THE QUALITY-COMPLIANCE COLLABORATIVE IN FQHCS

Illustrating the Evolving Model for American Healthcare

PRESENTERS

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Shasta Community Health Center (Redding).
## SURVEY

- How many participants serve as the Quality official at their health center?
- How many serve as the Compliance official?
- How many serve or have served as both?
- How many do so in a Federally Qualified Health Center (FQHC) or other type of primary care Community Health Center (CHC)?)

## WHAT IS AN FQHC?

- Under the Social Security Act, FQHC means:
  1. An entity that is receiving a PHSA Section 330 grant or is receiving funding through a contract with a PHSA Section 330 grant recipient;
  2. An entity that meets the requirements to receive a PHSA Section 330 grant as determined by HRSA;
  3. An entity that was treated by the Secretary of HHS as a comprehensive funded health center for the purposes of Medicare Part B as of 1/1/1990; or
  4. An outpatient program or facility operated by an Indian Tribe, Tribal Operations, or Urban Indian Organization receiving funds authorized in the Indian Health Care Improvement Act.

TYPES OF HEALTH CENTERS

- In addition to the FQHC designation, there are:
  - School-Based Health Centers
  - Nurse-Managed Health Clinics
  - Community Mental Health Centers
  - Native Hawaiian Health Care
  - Tribal Health Centers
  - Rural Health Clinics
  - Free Clinics
  - FQHC Look-Alikes

THE AFFORDABLE CARE ACT

- Appropriations to support the HRSA federal health center program have increased over the past decade. The increases began earlier, in 2000, but continued with supplemental funding under:
  - the American Recovery and Reinvestment Act (ARRA)
  - The Patient Protection and Affordable Care Act (ACA)

- Goal (specific to CHCs) → Build new health centers and increase services at existing health centers. The ACA's focus is to expand insurance coverage to the uninsured.

  *How does that impact community health centers?*
IMPACT ON COMMUNITY HEALTH CENTERS

- More individuals may seek care at health centers.
- Even though more people are insured under ACA, our focus remains not simply on the uninsured but the underserved.
- Reimbursements may increase because fewer people remain uninsured.
- Direct appropriations from ACA may help health centers provide care to expanded populations.
- Raising the bar – If we have a potentially greater impact on population health and how it impacts hospitals, it is not surprising that we would be held to certain quality and compliance standards.

WHAT WE ARE HERE TO TALK ABOUT...

- Quality
- Performance Metrics
- Compliance
COMPLIANCE

For over 20 years, the hospitals and health systems have been addressing the 7 elements outlined by the Office of the Inspector General (OIG):

1. Implementing practice standards (policies, procedures, standards of conduct).
2. Designating a point person (accountability OR “designated felon”)
3. Training and education
4. Effective communication
5. Internal auditing and monitoring
6. Responding to detective offenses and implementing corrective action
7. Disciplinary mechanisms that support a compliant and ethical culture

...and that approach to compliance has expanded to primary care and other focused areas of healthcare.

8. The Quality-Compliance Collaborative.

330 COMPLIANCE – QUALITY FOCUS

1. Federal Quality Data Collection, Analysis and Reporting Requirements. (HRSA’s UDS → Uniform Data System)
2. Identification of Effective Quality Improvement Models
3. Adopting and Adapting Effective Quality Improvement Models
4. Evaluating (Auditing & Monitoring) Quality Improvement Interventions
5. Sustaining Quality Improvement Interventions
6. Quality Improvement Partnerships
COMPLIANCE → QUALITY

- Survey Readiness and Certification/Re-Certification
- Policies and Procedures
- Training/Education
- Auditing and Monitoring
- Standards of Conduct

These extend well beyond the traditional idea of “Compliance topics.” At the heart of all surveys is the expectation that:

1. Our processes meet industry standards for quality of care and accountability.
2. We train our staff to follow these processes. Even better – we include our staff in the development of these processes to ensure applicability and adherence.
3. We CHECK to make sure we do what we say we do. And we respond as needed in a timely fashion.

WHEN IT GOES SIDEWAYS....

Rideout CEO to face charges

Aug. 23--The CEO of Rideout Memorial Hospital and another official are scheduled to be arraigned Tuesday on misdemeanor criminal charges.

The state Attorney General’s Office filed a two-count complaint in Yuba County Superior Court against Theresa Hamilton and Istikram Qaderi.

Hamilton, identified in the complaint as Theresa Hamilton-Casalegno, and Qaderi, the hospital’s senior vice president-chief quality officer, are charged with failing to report a suspected incident of dependent adult abuse and impeding others from reporting the abuse.

The charges are violations of the state Welfare and Institutions Code.

- Whether it is a survey gone wrong, or an event that triggers a review, the issue is not JUST a quality issue, or JUST a compliance issue. They intermingle.
## WHAT CAME OUT OF IT

### The Bad
- Nobody looks good in orange.
- Tons of $$$ went into efforts just to keep their hospital license and ability to bill Medicare.
- Plans for affiliating with a health system were put on hold.
- Community reputation took a big hit.
- Patients didn’t trust them.

### The Good
- Everyone HAS to start swimming in the same direction.
- Eventually, you find your rhythm and build better practices, create new/strong collaborative relationships.
- To an extent – The World According to Garp. Kinda......

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## GARP’S THEORY TESTED

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**Department of Justice**

U.S. Attorney’s Office

Eastern District of California

**FOR IMMEDIATE RELEASE**

Tuesday, December 6, 2016

**Rideout Health to Pay Civil Monetary Penalties to Resolve Controlled Substance Act Claims**

SACRAMENTO, Calif. — Rideout Health will pay the United States $2,425,000 to settle the federal claims of alleged violations of the Controlled Substances Act by three of Rideout Health’s facilities in Yuba and Sutter Counties: Rideout Memorial Hospital, Fremont Medical Center, and Feather River Surgery Center, United States Attorney Phillip A. Talbert announced today.

[Shasta Community Health Center logo]
THE BEST OF THE GOOD

- Quality and Compliance established themselves as the facilitators of best practices for clinical teams.
- Focus on revenue included a focus on quality.
- Good Practices:
  - OFIs led to PITs and KPIs (a veritable vegetable soup of collaborations!)
  - Policies no longer created in a vacuum; collaborative and they MEANT something
  - Culture check
  - No Silos, No Conflicts of Interest: Understanding respective roles and making them work cohesively

COMPLIANCE FOCUS

- Medicare & Medicaid regulations (Conditions for Coverage)
- False Claims Act (crossroads with Quality → medical necessity)
  - False Statement Act (18 USC §1001)
  - Mail and Wire Fraud Statutes (18 USC §1341, § 1343)
- Civil Monetary Penalties (CMP) Law
- HIPAA (crossroads with Quality → patient trust)
- Anti-Kickback Statue and Stark Law (focus on relationships vs. quality/need)
- 340B Discount Program (crossroads with Quality → ability to provide comprehensive care to our patients)
- MAIN GOAL: Protect Resources! Take care of Patients!
QUALITY/COMPLIANCE COLLABORATIVE

- Compliance has the responsibility and ability to shift culture.
- Compliance has the ability to hold the organization and its people accountable.
- Compliance should have the skills, resources and perspective to facilitate efforts that relate to the 7 elements.
- Quality knows where it needs to get, and should know what barriers are keeping us from getting there.
- Compliance can help Quality manage the culture and the processes to meet metrics.
- Meeting metrics means gaining resources to continue the effort.

HRSA EFFORTS TO EXPAND AND ACCELERATE QUALITY IMPROVEMENT

- Federal Quality Data Collection, Analysis, and Reporting Requirements
- Identification of Effective Quality Improvement Models
- Implementation of Effective Quality Improvement Models
- Evaluating Quality Improvement Interventions
- Sustaining Quality Improvement Interventions
- Quality Improvement Partnerships

*FQHC Compliance Officers need to understand how best to support these efforts to ensure continued 330 eligibility.*
QUALITY IMPROVEMENT

OBJECTIVES

1. American Healthcare System at a glance
2. Understanding Quality Improvement
3. Building a Culture of Quality
   • Moving to Value Based Care
   • SCHC example
Healthcare expenditure in the US is much higher than in other OECD countries. Here are some key points:

- Health spending averages $9,892 per person in the US (adjusted for local costs), much higher than in all other countries (the OECD average is $4,203).
- Health spending amounted to 17.2% of GDP, more than eight percentage points above the OECD average.
OBESITY RATES
(COMPAARED TO OTHER OECD COUNTRIES)

The United States has the highest prevalence of obesity in the OECD (38% of adults, compared with an OECD average of 19.4%), and the second highest overall share of population being overweight or obese (70%).

POOR HEALTH DESPITE HIGH SPENDING

OECD Health Data, 2009. Life expectancy at birth in different countries versus per capita expenditures on health care in dollar terms, adjusted for purchasing power. The United States is a clear outlier on the curve, spending far more than any other country yet achieving less.
WASTE IN AMERICAN HEALTHCARE

Systemic waste across the board

<table>
<thead>
<tr>
<th>Excess Cost Estimates</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unnecessary Services</td>
<td>$210 B</td>
</tr>
<tr>
<td>Inefficiently Delivered Services</td>
<td>$130 B</td>
</tr>
<tr>
<td>Excess Administrative Costs</td>
<td>$190 B</td>
</tr>
<tr>
<td>Prices That Are Too High</td>
<td>$105 B</td>
</tr>
<tr>
<td>Missed Prevention Opportunities</td>
<td>$55 B</td>
</tr>
<tr>
<td>Fraud</td>
<td>$75 B</td>
</tr>
<tr>
<td><strong>Total Excess Costs:</strong></td>
<td><strong>$765 B</strong></td>
</tr>
</tbody>
</table>

Source: Institute of Medicine, Roundtable on Value and Science-driven health care (2011). The learning health system and its innovation collaborative.

CONTEXT OF US HEALTHCARE COST GROWTH

Source: Institute of Medicine, Roundtable on Value and Science-driven health care (2011). The learning health system and its innovation collaborative. UC Davis Extension Healthcare Analytics Mike Minear presentation.
SCIENCE-PRACTICE GAP (UNIVERSAL CHALLENGE)

- The existence of a gap between science and practice is universally recognized.
- Clinical research findings and clinical practice guidelines that have promise to improve health move very slowly from the research setting into clinical practice, and many of these interventions never reach those who could benefit.
- It is estimated that it takes an average of 17 years to translate 14% of original research into benefit for patients and an average of 9 years for interventions recommended as evidence-based practices to be fully adopted.


MEDICAL DECISION BECOMING MORE COMPLEX (UNIVERSAL CHALLENGE)

The Learning Health System

Medical decisions becoming more complex

- Proteomics and other effector molecules
- Functional Genetics: Gene expression profiles
- Structural Genetics: e.g. SNPs, haplotypes
- Decisions by Clinical Phenotype


Source: Institute of Medicine, Roundtable on Value and Science-driven health care (2011). The learning health system and its innovation collaborative. UC Davis Extension Healthcare Analytics Mike Minear presentation.
UNDERSTANDING QUALITY IMPROVEMENT

THE HISTORY OF QUALITY

- Frederick Taylor: Scientific Management Principles
- Sampling inspection replaced unit-by-unit inspection. Walter Shewhart’s statistical quality control techniques
- Inclusion of ‘processes’ in quality practices. Shewhart laid the foundation for control chart
- Deming also emerged as a leader of quality movement in Japan and US.
- Birth of TQM (total quality management)
- ISO 9000 series of quality-management standards 1987
- Malcolm Baldridge National Quality Award established by congress
- Quality moves beyond manufacturing → Healthcare
- Malcolm Baldridge National Award added Healthcare
- Taiichi Ohno: Toyota Production System (Lean)
- Deming cycle → PDSA
- Six Sigma developed by Motorola

*TQM is the name for the philosophy of a broad and systemic approach to managing organizational quality.
DEFINING QUALITY IMPROVEMENT?

**Health Resources and Service Administration (HRSA)**

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

**Institute of Healthcare Improvement**

Quality improvement (QI) is an approach to getting better outcomes in systems by creating more reliable processes. QI is a way of thinking and organizing the achievement of an aim by starting small, developing and testing changes to the way we work, and using data for decision making to see what changes it will take to bring about improvement in the aim and in factors that contribute to that aim.

*Quality improvement is a method to improve systems*

GUIDING PRINCIPLES OF QI

**Triple Aim** is a framework developed by the Institute for Healthcare Improvement (IHI) that describes an approach to optimizing health system performance.

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.
TRIPLE AIM → QUADRUPLE AIM

Quadruple Aim

- Burnout among the health care workforce can threaten the success of Triple Aim by lowering patient satisfaction, overuse of resources and increase the possibility of errors.
- 46% of US physicians experience symptoms of burnout.
- 34% of hospital nurses, 37% of nursing home nurses and 22% of nurses working in other settings report burnout.

ADDRESSING THE QUADRUPLE AIM

1. Implement team documentation.
2. Use pre-visit planning and pre-appointment laboratory testing to reduce time wasted on the review and follow-up of laboratory results.
3. Expand roles allowing nurses and medical assistants to assume responsibility for preventive care and chronic care health coaching under physician-written standing orders.
4. Standardize and synchronize workflows for prescription refills, an approach which can save physicians 5 hours per week while providing better care.
5. Co-locate teams so that physicians work in the same space as their team members; this has been shown to increase efficiency and save 30 minutes of physician time per day.
6. To avoid shifting burnout from physicians to practice staff, ensure that staff who assume new responsibilities are well-trained.
QUALITY IMPROVEMENT MODELS

Quality improvement models present a systematic, formal framework for establishing QI processes in your practice. Examples of common QI models include the following:

1. **Model for Improvement (Plan-Do-Study-Act [PDSA] cycles) aka Deming Wheel:** The Institute for Healthcare Improvement’s Model for Improvement combines two popular QI models: Total Quality Management (TQM) and Rapid-Cycle Improvement (RCI). The result is a framework that uses PDSA cycles to test interventions on a small scale.

2. **Six Sigma:** Six Sigma is a method of improvement that strives to decrease variation and defects. It’s a strategy for process improvement and problem reduction by using the DMAIC methodology (define, measure, analyze, improve, control).

3. **Lean:** is an approach that drives out waste and improves efficiency in work processes so that all work adds value. This model defines value by what a customer (i.e., patient) wants. It maps how the value flows to the customer (i.e., patient), and ensures the competency of the process by making it cost effective and time efficient. Toyota’s 4P model.

4. **Many more……………..**

   Source: American Academy of Family Physicians

BUILDING A CULTURE OF QUALITY
MOVING TO VALUE BASED CARE
(QUALITY AN INTEGRAL PART)

Sustainability
- Monitoring
- Evaluating
- Ongoing problem solving

Daily Management of Operations
- Process
- People
- Visual Controls
- Technology/Analytics

Culture
- Mission/Vision
- Strategy
- Leadership

SHASTA COMMUNITY HEALTH CENTER EXAMPLE
BUILDING QUALITY IMPROVEMENT INFRASTRUCTURE
SHASTA COMMUNITY HEALTH CENTER

- Quality and Risk Management Committee oversight
- Monthly report out to the Board

Leadership & Governance

Committee Structure

- SCHC metric dashboard
- Analytics Platform: Eagle Dream Health
- SCHC Quality Intranet site

Reporting

Quality Support

- QI Coordinator/ Patient Care Navigator support
- Annual QI training for staff

Six Quality committees

COLLABORATIVE TEAM APPROACH
SHASTA COMMUNITY HEALTH CENTER

- Physician and administrative chair leads
- Multidisciplinary committee membership
- Yearly committee goals aligned with PCMH, HRSA and SCHC strategic priorities
- Shared decision making
QUALITY IMPROVEMENT STRUCTURE AT SCHC

- In addition to Quality personnel, the Compliance Officer serves as an advisor to all of these committees with the exception of Chart Review and M&M (to avoid conflicts of interest).

QUALITY/COMPLIANCE COLLABORATIVE

- Championing efforts for significant change
  - Example: Shift to Chart Review and M&M from “Peer Review”
- Employing collaborative management systems to support a quality/compliance culture:
  - Event Management (including risk assessment and corrective actions)
  - Policy Management (and training)
  - Contract Management (quality assurance)
CENTRALIZED REPOSITORY
SHASTA COMMUNITY HEALTH CENTER

To create transparency and a centralized location to store all SCHC Quality efforts, a collaborative web library is available to staff.

QUALITY DASHBOARD
SHASTA COMMUNITY HEALTH CENTER

<table>
<thead>
<tr>
<th>Indicator</th>
<th>SCHC Baseline (x/2015)</th>
<th>Target Source</th>
<th>Target</th>
<th>Indicator Source</th>
<th>Priority</th>
<th>CY18 YTD</th>
<th>CY17 YTD</th>
<th>CY16 YTD</th>
<th>Action (Next Step)</th>
<th>Active Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Site</td>
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</tr>
<tr>
<td>Diabetes Management - HbA1c Good Control (age 18-75)</td>
<td>71.3%</td>
<td>PHC 50th percentile</td>
<td>70.9%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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</tr>
<tr>
<td>Diabetes Management - Retinal Eye Exam (age 40-75)</td>
<td>58.9%</td>
<td>PHC 50th percentile</td>
<td>68.3%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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</tr>
<tr>
<td>Diabetes Management - Nephropathy (age 18-75)</td>
<td>87.7%</td>
<td>PHC 50th percentile</td>
<td>93.3%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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<tr>
<td>Controlling High Blood Pressure (age 18-75)</td>
<td>81.4%</td>
<td>PHC 50th percentile</td>
<td>71.7%</td>
<td>Eagle dream</td>
<td>Monitoring</td>
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<tr>
<td>Cervical Cancer Screening (age 21-64)</td>
<td>66.8%</td>
<td>PHC 50th percentile</td>
<td>70.8%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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<tr>
<td>Breast Cancer Screening (age 50-74)</td>
<td>46.7%</td>
<td>PHC 50th percentile</td>
<td>56.4%</td>
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<tr>
<td>Well Child Visits (age 0-2)</td>
<td>71.4%</td>
<td>PHC 50th percentile</td>
<td>82.0%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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<tr>
<td>Immunizations for Adolescents (age 9-13)</td>
<td>69.8%</td>
<td>PHC 50th percentile</td>
<td>70.9%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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<tr>
<td>Childhood Immunizations Status (age 0-2)</td>
<td>72.4%</td>
<td>PHC 50th percentile</td>
<td>82.0%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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<td>Anderson</td>
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<tr>
<td>Diabetes Management - HbA1c Good Control (age 18-75)</td>
<td>70.6%</td>
<td>PHC 50th percentile</td>
<td>70.9%</td>
<td>Eagle dream</td>
<td>Tier 1</td>
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</tbody>
</table>
A3 PROBLEM SOLVING TEMPLATE

PDSA CYCLE WORKSHEET

A. Department and Site (e.g. family practice at Main):
B. Topic of the PDSA:
C. Time frame of PDSA cycle:
D. Person Responsible for Implementing PDSA:

PRE-Planning Phase
Before selecting your intervention and implementing the Plan-Do-Study-Act (PDSA) cycle, focus on the pre-planning steps of the PDSA process, which are: investigation and problem framing.
- Define the barrier/problem using data.
- Determine its influence/controlling factors.
- Identify stakeholders.
- Set the criteria for determining success.
- Verify that you will have the resources needed to implement the intervention selected.

INTERVENTION SELECTION PROCESS:
1. What did you choose this intervention to test?
- Justify your choice with a description of the planning process (e.g., key driver diagram, fishbone, work flow process maps, literature review, etc.)

Note: The selected intervention for the PDSA cycle should be a new change (i.e., not an intervention that was already implemented). If the intervention was implemented previously, the intervention should be tested in a new site/environment or adapted for this PDSA cycle.

INTERVENTION DESCRIPTION MUST:
- Indicate what you are going to test. Be specific (one intervention per PDSA cycle).
- Specify who will be involved with testing the intervention (e.g., specific staff, targeted provider, etc.).

PDSA CYCLE TEMPLATE

Shasta Community Health Center
a california health center

A3 PROBLEM SOLVING TEMPLATE

Shasta Community Health Center
a california health center
## Clinician Practice Snapshot

### Access/Productivity

<table>
<thead>
<tr>
<th># New Patients with QE</th>
<th>0</th>
<th>No recorded instances.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> 2 patients/week</td>
<td></td>
<td></td>
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</tbody>
</table>

### QE/Nominal B for Clinic Day

<table>
<thead>
<tr>
<th># QE/Nominal B for Clinic Day</th>
<th>17</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> Minimum 16/day for PP, 20/day for Pediatric, 24/day for PCN Pop., Internal 16/day, NP/PA 16/day. All targets are in Qualifying encounters. Residents/fellows these targets do not apply for one year, new PCPs these targets do not apply for 6 months.</td>
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</tr>
</tbody>
</table>

### # Shifts Worked in UC or Saturday Clinics

<table>
<thead>
<tr>
<th># Shifts Worked in UC or Saturday Clinics</th>
<th>13</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evening</td>
<td></td>
<td></td>
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<tr>
<td>Saturday</td>
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</tr>
<tr>
<td><strong>Expectation:</strong> 4 Saturdays/yr, for FT OR 2 Saturdays/yr. FT if you have inpatient hours. 4 evenings=1 Saturday worked. Part time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### % Medically Complex Patients in Panel

<table>
<thead>
<tr>
<th>% Medically Complex Patients in Panel</th>
<th>45.40%</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> 33.00%</td>
<td></td>
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</tr>
</tbody>
</table>

### % Panel Size

<table>
<thead>
<tr>
<th>% Panel Size</th>
<th>0</th>
<th>No recorded instances.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> Panel considered full at 110%. Sizes are determined by patients in the panel in the last 18 months. No target.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Communication and Interaction

<table>
<thead>
<tr>
<th># Portal Messages Handled</th>
<th>459</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> No target</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Completed Documentation within 24 hrs</th>
<th>87.12%</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> 90%</td>
<td></td>
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</tbody>
</table>

### Average Action Time for Medication Tasks in Hours

<table>
<thead>
<tr>
<th>Average Action Time for Medication Tasks in Hours</th>
<th>24</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled Substance Management</td>
<td></td>
<td></td>
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<tr>
<td>eRx Task</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Management</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expectation:</strong> 72 hours</td>
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</tr>
</tbody>
</table>

### Average Action Time for PAQ Items in Hours

<table>
<thead>
<tr>
<th>Average Action Time for PAQ Items in Hours</th>
<th>27</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>EHR Document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIE Document</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scanned Document</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expectation:</strong> 72 hours</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Patient Care

<table>
<thead>
<tr>
<th>% Chart Review Compliance</th>
<th>1</th>
<th>1/1/2018 to 12/31/2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expectation:</strong> 40%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXAMPLES OF IMPROVEMENT PROJECTS

- Diabetes self-management support (for uncontrolled Diabetic patients)
- Colorectal Cancer Awareness Campaign – Increase FIT order completion rates
- Cervical Cancer Screening Awareness Campaign – ‘sneak-a-PAP’
- Streamlining patient check-out process for Family Practice
- Breast Cancer Screening - ‘MDI collaborative’
- Saturday well child days
- Pre-visit planning implementation
- Increasing portal enrollment
- Increasing Oral Health Assessments and Dental Visits for EIS patients
- Many more.....

COMPLIANCE METRICS
COMPLIANCE SUPPORT OF QUALITY

- Create a Management Compliance Committee (or review and enhance, if needed, an existing one).
- Members include quality and managers from patient care and support services units.
- Purpose of MCC is to discuss and develop goals, and ensure achievement of same. (Annual Work Plan)
  - Compliance facilitates
  - Risk Assessment Tools are used
  - Ensures appropriate perspectives are incorporated into planning, AND it creates buy in from the start.

COMPLIANCE WORK PLAN (CWP)

- Your risk assessment/method for determining priorities should always reflect back on patient care quality and safety. Is that not the intent of all the compliance regulations, ultimately?

What does that look like?
### RISK ASSESSMENT FOR CWP

| 2019 SCHC Compliance Work Plan Risk Assessment and Recommendations (from MCC): |
|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| **Failure Mode** | **Potential Causes/Other Notes** | **Scoring** | **Action Type** | **Outcome Measure** | **Person Responsible** | **Management Committee** |
| **Hazard Analysis** | | | | | | |
| **Security** | Probability | Risk Score | | | | |
| **Probability** | Total Score | | | | | |
| **Ongoing Development of an Effective Compliance Program** | This is a standing item for each year’s Work Plan. Catastrophic | Frequent | 25 | Control | See Work Plan | See Work Plan |
| **HRAA (Security & Privacy Management)** | See Work Plan | Catastrophic | Frequent | 16 | Control | See Work Plan | See Work Plan |
| **Incident Management** | See Work Plan | Catastrophic | Frequent | 16 | Control | See Work Plan | See Work Plan |
| **Risk** | See Work Plan | Catastrophic | Frequent | 16 | Control | See Work Plan | See Work Plan |
| **Quality Assurance** | See Work Plan | Catastrophic | Frequent | 16 | Control | See Work Plan | See Work Plan |
| **Facility Security** | See Work Plan | Major Impact | Frequent | 12 | Control | See Work Plan | See Work Plan |
| **CREDENTIALING & PRIVILEGING PROCESSES** | See Work Plan | Major Impact | Occasional | 9 | Control | See Work Plan | See Work Plan |
| **HIS CODING, AUDITING & MONITORING** | See Work Plan | Moderate Impact | Frequent | 8 | Control | See Work Plan | See Work Plan |
| **Policy Management** | See Work Plan | Moderate Impact | Frequent | 8 | Control | See Work Plan | See Work Plan |
| **Access Controls** | See Work Plan | Moderate Impact | Frequent | 8 | Control | See Work Plan | See Work Plan |

### COMPLIANCE WORK PLAN 2019

<table>
<thead>
<tr>
<th>PRIORITY FOCUS</th>
<th>SOURCE OF RISK IDENTIFICATION</th>
<th>WORK PLAN ACTIVITIES (Policies &amp; Procedures, Training, Audit &amp; Monitoring)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ongoing Development of an Effective Compliance Program</strong></td>
<td>Based on OIG Guidance and the Affordable Care Act</td>
<td>Policies: Create new or revised policies to address risk areas identified in the Compliance Program Effectiveness Review Assessment (2018) including but not necessarily limited to: - Inventory of Federal Programs - Effective Business Practices (Including Policies) - Effective Compliance Policies - Compliance as an Element of Evaluation - Record Retention Policy and Schedule (Regulatory, Subject Matter) - Social Media - Patient Incentives - Incident/Event Reporting - Subpoenas - Managing Agency and Law Enforcement Requests (Including Public Charge Issues under New Immigration Standards) Continue identification of policies due to changes in regulations, industry audits and other developments that support an effective compliance program, such as: Training: Create annual training schedule to address topics. Develop a thorough combination of online training, module training and on policy examination and questionsnaires. Utilize managers and directors for ongoing compliance discussions/training with staff. Auditing/Investigation: Assess effectiveness of Compliance electronic tracking/reporting systems: - Ethics Point - PolicyTech - Electronic Charts (CtChcks) - IT Security/Privacy Access Monitoring (Systems)</td>
</tr>
</tbody>
</table>
THE COLLABORATIVE

- Quality and Compliance start with culture. We have the standard respective metrics, as well as the moving targets.
- Don’t forget your MISSION, VISION and VALUES!
- And look at all the data to check...all the time....are we meeting our Mission?

---

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**And look at all the data to check...all the time....are we meeting our Mission?**
QUESTIONS?