an increase in the number of near misses and unsafe conditions reported following the culture-of-safety and responding-to-events trainings. New process for completing peer review audits has increased the rate of completion.

## *Proposed Future Activities*

In addition to continuing culture-of-safety and responding to incident training for new staff, a refresher course will be created and added to the annual training course bundle in the learning management system. A “good catch” program will also be initiated to encourage and reward staff for identifying near-miss events and unsafe conditions through event reporting.

# 2024 Annual Risk Management Report (ARMR)

## Risk Management Training

### *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 annual mandatory evidence-based virtual training to all health center clinical staff on the following risk related topics: Safe clinical Obstetric practice training from ECRI, Safe injection, HIPAA, and Bloodborne Pathogen training from NEOGOV, Hand Hygiene training from train.org. |
| Planning, review and completion of annual OB training. | 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. |
| Planning, review and completion of annual High-Risk Area (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. |
| Planning, review and completion of annual High Risk Area (Hand Hygiene) 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. |
| Planning, review and completion of annual HIPAA 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. |

# 2024 Annual Risk Management Report (ARMR)

| | |
|---|---|
| Planning, review and completion of annual Infection Prevention (BBP) 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. |

## *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 | 9.23% | 9.23% | 9.23% | 9.23% | 9.23% |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Safe Injection) training. | ≥90% by year-end | 0.00% | 19.05% | 19.05% | 19.05% | 19.05% |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Hand Hygiene) training. | ≥90% by year-end | 0.00% | 80.77% | 80.77% | 80.77% | 80.77% |
| FQHC Leadership | Planning , review and completion of annual HIPAA training. | ≥90% by year-end | 0.00% | 89.47% | 89.47% | 89.47% | 89.47% |
| FQHC Leadership | Planning , review and completion of annual Infection Prevention (BBP) training. | ≥90% by year-end | 0.00% | 58.09% | 58.09% | 58.09% | 58.09% |
| FQHC Leadership | Annual Training Completion Rate Goal of 90% | ≥90% by year-end | 1.85% | 51.32% | 51.32% | 51.32% | 51.32% |

## Training Tracker

| Department | Job Title | Clinical / Non-Clinical | Manager | Obstetrics: Safe, Equitable Care for All Women and Pregnant Care of the Postpartum Patient (CLINICAL STAFF) | Safe Injection Training (CLINICAL STAFF) | Cultural Competence (NEOGOV) (ALL) | HIPAA Privacy Rule (ALL) | Medicare and Medicaid Fraud and Abuse Prevention (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) | Mandatory Child Abuse Reporting Laws (CLINICAL STAFF) | Overdose Response with Naloxone (CLINICAL STAFF) (Annual?) | Counseling adolescent clients to encourage Family participation | Counseling adolescent clients to resist sexual coercion | Cultural competency in family planning care |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Family Planning | Medical Assistant | Clinical | Merylyn Yegon | 10/11/23 | 8/8/23 | 05/16/24 | 05/20/24 | 05/21/24 | 05/16/24 | 06/06/24 | 08/01/23 | 09/17/24 | 5/15/24 | 2/22/24 | 05/16/24 |
| Family Planning | Adv Prctcl Registered Nurse I | Clinical | Merylyn Yegon | 12/21/23 | 12/21/2023 | 12/13/23 | 12/28/23 | 05/16/24 | 05/16/24 | 05/16/24 | 12/28/23 | 09/24/24 | 2/12/24 | 2/26/24 | 2/26/24 |
| Ryan White | Community Health Worker I | Non-Clinical | Merylyn Yegon | N/A | N/A | 08/26/24 | 05/20/24 | 05/20/24 | 05/20/24 | N/A | N/A | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Community Health Nurse I | Clinical | Bernadette Meily | 09/08/23 | 8/9/23 | 05/16/24 | 05/21/24 | 05/29/24 | 05/29/24 | 05/29/24 | 05/17/24 | 09/17/24 | 2/14/24 | 2/14/24 | 05/29/24 |
| Primary Care Center | Patient Services Representative | Non-Clinical | Cassondra Major | N/A | N/A | 08/27/24 | 05/20/24 | 05/20/24 | 05/29/24 | N/A | 05/20/24 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Community Health Nurse II | Clinical | Bernadette Meily | | | | | 07/10/24 | | | 07/10/24 | 09/17/24 | | | |
| Family Planning | Mobile Unit Operator | Non-Clinical | Bernadette Meily | N/A | N/A | 05/17/24 | 05/22/24 | 05/17/24 | 05/17/24 | N/A | 05/17/24 | 09/24/24 | N/A | N/A | N/A |
| Sexual Health Clinic | Administrative Assistant II | Non-Clinical | Cassondra Major | N/A | N/A | 08/22/24 | 01/31/24 | 02/12/24 | 07/15/24 | N/A | 07/15/24 | 09/24/24 | N/A | N/A | N/A |
| Sexual Health Clinic | Medical Assistant | Clinical | Bernadette Meily | | | 09/03/24 | 09/03/24 | 09/03/24 | 09/03/24 | | 09/03/24 | 09/17/24 | | | |
| Family Planning | Administrative Assistant II | Non-Clinical | Bernadette Meily | N/A | N/A | 05/14/24 | 05/14/24 | 05/16/24 | 05/14/24 | 05/16/24 | 05/14/24 | 09/17/24 | 3/6/24 | 3/6/24 | 05/21/24 |
| Ryan White | Community Health Nurse I/Certifie | Clinical | Merylyn Yegon | 09/11/23 | N/A | 08/28/24 | 05/20/24 | 05/20/24 | 05/20/24 | 05/21/24 | 05/20/24 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Administrative Assistant II | Non-Clinical | Cassondra Major | N/A | N/A | 08/27/24 | 05/16/24 | 05/16/24 | N/A | N/A | N/A | 09/24/24 | N/A | N/A | N/A |
| Ryan White | Care Coordinator | Non-Clinical | Merylyn Yegon | N/A | N/A | 08/27/24 | 05/21/24 | 05/21/24 | N/A | N/A | 05/21/24 | 09/24/24 | N/A | N/A | N/A |
| Ryan White | Community Health Worker I | Non-Clinical | Cassondra Major | N/A | N/A | 09/16/24 | 05/21/24 | 05/30/24 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Ryan White | Community Health Nurse II | Clinical | Merylyn Yegon | 09/18/23 | 8/8/23 | 05/16/24 | 05/16/24 | 05/16/24 | 05/16/24 | 05/16/24 | 05/16/24 | 03/15/23 | N/A | N/A | N/A |
| Ryan White | Community Health Nurse II | Clinical | Merylyn Yegon | 09/19/23 | 8/8/23 | 08/15/24 | 05/15/24 | 05/15/24 | 05/15/24 | 05/16/24 | 05/15/24 | 09/24/24 | N/A | N/A | N/A |
| Ryan White | Sr Community Health Nurse | Clinical | Merylyn Yegon | 09/19/23 | 8/8/23 | 09/17/24 | 05/15/24 | 05/15/24 | 05/15/24 | 05/30/24 | 08/10/23 | 09/24/24 | N/A | N/A | N/A |
| Primary Care Center | Laboratory Assistant | Non-Clinical | Merylyn Yegon | N/A | 8/15/23 | 09/11/24 | 05/16/24 | 07/27/23 | 08/02/23 | 05/30/24 | 08/03/23 | N/A | N/A | N/A | N/A |
| Sexual Health Clinic | Administrative Assistant | Non-Clinical | Cassondra Major | N/A | N/A | 08/22/24 | 07/16/24 | 07/13/23 | 07/05/23 | N/A | 08/01/23 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Community Health Nurse II | Clinical | Merylyn Yegon | 09/11/23 | 5/20/24 | 09/13/24 | 05/16/24 | 05/15/24 | 05/15/24 | 05/16/24 | 05/15/24 | 09/24/24 | 2/15/24 | 2/22/24 | 05/16/24 |
| Primary Care Center | Medical Assistant | Clinical | Bernadette Meily | 09/26/23 | 8/2/23 | 05/21/24 | 05/16/24 | 05/28/24 | 05/16/24 | 05/21/24 | 05/16/24 | 09/17/24 | 3/15/24 | 3/15/24 | 05/28/24 |
| Ryan White | Medical Assistant | Clinical | Merylyn Yegon | 09/25/23 | 8/8/23 | 05/15/24 | 05/15/24 | 05/15/24 | 05/15/24 | 05/17/24 | 05/15/24 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Community Health Nurse I | Clinical | Bernadette Meily | | | 10/14/24 | 10/14/24 | | 10/15/24 | | 10/14/24 | | | | |
| Sexual Health Clinic | CHN Supervisor | Clinical | Merylyn Yegon | 09/07/23 | 07/31/23 | 05/15/24 | 07/24/24 | 07/17/23 | 07/13/23 | 05/16/24 | 07/17/23 | 01/18/22 | N/A | N/A | N/A |
| Primary Care Center | Medical Assistant | Clinical | Merylyn Yegon | 09/14/23 | 8/8/23 | 05/16/24 | 05/20/24 | 05/20/24 | 05/20/24 | 05/16/24 | 08/01/23 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Lead Patient Services Rep | Non-Clinical | Cassondra Major | N/A | N/A | 09/14/24 | 06/04/24 | 05/29/24 | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| Primary Care Center | Info & Referral Specialist | Non-Clinical | Cassondra Major | N/A | N/A | 08/26/24 | 05/20/24 | 05/20/24 | N/A | N/A | 05/20/24 | N/A | N/A | N/A | N/A |
| Primary Care Center | Medical Assistant | Clinical | Merylyn Yegon | 09/11/23 | 8/8/23 | 05/16/24 | 05/16/24 | 05/16/24 | 05/16/24 | 05/16/24 | 08/09/23 | 09/24/24 | N/A | N/A | N/A |
| Family Planning | Community Health Worker I | Non-Clinical | Bernadette Meily | N/A | N/A | 08/20/24 | 05/10/24 | 05/10/24 | 05/10/24 | 05/17/24 | 02/20/24 | 09/17/24 | 2/22/24 | 2/22/24 | 04/04/24 |
| Ryan White | Community Health Nurse II | Clinical | Merylyn Yegon | 09/01/23 | 6/4/24 | 08/23/24 | 05/21/24 | 05/21/24 | 05/21/24 | 05/21/24 | 05/24/24 | 09/24/24 | N/A | N/A | N/A |

# 2024 Annual Risk Management Report (ARMR)

## SWOT Analysis

| Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|
| Virtual, evidence-based, patient-safety focused, reputable, readily available training. New medical director. | Training plan did not specify a regular cadence to review and close training gaps. | 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. |

## Follow-up Actions

- Immediately update the Training plan to include a regular cadence for reviewing required training compliance and completion.
- The CEO, Medical Director and Risk Manager review the training tracker at least once per quarter with the FQHC Leadership Team to act on closing gaps identified by the training tracker.

## Conclusion

During 2024 a gap in compliance was discovered in SNCHC's Risk Management Training process. There was not a defined process for reviewing the progression of training completion. This error was discovered in March of 2025 during a HRSA/ECRI FTCA clinic training. Preparations for the FTCA clinic training required that the Risk Manager conduct an audit of 2024 risk management activities. During this audit, it was discovered that the training systems being used had no mechanism for automatically reminding the team to complete the annual training for FTCA compliance. This was unusual as most required SNHD/SNCHC training does have a mechanism for reminding team members and their supervisors of gaps in annual training completion. This finding uncovered that in 2024, most of the required FTCA training that should have occurred in the calendar 2024 year was non-compliant. This also meant that a manual process for reviewing the training progress needed to be developed and implemented by the leadership team. The training plan was updated in March of 2025 to include a regular cadence for leadership to review and correct gaps in FTCA required training, which is now occurring and the FQHC leadership team is acting on updated results presented. Training compliance ended at 51.32% for the 2024 year with a 90% goal. Immediate steps were taken in March of 2025 to get the team through the required FTCA training, not just to demonstrate the urgency with which the error needed to be corrected, but especially because the team had not received the training for more than a year and needed the information to continue operating in a way that protects patient safety. The urgent training that occurred in March brought the team into compliance for the year 2025 but cannot make up for the noncompliance for calendar year 2024.

### *Proposed Future Activities*

The training plan for next year will include a regular cadence for required FTCA training to be reviewed and name the medical director as the person owning the oversight of training completion each year. Annual training will be conducted earlier in the year, so there is time to close any gaps in training discovered for clinical risk training before the end of the year approaches. This will allow for a more proactive approach to preventing gaps in the team's training.

## 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 |
|---|---|
| # 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.<br><br>The health center monitors the number of grievances opened per quarter. No minimum nor maximum threshold is set.<br><br>For 2024, there were 4 patient grievances reported, two in Q1 and two in Q4. |
| % 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.<br><br>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. |

# 2024 Annual Risk Management Report (ARMR)

| Risk Activity Focus Area/Measure | Summary Description of Assessment/Methodology/Indicators |
|---|---|
| Patient Satisfaction Scores | The health center asks its patients to take a patient satisfaction survey after the visit. The survey is provided through a QR code and a website. If necessary, SNCHC can provide an electronic device on which the patients may take the survey. Data gathered from the patient surveys directs process and program improvements to enhance the patient experience.<br><br>The threshold for patient satisfaction surveys is ≥90% |
| # of HIPAA breaches | The health center encourages all staff to report suspected HIPAA breaches. After visit summary handouts, which contain protected health information, have been unintentionally be given to the wrong patient historically. This year the health center continues to work on process improvements as identified from last year's RCA associated with these types of breaches.<br><br>The health center monitors the number of HIPAA breaches involving visit handouts per quarter. No minimum nor maximum threshold is set. |
| # 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 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 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 Pregnant Pts who had a visit with a Health Center LIP | 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 or other women's health specialist to receive prenatal care. This is UDS required data. |
| # 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. |
| % 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. |

# 2024 Annual Risk Management Report (ARMR)

| | |
|---|---|
| # of Birthweights by Race Captured | The number of babies who have documented race and birthweight data documented in the EMR, who were born to health center patients, who reported being pregnant at the time the pregnant patient had a health center visit. |
| 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.<br>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. |

## *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 | # Grievances | Avg/qtr | 2 | 0 | 0 | 2 | 4 |
| QI/MD/Ops Mgrs./RM | # Grievances resolved | 100% | 2 | 0 | 0 | 2 | 100% |
| QI/MD/Ops Mgrs./RM | Patient Satisfaction Scores | ≥90% | 97.8% | 97.7% | 97.8% | 98.3% | 97.9% |
| Compliance/RM | HIPAA breaches - wrong visit handouts | Total # of breaches | 0 | 0 | 0 | 0 | 0 |
| QI/MD/Ops Mgrs./RM | # of Pts eligible for Pregnancy Intention Screening | Total # | 1325 | 897 | 1419 | 586 | 4227 |
| QI/MD/Ops Mgrs./RM | # of Pts Screened for Pregnancy Intention | Total # | 550 | 363 | 589 | 421 | 1923 |
| QI/MD/Ops Mgrs./RM | % of Pts Screened for Pregnancy Intention | >75% | 41.51% | 40.47% | 41.51% | 71.84% | 45.49% |
| QI/MD/Ops Mgrs./RM | # of Pregnant Pts Seen | Total # | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Pregnant pts referred out for prenatal care | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Prenatal Pts w Documented Trimester of Pregnancy When First | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | % of Prenatal Pts w Documented Trimester of Pregnancy When First | >75% | 100% | 100% | 100% | 100% | 100% |
| QI/MD/Ops Mgrs./RM | # of Birthweights by Race Captured | Total # | 0 | 0 | 0 | 0 | 0 |
| RM/HR | Credentialing and privileging file review rate | 100% | 100% | 100% | 100% | 100% | 100%* |

# 2024 Annual Risk Management Report (ARMR)

## Credentialing and Privileging Tracker – All compliant as of 12/31/2024

| Loc | Employee | Job Title | Hire Date | Bilingual Pay | FTE | JD | Gov. ID | Lic. Type | State License | CPR/BLS | Edu Verif. | NPDB | OIG | Priv Appr |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 337 | Alfaro, Stacey | Medical Assistant | 5/28/2024 | N/A | 1.00 | 5/7/2024 | 8/14/2028 | N/A | N/A | N/A | 5/15/2024 | 6/12/2024 | 5/15/2024 | 5/7/2024 |
| 309 | Andrade, Daysi | Medical Assistant | 1/3/2022 | Spanish | 1.00 | 3/26/2025 | 11/26/2024 | N/A | N/A | N/A | 12/5/2021 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Basa, Doris | Medical Assistant | 11/12/2024 | N/A | 1.00 | 10/24/2024 | 9/8/2027 | N/A | N/A | N/A | 11/4/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 350 | Calito, Maria | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 8/27/2030 | N/A | N/A | N/A | 8/21/2024 | 1/30/2025 | 8/21/2024 | 8/6/2024 |
| 338 | Diaz Villa, Banessa | Medical Assistant | 1/28/2019 | Spanish | 1.00 | 3/26/2025 | 8/12/2031 | MA | 6/18/2025 | N/A | 1/31/2019 | 6/30/2024 | 5/29/2024 | 3/26/2025 |
| 309 | Diaz, Michelle | Medical Assistant | 3/26/2018 | Spanish | 1.00 | 3/27/2025 | 6/27/2031 | LA | 5/27/2025 | N/A | 3/15/2018 | 7/25/2024 | 5/29/2024 | 3/27/2025 |
| 337 | Dominguez, Liliana | Medical Assistant | 7/10/2017 | Spanish | 1.00 | 3/27/2025 | 8/17/2030 | N/A | N/A | N/A | 6/8/2017 | 7/25/2024 | 5/29/2024 | 3/27/2025 |
| 337 | Fajardo, Claudette | Medical Assistant | 5/13/2019 | Spanish | 1.00 | 3/26/2025 | 4/15/2029 | N/A | N/A | N/A | 5/6/2019 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Iniguez Barrera, Ricardo | Medical Assistant | 11/12/2024 | Spanish | 1.00 | 10/22/2024 | 9/13/2027 | N/A | N/A | N/A | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/22/2024 |
| 350 | Martinez, Monica | Medical Assistant | 4/10/2023 | Spanish | 1.00 | 4/3/2025 | 2/29/2031 | N/A | N/A | N/A | 4/4/2023 | 7/13/2024 | 5/29/2024 | 4/3/2025 |
| 338 | Miller, Tanisha | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 9/10/2031 | N/A | N/A | N/A | 8/15/2024 | 1/30/2025 | 8/15/2024 | 8/6/2024 |
| 337 | Nyberg, Chantel | Medical Assistant | 8/21/2023 | N/A | 1.00 | 6/29/2023 | 7/7/2025 | N/A | N/A | N/A | 8/15/2023 | 3/19/2024 | 5/29/2024 | 6/29/2023 |
| 337 | Orea-Valencia, Mirelly | Medical Assistant | 6/4/2018 | Spanish | 1.00 | 3/26/2025 | 8/23/2028 | N/A | N/A | N/A | 5/29/2018 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Ortega Martinez, Itzel | Medical Assistant | 11/30/2020 | Spanish | 1.00 | 3/26/2025 | 7/23/2026 | N/A | N/A | N/A | 11/5/2020 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 353 | Ortega Martinez, Leydi | Medical Assistant | 11/12/2024 | Spanish | 1.00 | 10/24/2024 | 10/15/2026 | N/A | N/A | 11/1/2026 | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 350 | Perez, Jose | Medical Assistant | 7/15/2019 | Spanish | 1.00 | 10/24/2023 | 12/10/2026 | N/A | N/A | N/A | 6/18/2019 | 1/30/2025 | 5/29/2024 | 10/24/2023 |
| 338 | Quiroz, Patricia | Medical Assistant | 5/13/2019 | Spanish | 1.00 | 3/26/2025 | 11/21/2029 | N/A | N/A | N/A | 5/10/2019 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 337 | Royal, Yvonne | Medical Assistant | 9/3/2024 | Spanish | 1.00 | 8/6/2024 | 8/29/2026 | N/A | N/A | N/A | 8/13/2024 | 1/30/2025 | 8/13/2024 | 8/6/2024 |
| 350 | Santillan, Myra | Medical Assistant | 10/29/2018 | Spanish | 1.00 | 10/24/2023 | 4/29/2026 | N/A | N/A | N/A | 10/15/2018 | 7/25/2024 | 5/29/2024 | 10/24/2023 |
| 309 | Valdes Ayala, Beatriz | Medical Assistant | 11/5/2018 | Spanish | 1.00 | 3/26/2025 | 3/19/2027 | N/A | N/A | N/A | 10/23/2018 | 7/25/2024 | 5/29/2024 | 3/26/2025 |
| 309 | Villalobos, Yolanda | Medical Assistant | 9/3/2019 | Spanish | 1.00 | 10/23/2023 | 1/11/2030 | N/A | N/A | N/A | 8/16/2019 | 7/25/2024 | 5/29/2024 | 10/23/2023 |
| 337 | Basa, Doris | Medical Assistant | 11/12/2024 | N/A | 1.00 | 10/24/2024 | 9/8/2027 | N/A | N/A | N/A | 11/5/2024 | 1/30/2025 | 11/5/2024 | 10/24/2024 |
| 337 | Guerrero, Jocelyne | Medical Assistant | 3/17/2025 | Spanish | 1.00 | 2/19/2025 | 1/2/2026 | N/A | N/A | N/A | 2/18/2025 | 3/17/2025 | 2/18/2025 | 2/19/2025 |

## SWOT Analysis

| Strengths | Weaknesses | Opportunities | Threats |
|---|---|---|---|
| Grievance responses to patients were immediate upon incidents being reported<br><br>No HIPAA breaches were reported for 2024. | Data for pregnant patients, their trimesters of pregnancy when first presenting, and are being captured, but not in a structured reportable manner. Manual work is currently providing these data.<br><br>No follow up efforts are currently being made to capture the race and birthweights of the babies born to health center patients who reported being pregnant. | Outreach process for connecting with patients who were pregnant beginning Q2 of the previous year needs to be implemented. Medical director and QMC will head up these efforts with the Informatics and IT teams. Monthly review meetings have been established to begin improving process and results. | Moving from an in-house server based EMR system to a cloud-based EMR system created many holes in the way data is captured, measured, and reported. These issues are being corrected through collaboration with eCW and AZARA. |

# 2024 Annual Risk Management Report (ARMR)

## *Follow-up Actions*

The following activities were executed and reviewed quarterly by the FQHC Leadership Team.

| Clinical Obstetric Measures | | | |
|---|---|---|---|
| **Goal #5:** Implement workflow to track prenatal services and baby birth weights to help mitigate obstetric risks, and ensure appropriate care is received. | CY23 0 prenatal visits/referrals documented<br>CY23 0 newborn birth weights documented | • Verify eCW documentation requirements to capture data for patients by age who received prenatal visits/referrals by trimester of pregnancy<br>o UDS Table 6b Sections A & B<br>• Verify eCW documentation requirements to capture data for the newborn birthweights (in grams) being documented by race/ethnicity.<br>o UDS Table 7a - Birthweight<br>• FQHC Operations Managers to develop and implement a workflow and process to<br>o document and track prenatal pts by age and<br>o document and track prenatal pts by which trimester their pregnancy is in per UDS requirements<br>o document whether SNCHC conducted the prenatal visit or provided the patient with a referral to another provider for prenatal care per UDS requirements.<br>▪ Follow up with referred patients to document status of pregnancy, and ensure prenatal, intrapartum, and postpartum care needs are planned.<br>• FQHC Operations Managers to develop and implement a workflow and process to document and track newborn birth weights by race, per UDS requirements.<br>• Adopt new Pregnancy Intention Screening practices to satisfy new UDS measures. | **Q1:<br>1. 0<br>2. 0<br>3. 0<br>4. 0<br>5. 550 / 1325 – 41.51%<br>**Q2:<br>1. 34<br>2. 0<br>3. 0<br>4. 0<br>5. 363 / 897 – 40.5%%<br>**Q3:<br>1. 10<br>2. 0<br>3. 0<br>4. 0<br>5. 589 / 1419 – 41.51%<br>**Q4:<br>1. 11<br>2. 0<br>3. 0<br>4. 0<br>5. 421/586 – 71.84%<br>**CY24 Results:<br>1. 55<br>2. 0<br>3. 0<br>4. 0<br>5. 1,923 / 4,227 – 45.5% |

HIPAA breach prevention activities from the annual risk assessment were a part of the risk and patient safety activities.

| CY24 Goals | CY24 Activities (What, Who, When) | CY24 Performance |
|---|---|---|
| | | 3 & 6 Month Follow Up |
| **Goal #1:** Ongoing observation is needed to ensure conversations continue to only occur confidentially either in patient rooms, or other designated areas where the public does not have access, whenever possible. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in oral communication regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify and define areas for verbally discussing PHI, so communication only occurs away from other patients. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected.<br>November 2024 – Complete. This issue has greatly improved. Spot checks following initial assessment occur every month, and conditions and behaviors are consistent with HIPAA regulations. |
| | | 3 & 6 Month Follow Up |

| | | |
|---|---|---|
| **Goal #2:** Ongoing observation is needed to ensure the computer screens remain protected. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of electronic PHI.<br>• Operations Managers cover expectations and risks at huddles regularly.<br>• Operations Managers identify any computer screens that need a privacy cover and get it on order and installed through IT. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected.<br>November 2024 – Complete. Once a team member's computer monitor did not have a protective screen. When witnessed, it was immediately corrected. No other issues or potential issues have been reported. |
| | | 3 & 6 Month Follow Up |
| **Goal #3:** Ongoing observation is necessary to ensure the team's behaviors continue to mitigate paper/fax risk. | • Operations Managers regularly walk through potential risk areas throughout the day with the intention of observing continued confidentiality in use of printers and fax machines regarding PHI.<br>• Operations Managers cover expectations and risks at huddles regularly. | August 2024 – Team and Managers report that managers are walking through high traffic areas multiple times a day. No issues have been witnessed or reported. Topics of HIPAA compliance are covered in huddles and staff meetings consistently, including discussions regarding PHI and PII, as well as logging out of computer stations when leaving them, placing materials with PHI/PII in locked shredding bins, keeping file cabinets locked, printers free of documents, and computer screens protected.<br>November 2024 – Complete. This issue is an ongoing area of risk, however, the workflows and protocols in place are effectively and consistently mitigating any potential risk. |

## *Conclusions*

Risk and patient safety activities described in last year's risk management plan were implemented as written.

High-risk activities (infection control, pharmacy, and HIPAA) were assessed, and actions were taken. Several steps were taken throughout the year to correct data collection, and mapping issues. Structured data elements still need to be tested and proven in order to implement the staff training needed to improve the metrics being measured for risk and patient safety activities.

More work is necessary to ensure data being captured is accurate, and that it is being more closely monitored.

## *Proposed Future Activities*

There is a monthly meeting that has been organized to begin scrutinizing and testing structured data collection, aggregation, analysis, and reporting. Meetings will incorporate the inspection and improvement of risk, patient safety, and UDS mandated data. Meeting invitees will be the medical director, risk manager, quality management coordinator, operations managers, informatics scientists, IT, and the administrative supervisor.

# 2024 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.<br><br>The health center monitors the number 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. |

### *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 2024. Continued prevention strategies are being deployed to keep this statistic as low as possible.

### *Conclusion*

No claims activities occurred in 2024. 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 2024 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 | | | Infection Prevention and Control | Obstetrics | **2** |
| RM | # Completed quarterly assessments | Min 1/qtr | **1** | **1** | **1** | **1** | **4** |
| RM | % Open action plans | ≤75% | **0%** | **0%** | **75%** | **100%** | **44%** |

| Adverse Events/ Incident Reports | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual Total** |
| Center staff | # Sentinel Incidents | Total /qtr. | 1 | 0 | 0 | 0 | **1** |
| Center staff | # High Risk Incidents | Total /qtr. | 2 | 4 | 6 | 3 | **15** |
| Center staff | # Medium Risk Incidents | Total /qtr. | 12 | 8 | 18 | 14 | **52** |
| Center staff | # Low Risk Incidents/Near Misses | Total /qtr. | 2 | 0 | 0 | 0 | **2** |
| Quarterly Incident Totals | | Prior Year - 65 | 17 | 12 | 24 | 17 | 70 |
| RM | # Root Cause Analyses (RCA) completed per qtr. | Total /qtr. | 5 | 5 | 8 | 3 | 21 |
| Medical Director | # Peer review audits completed (5/provider/qtr) | 80% | **0%** | **0%** | **94%** | **96%** | **47.50%** |

| 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 | 9.23% | 9.23% | 9.23% | 9.23% | **9.23%** |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Safe Injection) training. | ≥90% by year-end | 0.00% | 19.05% | 19.05% | 19.05% | **19.05%** |
| FQHC Leadership | Planning , review and completion of annual High Risk Area (Hand Hygiene) training. | ≥90% by year-end | 0.00% | 80.77% | 80.77% | 80.77% | **80.77%** |
| FQHC Leadership | Planning , review and completion of annual HIPAA training. | ≥90% by year-end | 0.00% | 89.47% | 89.47% | 89.47% | **89.47%** |
| FQHC Leadership | Planning , review and completion of annual Infection Prevention (BBP) training. | ≥90% by year-end | 0.00% | 58.09% | 58.09% | 58.09% | **58.09%** |
| FQHC Leadership | Annual Training Completion Rate Goal of 90% | ≥90% by year-end | 1.85% | 51.32% | 51.32% | 51.32% | **51.32%** |

| Risk and Patient Safety Activities | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Person responsible** | **Measure/ Key Performance Indicator** | **Threshold** | **Q1** | **Q2** | **Q3** | **Q4** | **Annual Total** |
| QI/MD/Ops Mgrs./RM | # Grievances | Avg/qtr | 2 | 0 | 0 | 2 | 4 |
| QI/MD/Ops Mgrs./RM | # Grievances resolved | 100% | 2 | 0 | 0 | 2 | **100%** |
| QI/MD/Ops Mgrs./RM | Patient Satisfaction Scores | ≥90% | **97.8%** | **97.7%** | **97.8%** | **98.3%** | **97.9%** |
| Compliance/RM | HIPAA breaches – wrong visit handouts | Total # of breaches | 0 | 0 | 0 | 0 | **0** |
| QI/MD/Ops Mgrs./RM | # of Pts eligible for Pregnancy Intention Screening | Total # | 1325 | 897 | 1419 | 586 | 4227 |
| QI/MD/Ops Mgrs./RM | # of Pts Screened for Pregnancy Intention | Total # | 550 | 363 | 589 | 421 | 1923 |
| QI/MD/Ops Mgrs./RM | % of Pts Screened for Pregnancy Intention | >75% | **41.51%** | **40.47%** | **41.51%** | **71.84%** | **45.49%** |
| QI/MD/Ops Mgrs./RM | # of Pregnant Pts Seen | Total # | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Pregnant pts referred out for prenatal care | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | # of Prenatal Pts w Documented Trimester of Pregnancy When First Seen | # of Prenatal Pts Referred | 18 | 16 | 10 | 11 | 55 |
| QI/MD/Ops Mgrs./RM | % of Prenatal Pts w Documented Trimester of Pregnancy When First Seen | >75% | **100%** | **100%** | **100%** | **100%** | **100%** |
| QI/MD/Ops Mgrs./RM | # of Birthweights by Race Captured | Total # | 0 | 0 | 0 | 0 | 0 |
| RM/HR | Credentialing and privileging file review rate | 100% | 100% | 100% | 100% | 100% | **100%*** |

| 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 |

| Color Coding Key |
|---|
| Not Compliant |
| Approaching Compliance |
| Compliant |