2025 FTCA Deeming Application Clinic

Pre-Work Booklet

HRSA Health Center Program

Welcome to the 2025 FTCA Deeming Application

The purpose of this booklet is to present you with an overview of key parts of the clinic, answers to common questions, and the pre-work you'll use to practice completing your FTCA deeming application.

The clinic provides an opportunity to attend interactive sessions that cover each area of the FTCA deeming application and apply knowledge by doing hands-on activities to practice completing the application. The clinic's virtual platform also allows attendees to review and download resources to help you complete your FTCA deeming application.

Active participation in the discussion, learning more about the components of deeming applications, and networking with attendees from other health centers are the goals. Together let's make the 2025 FTCA Deeming Application Clinic a success!

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Attendee Expectations

To promote an environment of collaboration and learning, we ask all attendees to:

1. Fully engage in sessions – the time attendees have taken to commit to attending the clinic is invaluable. All attendees are asked to use that time to fully engage in sessions by viewing the presentation, and by participating in answering polling questions. For additional questions, please use the BPHC Contact Form or call 877-464-4772, Option 1. 8 a.m. to 5:30 p.m. ET, Monday - Friday (except federal holidays).

2. Complete required pre-work – Pre-work was designed to give each attendee the opportunity to review FTCA deeming applications with subject matter experts. The goal is to help applicants understand how applications are assessed when being reviewed by HRSA. For attendees to benefit from this opportunity, please complete the required pre-work outlined in this booklet.

3. Adhere to professional guidelines – All attendees are expected to exhibit professionalism in their interactions throughout the clinic. This includes being on time for sessions, paying attention to the presentations and direction given, and showing respect for others when providing feedback and chatting.

Certificates

To obtain a certificate of completion for the 2025 FTCA Deeming Application Clinic, attendees must:

1. Register individually for the clinic
2. Attend all sessions
3. Complete all evaluations

A certificate of completion will be sent to the email address each participant used to register for the clinic within thirty days.

For questions and concerns, please contact hrsasupport@acentra.com.

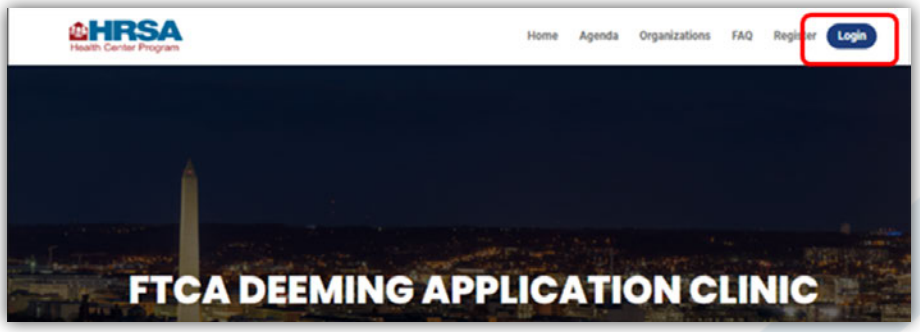
Virtual Platform

Virtual Platform

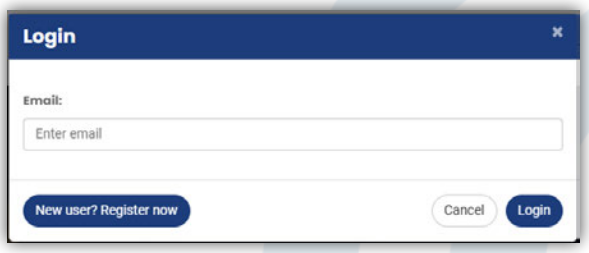
The 2025 FTCA Deeming Application Clinic will be held on the vFairs virtual platform.

2025 FTCA Deeming Clinic URL: https://hrsadeemingapplicationclinic.vfairs.com/

To log in, access the login button on the navigation bar.

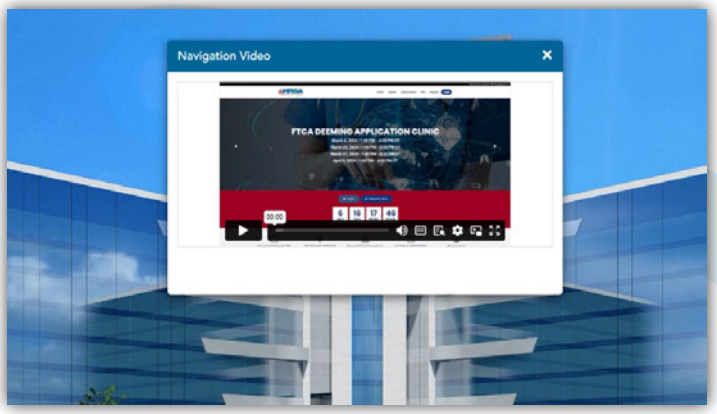


Enter the email address provided during registration. This is also noted as the username in your registration email. This email would have been sent from vFairs (noreply@vFairs.com).



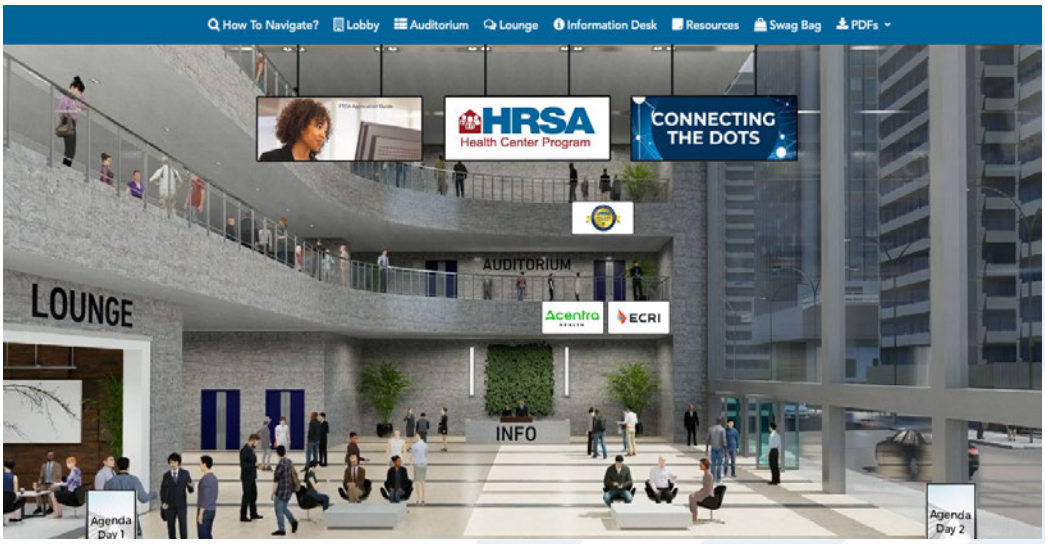
External Environment

Upon logging in, the vFairs external environment will be visible. The navigation video appears as a pop-up. Please view the navigation video, then click on the entrance of the virtual convention center to enter the lobby.



Lobby

After entering the virtual convention center, the lobby will be available. This is the hub for all areas and features of the platform and can be used to navigate to all areas of the clinic. The large banners at the top of the screen are clickable and provide information for additional educational resources. Agendas are accessible by clicking the agenda banners on the bottom of the screen. The navigation bar at the top of the screen also has links to all areas of the clinic.



Auditorium

The auditorium contains links to agendas and live presentations. Attendees can click on the screen to access the agenda, containing links to each session. After the clinic has ended, links will be available to on-demand sessions for one year.

Lounge

The lounge is where attendees can access chat rooms for:

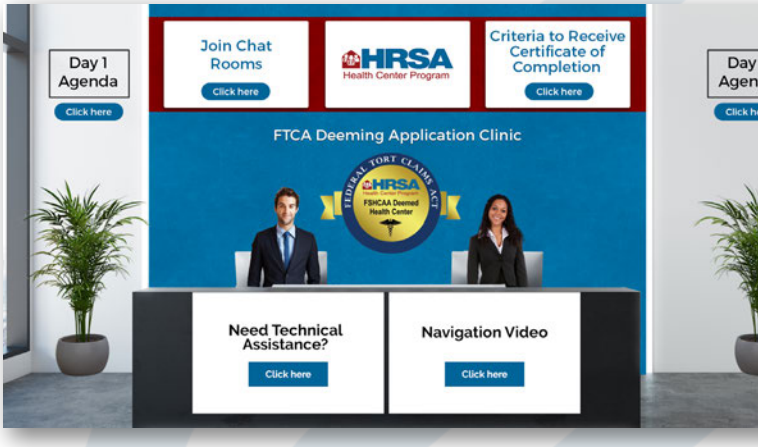
- technical assistance from vFairs
- live chat with ECRI representatives
- networking with other health centers

Representatives for each chat room will be available during breaks and after the live presentations. Attendees can chat with representatives or leave them a message. To close the chat function, simply click the minimize icon.

Note: Popping noises from chat notifications during the presentation are an indication that chat settings are set to allow notifications. To undo this, open a chat, click on settings with the notification that looks like a bell at the top, then uncheck the box to allow notifications.

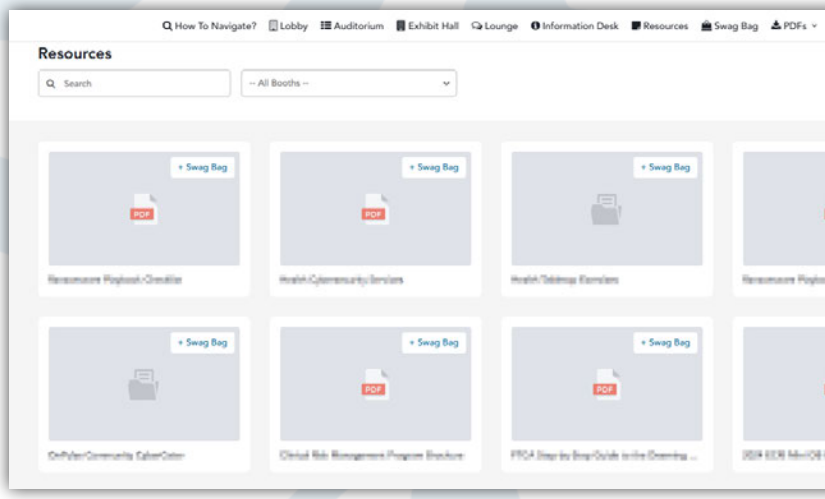
Information Desk

The information desk is where attendees can receive technical assistance from vFairs. Other useful features such as information on certificate criteria, and links to agendas, chat rooms, and the vFairs navigation video are also available.



Resources

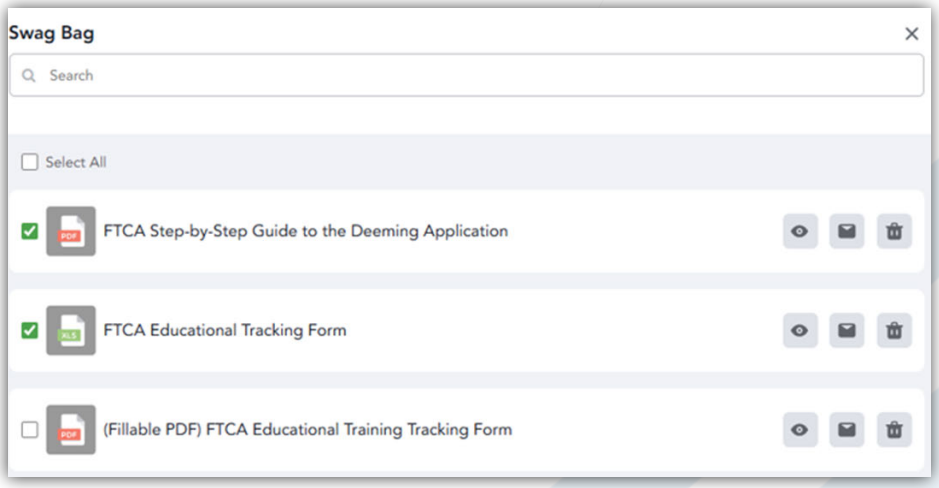
Documents relevant to FTCA deeming applications can be found in the “Resources” section. These documents can be downloaded and/or added to your swag bag to email to yourself later.

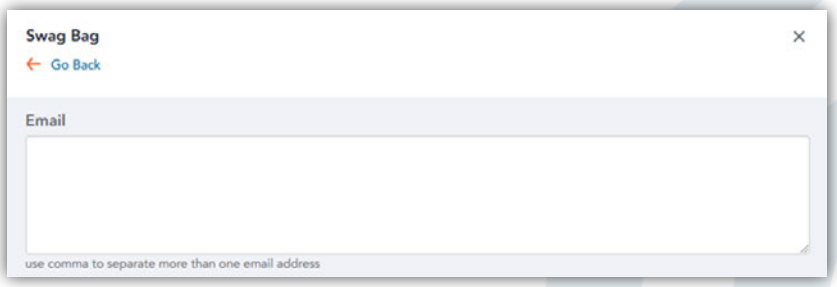


Swag Bag

To use the swag bag, simply select the files you would like to receive via email by checking the box next to the name of the document:

- Enter the preferred email address where documents should be sent. If the documents are being sent to multiple addresses, use a comma to separate more than one email address.

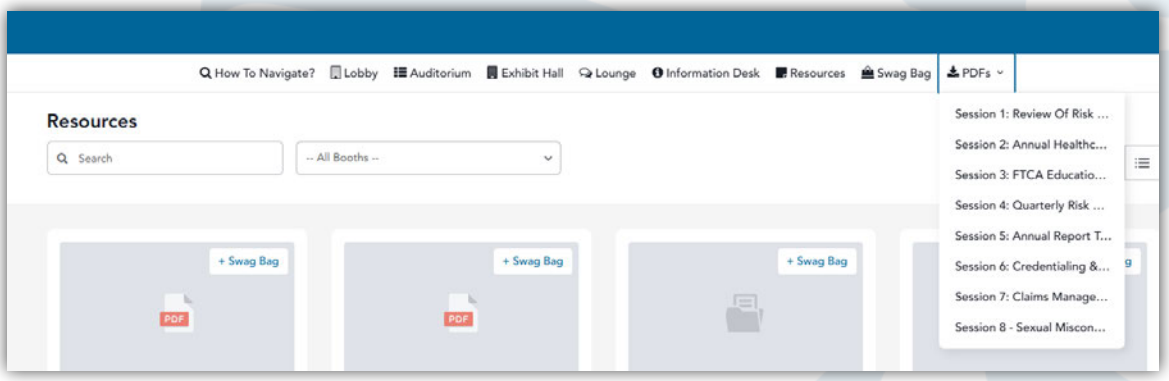




PDFs

After the clinic has concluded, PDFs of the presentations will be available to attendees.

To view/download the PDFs of the presentations, click on the “PDFs” area of the navigation bar. A dropdown with all available presentations will appear. After clicking on the selected session, the document will open in your browser.



FTCA Program Reminders

FTCA Program Reminders

Reporting Period:

The FTCA application requires information from the health center covering the period from January 1 to December 31 of the previous year of submission of the application. For applications submitted in 2025, the information submitted must cover January 1, 2024 to December 31, 2024. Submitting information that does not cover this reporting period, or includes dates beyond the reporting period, will be considered non-compliant. Information submitted for this timeframe should include:

- The annual risk management educational training plan and all associated FTCA education training tracking forms for clinical staff (topics include obstetrical training, infection control training, HIPAA training, and areas of high-risk training)
- Proof that the risk manager has received risk management training
- Quarterly risk assessments (one risk assessment must be completed within each calendar quarter:
- Quarter 1: January 1, 2024 – February 29, 2024
- Quarter 2: March 1 – May 31, 2024
- Quarter 3: June 1 – August 31, 2024
- Quarter 4: September 1, 2024 – December 31, 2024
- The data within the annual report provided to the board and key management staff on health care risk management activities

Tracking of Required Risk Management Training:

All documentation for completion of required trainings must be submitted using the FTCA Educational Training Tracking Tool. The tool can be downloaded here: FTCA Educational Training Tracking Tool.

Redeeming Application Coverage Date Range:

The 2025-01 PAL covers both FTCA applications requesting initial deeming and an annual FTCA redeeming application for coverage for CY 2026 (January 1, 2026 – December 31, 2026).

Application Submission Dates:

All FTCA deeming applications must be submitted electronically through the FTCA deeming module within the EHBs. The EHBs system will be available to begin receiving CY 2026 deeming applications on February 27, 2025. Each currently deemed entity must submit a redeeming application for itself and any subrecipients (as applicable) by June 27, 2025, to be eligible to be deemed during CY 2026 without a gap in coverage. Health centers should submit their applications well in advance of the deadline if possible.

Overview of the Deeming Application Process

Health center application

The application process and guidance for submitting deeming applications for Federal Tort Claims Act (FTCA) medical malpractice coverage are detailed within Program Assistance Letter (PAL) 2025-01 (PDF - 656 KB).

Initial applications

Health centers may submit an initial deeming application via the electronic, web based EHBs system at any time during the year when the system is open to accept applications. However, it is strongly suggested that grantees request initial FTCA coverage well in advance of their desired coverage start date.

After reviewing the FTCA PAL, grantees submitting an initial deeming application should consult with the FTCA Program with any additional questions. Coverage for initial applicants will begin on the date their application is approved.

Redeeming applications

All currently deemed grantees must submit an FTCA redeeming application and submit redeeming applications for any sub-recipients (as applicable) on or before June 24, 2024, to be eligible to be deemed for the entirety of CY 2025 without a gap in coverage.

Grantees are responsible for ensuring that the information needed to complete their redeeming application has been successfully submitted to HRSA through the EHBs. If additional information or clarification is necessary to support an application, HRSA may notify the grantee through the EHBs. The grantee will be given ten (10) business days from the date of such EHBs notification to resubmit the application with the requested information. Grantees must provide a timely response to all requests for information to assure a timely review and notification. Grantees who do not offer a responsive submission within ten (10) business days after receiving notice may have their application determined incomplete and voided. If the application is voided, the grantee will receive notification and will be required to resubmit its redeeming application if it wishes to obtain deemed status.

Deeming Clinic Pre-Work

Deeming Clinic Pre-Work

Instructions

Note: This mock application activity is for educational and training purposes only. It utilizes fictional application documents and characters inspired by the popular television shows Health Center A and Health Center B. All names, characters, and scenarios used in this activity are purely fictional and do not represent real individuals, organizations, or events. Any resemblance to real people or actual organizations is entirely coincidental. This activity is intended to simulate real-world application scenarios in a controlled and fictional context to enhance learning development.

Scenario Overview:

For this exercise, you will complete a review of mock FTCA deeming applications for two fictional health centers. Health Center A and Health Center B are mid-size health centers that have submitted their 2025 FTCA redeeming applications. Your assistance is needed to finalize the review of the following:

- Risk Management Policy and Procedures Documents
- Annual Health Care Risk Management Training Plan
- Proof of OB Training Completion
- Quarterly Risk Assessments
- Annual Report
- Credentialing and Privileging Policy
- Credentialing and Privileging List
- Claims History

Review each document and complete the review rubric associated with each document.

Review the mock hospitalization tracking policies provided for the elements listed in the table below.

Document your review of each mock application's hospitalization tracking policy in the dark blue columns titled "Pre-Work" by answering each question with the following scale:

- Yes (2 points): All required elements are clearly included
- Almost (1 point): Includes some required elements but lacks sufficient detail in certain areas
- No (0 points): Does not include the required elements or is too unclear to determine if they are included

After reviewing all elements, add the numbers for each element to determine the total and enter the number in the space provided.

Do not use the red columns labeled "Clinic" at this time.

Bookmarking

To bookmark this document, please navigate to the appropriate page , then click the "Bookmarks" icon in the toolbar, and select "New Bookmark" to add a new bookmark with a descriptive name; you can also right-click on the page and choose "Add Bookmark", depending on your software version.

Taking Notes

There are three options for taking notes:

a. Place notes in the “Comments” section of each rubric.

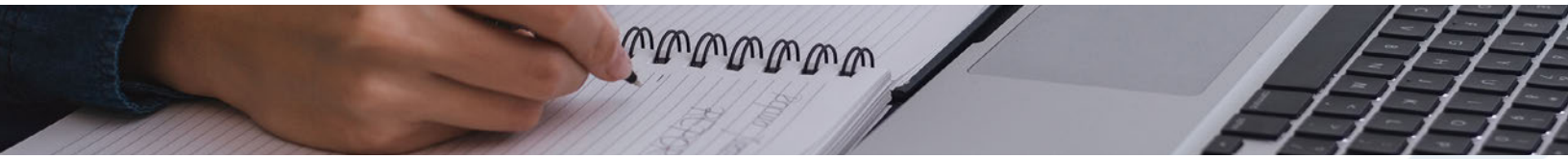
b. Add notes to the pages titled “Notes”

c. Right click on an area and select “Insert Comment”.

The mock deeming applications will be reviewed again during the review sessions of the FTCA Deeming Application Clinic.

Please do not complete the last 2 columns, as those will be used during those sessions.

Referral Tracking Policy



Health centers must have policies and procedures for tracking referrals. Note that the policies must provide HRSA with enough information to understand the procedures and processes that have been implemented within the health center. Failure to provide sufficient details and to address how the health center addresses the key points that comprise these procedures may be viewed as non-compliance with FTCA requirements.

Review

After completing a review of the Referral Tracking Policy, add up the scores for each question to determine the total:

- 8-10 points: The Referral Tracking Policy is comprehensive and ensures effective tracking of referrals.
- 5-7 points: The Referral Tracking Policy is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-4 points: The Referral Tracking Policy does not meet basic requirements for a functional method of tracking.

Resources

FTCA Deeming Application Tracking Policies: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-ta-resource-tracking-policies.pdf

Referral Tracking Policy

Click here to review the Referral Tracking Policy for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Referral Tracking Policy	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Referral Tracking Policy include a system to track all referrals from their origin until they are returned or evaluated by a provider? This system should include the origin of the referral, status of the referral, and the administrative and clinical details of the referral.	**N/A**		**N/A**	
Does the Referral Tracking Policy include processes for follow-up with the referral provider(s) in a timely manner to ensure that information is received back from the referral provider(s)? This includes specific processes and time frames for transmission, receipt, and follow-up of referral results.	**N/A**		**N/A**	
Does the Referral Tracking Policy include identified titles of staff who are responsible for each of the duties throughout the referral process?	**N/A**		**N/A**	
Does the Referral Tracking Policy include processes for documenting all patient referrals in the patient's medical record and for documenting efforts to follow up with patients who miss referral appointments? This includes the number of attempts made to reach the patient and the way those attempts were made (e.g., phone calls, certified letter with delivery confirmation).	**N/A**		**N/A**	
Does the Referral Tracking Policy include approval and signature by the governing board or the individual/committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	**N/A**		**N/A**	
Total	**0**		**0**	

Referral Tracking Policy

Click here to review the Referral Tracking Policy for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
Referral Tracking Policy	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Referral Tracking Policy include a system to track all referrals from their origin until they are returned or evaluated by a provider? This system should include the origin of the referral, status of the referral, and the administrative and clinical details of the referral.	**N/A**		**N/A**	
Does the Referral Tracking Policy include processes for follow-up with the referral provider(s) in a timely manner to ensure that information is received back from the referral provider(s)? This includes specific processes and time frames for transmission, receipt, and follow-up of referral results.	**N/A**		**N/A**	
Does the Referral Tracking Policy include identified titles of staff who are responsible for each of the duties throughout the referral process?	**N/A**		**N/A**	
Does the Referral Tracking Policy include processes for documenting all patient referrals in the patient's medical record and for documenting efforts to follow up with patients who miss referral appointments? This includes the number of attempts made to reach the patient and the way those attempts were made (e.g., phone calls, certified letter with delivery confirmation).	**N/A**		**N/A**	
Does the Referral Tracking Policy include approval and signature by the governing board or the individual/committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Hospitalization Tracking Policy

Health centers must have policies and procedures for tracking hospitalizations, including emergency department (ED) visits. Note that the policies must provide HRSA with enough information to understand the procedures and processes that have been implemented within the health center. Failure to provide sufficient details and to address how the health center addresses the key points that comprise these procedures may be viewed as non-compliance with FTCA requirements.

Review

After completing a review of the Hospitalization Tracking Policy, add up the scores for each question to determine the total:

- 7-8 points: The Hospitalization Tracking Policy is comprehensive and ensures effective tracking of hospitalizations and ED visits.
- 4-6 points: The Hospitalization Tracking Policy is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-3 points: The Hospitalization Tracking Policy does not meet basic requirements for a functional method of tracking.

Resources

FTCA Deeming Application Tracking Policies: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-ta-resource-tracking-policies.pdf

Hospitalization Tracking Policy

Click **here** to review the Hospitalization Tracking Policy for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Hospitalization Tracking Policy include tracking and monitoring system for receiving information regarding hospital or emergency department (ED) admissions? This applies to cases where the health center sends a patient to the ED and where the patient has entered the ED on their own. This system includes: • Patient information • Date of admission or visit • Date of notification • Reason for visit (if known) • Documentation received • Documentation requested (including date requested) • Follow-up initiated with the hospital and/or patient (including date initiated)	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include identified staff members, by title, who are responsible for receiving ED and hospital admission information and monitoring the mechanism that is used for receiving hospital and ED admission information?	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include a mechanism for follow-up with the patient, provider, or outside facility to request pertinent medical information (e.g., diagnostic studies, discharge summary) related to a hospital or ED visit?	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include approval and signature by the governing board or the individual/ committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	**N/A**		**N/A**	
Total	**0**		**0**	

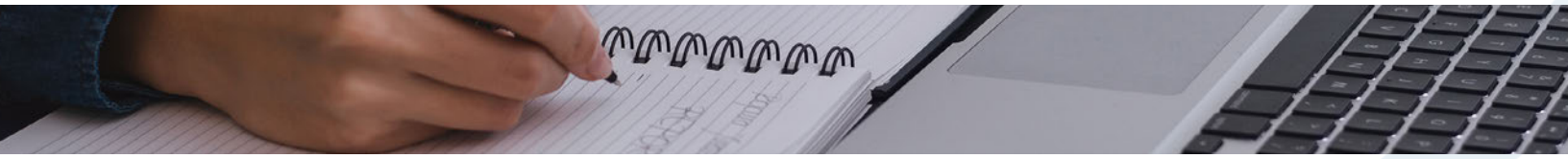
Hospitalization Tracking Policy

Click **here** to review the Hospitalization Tracking Policy for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Hospitalization Tracking Policy include tracking and monitoring system for receiving information regarding hospital or emergency department (ED) admissions? This applies to cases where the health center sends a patient to the ED and where the patient has entered the ED on their own. This system includes: • Patient information • Date of notification • Documentation received • Documentation requested (including date requested) • Follow-up initiated with the hospital and/or patient (including date initiated) • Date of admission or visit • Reason for visit (if known)	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include identified staff members, by title, who are responsible for receiving ED and hospital admission information and monitoring the mechanism that is used for receiving hospital and ED admission information?	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include a mechanism for follow-up with the patient, provider, or outside facility to request pertinent medical information (e.g., diagnostic studies, discharge summary) related to a hospital or ED visit?	**N/A**		**N/A**	
Does the Hospitalization Tracking Policy include approval and signature by the governing board or the individual/ committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Diagnostic Tracking Policy



Health centers must have policies and procedures for tracking diagnostic tests and their results. Note that the policies must provide HRSA with enough information to understand the procedures and processes that have been implemented within the health center. Failure to provide sufficient details and to address how the health center addresses the key points that comprise these procedures may be viewed as non-compliance with FTCA requirements.

Review

After completing a review of the Diagnostic Tracking Policy, add up the scores for each question to determine the total:

- 10-12 points: The Diagnostic Tracking Policy is comprehensive and ensures effective tracking of ordered diagnostic tests and their results.
- 6-9 points: The Diagnostic Tracking Policy is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-5 points: The Diagnostic Tracking Policy does not meet basic requirements for a functional method of tracking.

Resources

FTCA Deeming Application Tracking Policies: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-ta-resource-tracking-policies.pdf.

Diagnostic Tracking Policy (1 of 2)

Click **here** to review the Diagnostic Tracking Policy for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Diagnostic Tracking Policy	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Diagnostic Tracking Policy include a tracking and monitoring system for all diagnostic tests? This should include, at a minimum: • Patient information • Ordering provider • Date results were received • Provider who reviewed the results • Communication of results to the patient, including unsuccessful communication attempts and follow-up • Date test was ordered • List of tests ordered • Follow-up recommended by provider	**N/A**		**N/A**	
Does the Diagnostic Tracking Policy include agreements with lab vendors that clearly define "critical lab values" and processes for contacting the health center providers? If the health center provides on-site lab services, the policy speaks to the lab policies and procedures, clearly defining "critical lab values" and notification procedures.	**N/A**		**N/A**	
Does the Diagnostic Tracking Policy include the following for critical test results? • Time frame for communication of results to providers • Acceptable means of communication to provider and patient (e.g., verbal contact only) • Procedures for contacting back-up or surrogate providers if the ordering provider is not immediately available to receive results • Procedures for making every effort to contact the patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact the patient • Tracking critical lab results, monitoring to ensure no problems arise, and audits reported to QI/QA committee as part of the program	**N/A**		**N/A**	

Diagnostic Tracking Policy (2 of 2)

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	Comments	Review: 2= Yes 1 = Almost 0 = No	Comments
Does the Diagnostic Tracking Policy include the following for abnormal tests? • Acceptable means of communication to provider and patient (e.g., verbal, electronic) • Time frame for communicating results to the patient (e.g., not to exceed 14 days) • Efforts made to contact the patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact the patient (notification should include more than just a certified letter)	N/A		N/A	
Does the Diagnostic Tracking Policy include assigned responsibility for documenting all pertinent diagnostic tracking activities and maintaining documentation as part of the patient's medical record? Documentation should include the following: • Acknowledgment of receipt of result • Actions taken related to the patient • Patient notification, including date and time of notification, means used to communicate results (e.g., phone call, letter), and person spoken to (if applicable) • All attempts to contact the patient if the patient cannot be reached • Other clinical information as appropriate	N/A		N/A	
Does the Diagnostic Tracking Policy include approval and signature by the governing board or the individual/committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	N/A		N/A	
Total	0		0	

Diagnostic Tracking Policy (1 of 2)

Click **here** to review the Diagnostic Tracking Policy for **Health Center B**. Document your findings in the chart below:

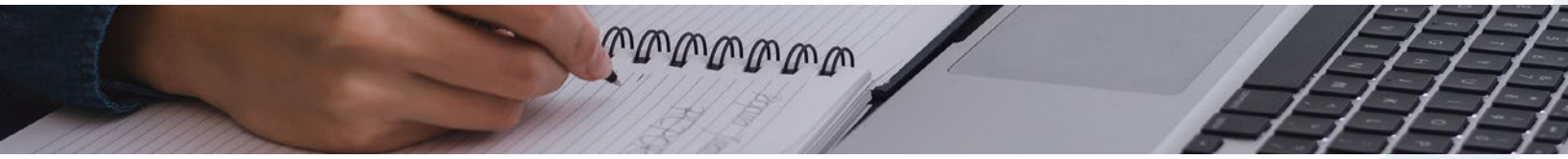
	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Diagnostic Tracking Policy include a tracking and monitoring system for all diagnostic tests? This should include, at a minimum: • Patient information • Ordering provider • Date results were received • Provider who reviewed the results • Communication of results to the patient, including unsuccessful communication attempts and follow-up • Date test was ordered • List of tests ordered • Follow-up recommended by provider	**N/A**		**N/A**	
Does the Diagnostic Tracking Policy include agreements with lab vendors that clearly define "critical lab values" and processes for contacting the health center providers? If the health center provides on-site lab services, the policy speaks to the lab policies and procedures, clearly defining "critical lab values" and notification procedures.	**N/A**		**N/A**	
Does the Diagnostic Tracking Policy include the following for critical test results? • Time frame for communication of results to providers • Acceptable means of communication to provider and patient (e.g., verbal contact only) • Procedures for contacting back-up or surrogate providers if the ordering provider is not immediately available to receive results • Procedures for making every effort to contact the patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact the patient • Tracking critical lab results, monitoring to ensure no problems arise, and audits reported to QI/QA committee as part of the program	**N/A**		**N/A**	

Diagnostic Tracking Policy (2 of 2)

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	Comments	Review: 2= Yes 1 = Almost 0 = No	Comments
Does the Diagnostic Tracking Policy include the following for abnormal tests? • Acceptable means of communication to provider and patient (e.g., verbal, electronic) • Time frame for communicating results to the patient (e.g., not to exceed 14 days) • Efforts made to contact the patient for follow-up (e.g., visiting shelter, enlisting help from authorities) • Documentation of successful and unsuccessful attempts to contact the patient (notification should include more than just a certified letter)	N/A		N/A	
Does the Diagnostic Tracking Policy include assigned responsibility for documenting all pertinent diagnostic tracking activities and maintaining documentation as part of the patient's medical record? Documentation should include the following: • Acknowledgment of receipt of result • Actions taken related to the patient • Patient notification, including date and time of notification, means used to communicate results (e.g., phone call, letter), and person spoken to (if applicable) • All attempts to contact the patient if the patient cannot be reached • Other clinical information as appropriate	N/A		N/A	
Does the Diagnostic Tracking Policy include approval and signature by the governing board or the individual/committee designed by the board for approval (see Health Center Program Compliance Manual Chapter 19: Board Authority)?	N/A		N/A	
Total	0		0	

Notes

Risk Management Training Plan



Health centers are required to develop and implement a written risk management training plan each year. This plan must:

Specify that all providers and staff at the health center will participate in risk management training.

Clearly outline the topics to be covered in the training programs.

Include detailed procedures for tracking and documenting the completion of training for all providers and staff.

Important Note: Obstetrics training must include training for all clinical staff, including licensed independent practitioners (LIPs), other licensed or certified practitioners (OLCPs), and other clinical staff (OCS).

Review

After completing a review of the Risk Management Training Plan, add up the scores for each question to determine the total:

- 10-12 points: The Risk Management Training Plan is a comprehensive and effective plan for completing required trainings.
- 6-9 points: The Risk Management Training Plan is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-5 points: The Risk Management Training Plan does not meet basic requirements for a functional training plan.

Resources

FTCA Compliance Tool: Risk Management Training Plan: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-compliance-tool-risk-management-training-plan.pdf.

Risk Management Training Plan

Click **here** to review the Risk Management Training Plan for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Risk Management Training Plan	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Risk Management Training Plan include start and completion dates that fall within the timeframe of January 1, 2024, to December 31, 2024? Note: Training dates outside of this timeframe will not be accepted..	**N/A**		**N/A**	
Does the Risk Management Training Plan include the following required training topics? • HIPAA • Infection Control • OB • Areas of High Risk	**N/A**		**N/A**	
Does the Risk Management Training Plan include a clear and comprehensive overview with enough detailed information to fully understand how the training was conducted?	**N/A**		**N/A**	
Does the Risk Management Training Plan include the following details for each listed training? • Title of Training • Brief Description of the Training • Topic Area • Start and Completion Dates	**N/A**		**N/A**	
Does the Risk Management Training Plan include training requirements for all clinical staff, including Licensed Independent Practitioners (LIPs), Other Licensed or Certified Practitioners (OLCPs), and Other Clinical Staff (OCS), as well as non-clinical staff?	**N/A**		**N/A**	
Does the Risk Management Training Plan include an OB training requirement for ALL clinical staff (LIP, OLCP, OCS)?	**N/A**		**N/A**	
Total	**0**		**0**	

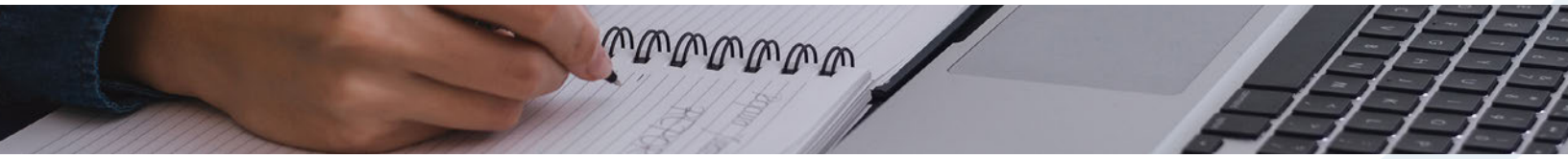
Risk Management Training Plan

Click **here** to review the Risk Management Training Plan for **Health Center B**. Document your findings in the chart below:

Risk Management Training Plan	Review: 2= Yes 1 = Almost 0 = No	Comments	Review: 2= Yes 1 = Almost 0 = No	Comments
Does the Risk Management Training Plan include start and completion dates that fall within the timeframe of January 1, 2024, to December 31, 2024? Note: Training dates outside of this timeframe will not be accepted..	N/A	test	N/A	
Does the Risk Management Training Plan include the following required training topics? • HIPAA • Infection Control • OB • Areas of High Risk	N/A		N/A	
Does the Risk Management Training Plan include a clear and comprehensive overview with enough detailed information to fully understand how the training was conducted?	N/A		N/A	
Does the Risk Management Training Plan include the following details for each listed training? • Title of Training • Brief Description of the Training • Topic Area • Start and Completion Dates	N/A		N/A	
Does the Risk Management Training Plan include training requirements for all clinical staff, including Licensed Independent Practitioners (LIPs), Other Licensed or Certified Practitioners (OLCPs), and Other Clinical Staff (OCS), as well as non-clinical staff?	N/A		N/A	
Does the Risk Management Training Plan include an OB training requirement for ALL clinical staff (LIP, OLCP, OCS)?	N/A		N/A	
Total	0		0	

Notes

OB Training Documentation



Health centers must include obstetrical (OB) training as part of their annual risk management training plan for all clinical staff, including Licensed Independent Practitioners (LIPs), Other Licensed or Certified Practitioners (OLCPs), and Other Clinical Staff (OCS), who have contact with prenatal patients, postpartum patients, and individuals of reproductive age. The OB training requirement applies even if the health center does not provide labor and delivery services.

Important Notes:

- OB training is mandatory for all clinical staff (LIPs, OLCPs, OCS).
- OB training for non-clinical staff is optional. Non-clinical staff should only be included if the center has determined they are required to complete OB training because of clinically related contact with patients of reproductive age.
- Names on the FTCA Educational Training Tracking Form must match those on the Credentialing and Privileging List.

Review

After completing a review of the OB Training Documentation, add up the scores for each question to determine the total:

- 7-8 points: The OB Training Documentation is a comprehensive and effective method for documenting completed trainings.
- 4-6 points: The OB Training Documentation is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-3 points: The OB Training Documentation does not meet basic requirements for functional training documentation.

OB Training Documentation

Click **here** to review the OB Training Documentation for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the OB Training Documentation demonstrate dates of Completion within the period of January 1, 2024 – December 31, 2024? Note: Dates outside of this timeframe will not be accepted.	**N/A**		**N/A**	
Does the OB Training Documentation demonstrate completed fields for the following: • Title of Training • Brief Description of Training • Topic Area • Date Training Initially Offered	**N/A**		**N/A**	
Does the OB Training Documentation demonstrate completion of OB training by all clinical staff, including LIPs, OLPS, and OCS?	**N/A**		**N/A**	
Does the OB Training Documentation demonstrate alignment of the clinical staff listed on the FTCA Educational Training Tracking Tool with those on the Credentialing and Privileging List? Click here to view the Credentialing and Privileging List for St. Elsewhere.	**N/A**		**N/A**	
Total	**0**		**0**	

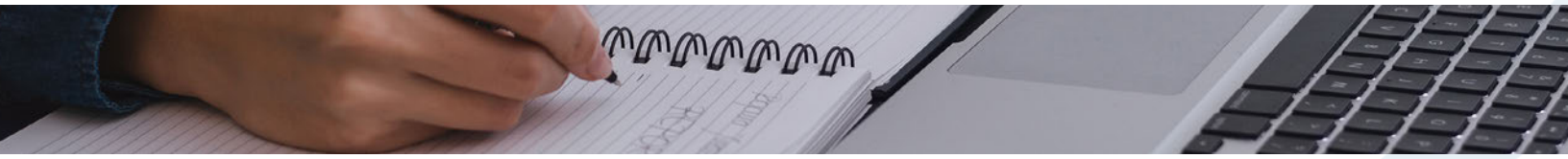
OB Training Documentation

Click **here** to review the OB Training Documentation for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
	Review: 2= Yes 1 = Almost 0 = No	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the OB Training Documentation demonstrate dates of Completion within the period of January 1, 2024 – December 31, 2024? Note: Dates outside of this timeframe will not be accepted.	**N/A**		**N/A**	
Does the OB Training Documentation demonstrate completed fields for the following: • Title of Training • Brief Description of Training • Topic Area • Date Training Initially Offered	**N/A**		**N/A**	
Does the OB Training Documentation demonstrate completion of OB training by all clinical staff, including LIPs, OLPS, and OCS?	**0**		**N/A**	
Does the OB Training Documentation demonstrate alignment of the clinical staff listed on the FTCA Educational Training Tracking Tool with those on the Credentialing and Privileging List? Click here to view the Credentialing and Privileging List for St. Elsewhere	**0**		**N/A**	
Total	**0**		**0**	

Notes

Quarterly Risk Assessments



Health centers are required to complete four comprehensive quarterly risk assessments and associated action plans for each calendar quarter within each calendar year. Each quarterly assessment (for example, a completed tool or checklist with detailed information, outcomes, and follow-up actions) must demonstrate that the health center has conducted a comprehensive review of activities and risks for that period.

Important Note: A complete risk assessment includes several steps. While a tool may be used to guide the process, simply submitting a tool is not sufficient for a complete risk assessment.

Review

After completing a review of the Quarterly Risk Assessments, add up the scores for each question to determine the total:

- 14-16 points: The Quarterly Risk Assessments are a comprehensive and effective method for assessing and communicating risk.
- 8-13 points: The Quarterly Risk Assessments are adequate but could benefit from additional clarity or detail in one or more areas.
- 0-7 points: The Quarterly Risk Assessments do not meet basic requirements for functional risk assessments.

Resources

FTCA Deeming Application Step-by-step guide: https://members.ecri.org/assets/document/the-federal-tort-claims-act-ftca-deeming-application-a-step-by-step-guide-f (please log in to the ECRI website at www.ecri.org to access the Guide).

Quarterly Risk Assessments

Click the below links to review the Quarterly Risk Assessments for **Health Center A**. Document your findings in the chart below.

Quarter 1 Quarter 2 Quarter 3 Quarter 4

	Pre-Work		Clinic	
Quarterly Risk Assessment	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Are four Quarterly Risk Assessments included? • Quarter 1: January 1, 2024 - March 31, 2024 • Quarter 2: April 1, 2024 - June 30, 2024 • Quarter 3: July 1, 2024 - September 30, 2024 • Quarter 4: October 1, 2024 – December 31, 2024	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 1 focus on a clinical or patient safety-related process?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 2 provide identification, analysis, and evaluation of potential hazards?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 2 demonstrate prioritization of areas needing improvement?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 3 demonstrate an action plan with identified steps to mitigate the risks?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 3 demonstrate SMART goals for improvement as part of the action plan?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 4 demonstrate measured outcomes to evaluate the effectiveness of the action plan?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 4 demonstrate progress documented in a way that can be shared with the governing board and/or key stakeholders?	**N/A**		**N/A**	
Total	**0**		**0**	

Quarterly Risk Assessments

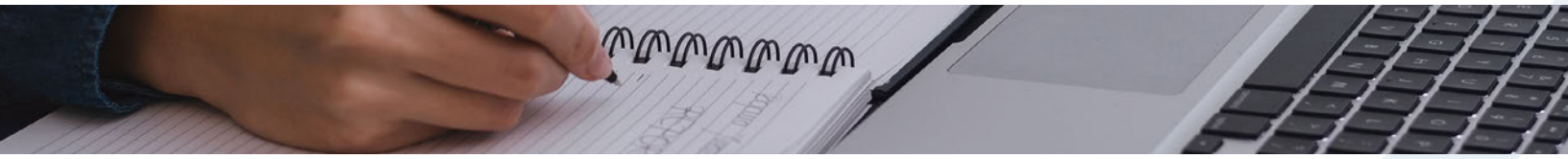
Click the below links to review the Quarterly Risk Assessments for **Health Center B**. Document your findings in the chart below.

Quarter 1 Quarter 2 Quarter 3 Quarter 4

	Pre-Work		Clinic	
Quarterly Risk Assessment	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Are four Quarterly Risk Assessments included? • Quarter 1: January 1, 2024 - March 31, 2024 • Quarter 2: April 1, 2024 - June 30, 2024 • Quarter 3: July 1, 2024 - September 30, 2024 • Quarter 4: October 1, 2024 – December 31, 2024	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 1 focus on a clinical or patient safety-related process?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 2 provide identification, analysis, and evaluation of potential hazards?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 2 demonstrate prioritization of areas needing improvement?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 3 demonstrate an action plan with identified steps to mitigate the risks?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 3 demonstrate SMART goals for improvement as part of the action plan?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 4 demonstrate measured outcomes to evaluate the effectiveness of the action plan?	**N/A**		**N/A**	
Does the Quarterly Risk Assessment for quarter 4 demonstrate progress documented in a way that can be shared with the governing board and/or key stakeholders?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Annual Report to the Board



Health centers must report to the board and key management staff on health care risk management activities and progress meeting goals at least annually. The format of the report may vary, however, health centers must ensure that all FTCA-required criteria are met.

Review

After completing a review of the Annual Report to the Board, add up the scores for each question to determine the total:

- 8-10 points: The Annual Report to the Board is a comprehensive and effective method for reporting risk management activities to the board.
- 5-7 points: The Annual Report to the Board is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-4 points: The Annual Report to the Board does not meet basic requirements for functional reporting to the board.

Resource

FTCA Compliance Tool: Risk Management Annual Report to Board: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/ftca-compliance-tool-risk-management-annual-report.pdf.

Annual Report to the Board

Click **here** to review the Annual Report to the Board for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Annual Report to the Board	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Annual Report to the Board demonstrate completed clinical risk management activities conducted by the health center (e.g., quarterly risk assessments, risk management projects) from January 1, 2024, to December 30, 2024?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the status of the health center's progress related to established annual risk management goals? This should include data trends and analysis regarding topics including, but not limited to: sentinel events, adverse events, near misses, falls, wait times, patient satisfaction information, trainings completed, and other clinical risk management data points selected by the health center.).	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate proposed risk management activities that relate and/or respond to identified areas of high organizational risk as determined from the data presented?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the date when the report was presented to the board?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the date the report was approved by the board?	**N/A**		**N/A**	
Total	**0**		**0**	

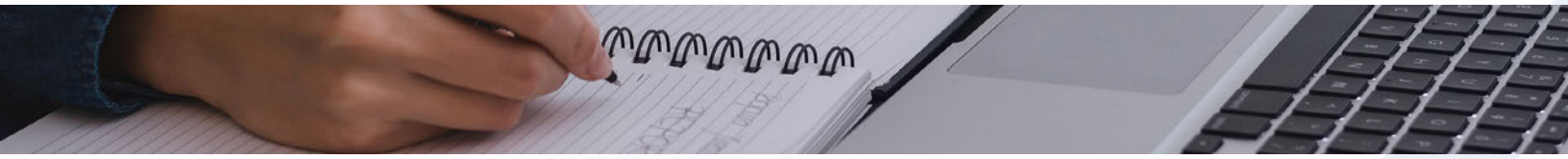
Annual Report to the Board

Click **here** to review the Annual Report to the Board for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
Annual Report to the Board	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Annual Report to the Board demonstrate completed clinical risk management activities conducted by the health center (e.g., quarterly risk assessments, risk management projects) from January 1, 2024, to December 30, 2024?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the status of the health center's progress related to established annual risk management goals? This should include data trends and analysis regarding topics including, but not limited to: sentinel events, adverse events, near misses, falls, wait times, patient satisfaction information, trainings completed, and other clinical risk management data points selected by the health center.).	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate proposed risk management activities that relate and/or respond to identified areas of high organizational risk as determined from the data presented?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the date when the report was presented to the board?	**N/A**		**N/A**	
Does the Annual Report to the Board demonstrate the date the report was approved by the board?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Credentialing and Privileging (C&P) Operating Procedures for All Clinical Staff Members



All health centers must have written policies and operating procedures that outline the process for credentialing and privileging all clinical staff members, including processes for initial and recurring review of credentials and initial review and approval of privileges as well as re-privileging on an ongoing basis.

Credentialing Policy and Procedures:

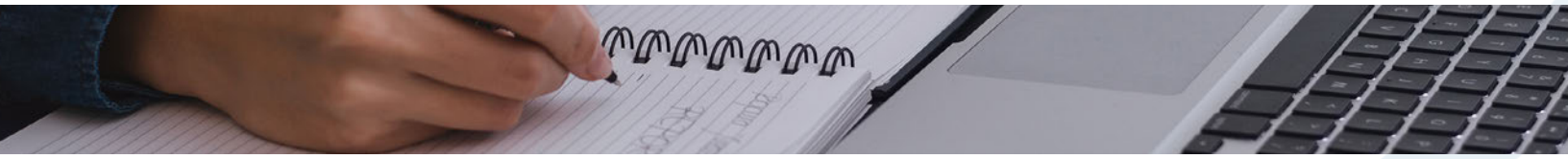
- Health centers' written policies and operating procedures must outline the processes for credentialing all clinical staff members. The requirement includes any clinical staff member in the health center, including providers, nurses, pharmacists, dentists, social workers, community health workers, medical and dental assistants, medical residents, students, volunteers, and other clinical staff.

Privileging Policy and Procedures:

- Health centers' must have written procedures that outline the processes for granting and reviewing privileges for all clinical staff. When a healthcare provider initially applies for a position in the health center, they will request privileges for specific procedures and services they perform (e.g., removing skin lesions performing gynecological services) and specific populations for who they will provide care (e.g., obstetrics patients, infants).

- The written privileging procedures that outline the process must be on an ongoing basis and must include the verification of each professional's current clinical competence for the delineated scope and content of patient services, fitness for duty, immunization, and communicable disease status.

Important Note: The use of temporary credentialing and privileging is determined by HRSA on a case-by-case basis to support healthcare professionals, including volunteers, in responding to certain declared public health emergencies and extraordinary circumstances affecting the health center's population or community at large.



Review

After completing a review of the C&P Operating Procedures, add up the scores for each question to determine the total:

- 18-22 points: The C&P Operating Procedures are a comprehensive and adequate method for outlining C&P processes.
- 11-17 points: The C&P Operating Procedures are adequate but could benefit from additional clarity or detail in one or more areas.
- 0-10 points: The C&P Operating Procedures do not meet basic requirements for establishing C&P processes.

Resources:

Program Assistance Letter 2024-01: PAL 2024-01: Temporary Privileging of Clinical Providers by Deemed Public Health Service Employee Health Centers Impacted by Certain Declared Emergencies of Other Emergency Situations

FTCA Compliance Tool: Credentialing and Privileging Process (PDF): https://bphc.hrsa.gov/compliance/compliance-manual/chapter5

Credentialing and Privileging Policy and Procedures (1 of 2)

Click **here** to review the Credentialing and Privileging Operating Procedures for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Credentialing and Privileging Policy and Procedures:	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Do the Credentialing and Privileging Operating Procedures include requirements for the initial and recurring review of credentials and the initial granting and renewal of privileges for all clinical staff including those listed below? • Licensed independent practitioners (LIPs) • Other licensed or certified practitioners (OLCPs) • Other clinical staff (OCS)	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include primary source verification of current licensure, registration, and certification for all clinical staff?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of education and training using the following: • Primary sources for LIPs • Primary or other sources for OLCPs and OCS	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include completion of query through the National Practitioner Data Bank (NPDB)?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of the professional's identity using government-issued picture identification for initial credentialing?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of Drug Enforcement Administration (DEA) registration when applicable?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of current basic life support (BLS) training?	**N/A**		**N/A**	

Credentialing and Privileging Policy and Procedures (2 of 2)

Click **here** to review the Credentialing and Privileging Operating Procedures for **Health Center A**. Document your findings in the chart below:

	Pre-Work		Clinic	
Credentialing and Privileging Policy and Procedures:	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Do the Credentialing and Privileging Operating Procedures include verification of fitness for duty, including communicable disease status?	N/A		N/A	
Do the Credentialing and Privileging Operating Procedures include verification of current clinical competence?	N/A		N/A	
Do the Credentialing and Privileging Operating Procedures include a process for denying, modifying, or removing privileges?	0		N/A	
Do the Credentialing and Privileging Operating Procedures include temporary credentialing and privileging language that aligns with the PAL 2024-01?	N/A		N/A	
Total	0		0	

Credentialing and Privileging Policy and Procedures (1 of 2)

Click **here** to review the Credentialing and Privileging Operating Procedures for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
Credentialing and Privileging Policy and Procedures:	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Do the Credentialing and Privileging Operating Procedures include requirements for the initial and recurring review of credentials and the initial granting and renewal of privileges for all clinical staff including those listed below? • Licensed independent practitioners (LIPs) • Other licensed or certified practitioners (OLCPs) • Other clinical staff (OCS)	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include primary source verification of current licensure, registration, and certification for all clinical staff?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of education and training using the following: • Primary sources for LIPs • Primary or other sources for OLCPs and OCS	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include completion of query through the National Practitioner Data Bank (NPDB)?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of the professional's identity using government-issued picture identification for initial credentialing?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of Drug Enforcement Administration (DEA) registration when applicable?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of current basic life support (BLS) training?	**N/A**		**N/A**	

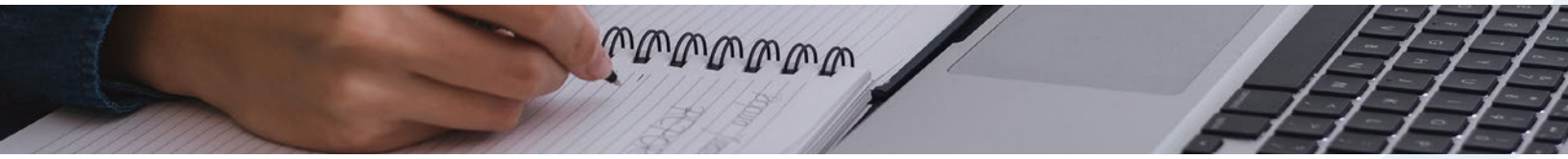
Credentialing and Privileging Policy and Procedures (2 of 2)

Click **here** to review the Credentialing and Privileging Operating Procedures for **Health Center B**. Document your findings in the chart below:

	Pre-Work		Clinic	
Credentialing and Privileging Policy and Procedures:	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Do the Credentialing and Privileging Operating Procedures include verification of fitness for duty, including communicable disease status?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include verification of current clinical competence?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include a process for denying, modifying, or removing privileges?	**N/A**		**N/A**	
Do the Credentialing and Privileging Operating Procedures include temporary credentialing and privileging language that aligns with the PAL 2024-01?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Credentialing and Privileging (C&P) List



Health centers must enter all clinical staff credentialing and privileging information directly into the application form via the EHBs system. The health centers must maintain a complete Credentialing and Privileging List in the application form confirming that the most recent dates for renewal of credentials and privileges occurred within two years before the application date.

Important Notes:

- All credentialing and privileging dates must be within two years of the date of application submission.
- All clinic staff who are currently active (including employed staff, contractors, volunteers, and locum tenens providers) must be entered into the credentialing and privileging list in EHBs.

Review

After completing a review of the Credentialing and Privileging List, add up the scores for each question to determine the total:

- 5-6 points: The C&P List is a comprehensive and effective method for tracking and reporting credentialing and privileging of staff.
- 3-4 points: The C&P List is adequate but could benefit from additional clarity or detail in one or more areas.
- 0-2 points: The C&P List does not meet basic requirements for functional tracking of C&P activities.

Resources

Health Centers Quick Reference Guide for Completing the FTCA Credentialing and Privileging List in EHB (PDF)

Credentialing and Privileging Lists

Click **here** to review the Credentialing and Privileging Lists for **Health Center A**. Document your findings in the chart below.

	Pre-Work		Clinic	
Credentialing and Privileging Lists	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Credentialing and Privileging List demonstrate credentialing of all clinical staff within two years of the application submission date? Note: Cross-check the date the application was submitted and the C&P dates entered for each staff member in the C&P list	**N/A**		**N/A**	
Does the Credentialing and Privileging List demonstrate privileging of all clinical staff within two years of the application submission date? Note: Cross-check the date the application was submitted and the C&P dates entered for each staff member in the C&P list.	**0**		**N/A**	
Does the Credentialing and Privileging List demonstrate alignment with the clinical staff documented on the FTCA Educational Training Tracking Tool as having completed OB training?	**N/A**		**N/A**	
Total	**0**		**0**	

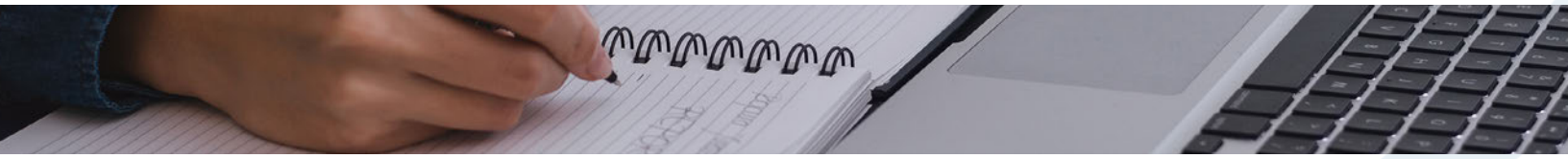
Credentialing and Privileging Lists

Click **here** to review the Credentialing and Privileging Lists for **Health Center B**. Document your findings in the chart below.

	Pre-Work		Clinic	
Credentialing and Privileging Lists	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the Credentialing and Privileging List demonstrate credentialing of all clinical staff within two years of the application submission date? Note: Cross-check the date the application was submitted and the C&P dates entered for each staff member in the C&P list	**N/A**		**N/A**	
Does the Credentialing and Privileging List demonstrate privileging of all clinical staff within two years of the application submission date? Note: Cross-check the date the application was submitted and the C&P dates entered for each staff member in the C&P list.	**N/A**		**N/A**	
Does the Credentialing and Privileging List demonstrate alignment with the clinical staff documented on the FTCA Educational Training Tracking Tool as having completed OB training?	**N/A**		**N/A**	
Total	**0**		**0**	

Notes

Claims History



This program requirement only applies to health centers who have had a medical malpractice claim or allegation within the past five years from the date of application submission. If a health center has had a medical malpractice claim or allegation within the past five years from the date of application submission, they must attach a document that lists all claims filed during that period.

Review

After completing a review of the Claims History, add up the scores for each question to determine the total:

- 2 points: The Claims History is a comprehensive list of previous claims, analysis of each claim, and steps to mitigate future claims.
- 1 point: The Claims History is adequate but could benefit from additional clarity or detail.
- 0 points: The Claims History does not meet basic requirements for reporting the history of claims.

Claims History

Click **here** to review the Claims History for **Health Center A**. Document your findings in the chart below.

	Pre-Work		Clinic	
Claims History	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the FTCA Claims History include the general facts of the incident including the name of the providers, etc.? Note: A copy of the NPDB report should not be in this section.	N/A		N/A	
Does the FTCA Claims History include a summary of the review and investigation of the claim?	N/A		N/A	
Does the FTCA Claims History include a summary of all mitigation steps and actions that were taken and will be taken?	N/A		N/A	
Total	0		0	

Claims History

Click **here** to review the Claims History for **Health Center B**. Document your findings in the chart below.

	Pre-Work		Clinic	
Claims History	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**	**Review: 2= Yes 1 = Almost 0 = No**	**Comments**
Does the FTCA Claims History include the general facts of the incident including the name of the providers, etc.? Note: A copy of the NPDB report should not be in this section.	**N/A**		**N/A**	
Does the FTCA Claims History include a summary of the review and investigation of the claim?	**N/A**		**N/A**	
Does the FTCA Claims History include a summary of all mitigation steps and actions that were taken and will be taken?	**N/A**	Notes	**N/A**	
Total	**0**		**0**	

Notes

Notes

Notes

Glossary of FTCA-Specific Terms

Initial Deeming Applications – Applications submitted by first-time organizations looking to become part of the FTCA program and accepted on a rolling basis.

Redeeming (Annual) Applications - Applications submitted by health centers who are already deemed and part of the program.

Supplemental - Applications submitted for coverage for new individuals outside of an initial or redeeming application and can be submitted throughout the year.

Compliance Notice - A legal document that provides health centers with a chance to correct their application in order to be deemed (similar to re-applying with an updated application).

Entity - Health Center Program award recipient or subrecipient.

BPHC - Bureau of Primary Health Care

C&P – Credentialing and Privileging

CAP - Compliance Action Plan

CM – Claims Management

DHHS - United States Department of Health and Human Services

EHBs - Electronic Handbooks

FAP - FTCA Action Plan

FTCA - Federal Tort Claims Act

HIPAA - Health Insurance Portability and Accountability Act of 1996

HRSA - Health Resources and Services Administration

NDA - Notice of Deeming Award

PAL - Program Assistance Letter

POM - Program Oversight Module

RM – Risk Management

SOP - Standard Operating Procedure

QI/QA - Quality Improvement/Quality Assurance

Health Center A	**ORIGINAL DATE:** April 28, 2016 **LATEST REVISION DATE:** November 8, 2024
SUBJECT: Referral Tracking Procedure	**APPLICABLE TO:** Clinical Staff, Care Coordinators

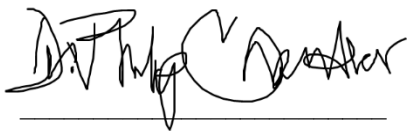
PURPOSE:

To ensure all referrals are tracked and documented.

Step	Process
1) External Referrals	1) When the needs of the patient are outside the scope of the services provided by Health Center A, the clinical staff member refers the patient to the appropriate external provider. 2) The clinical staff member discusses the referral with the patient and enters the referral in the designated system. The referral should include the patient's name, DOB, date of the referral, relevant information regarding the patient's medical condition, reason for referral, current assessment, and treatment/services requested. 3) The Care Coordinator schedules an appointment with the external provider. 4) The Care Coordinator notifies the patient of the appointment date and time. 5) The Care Coordinator files a copy of the referral form, notes, or other documentation about the status or outcome of the referred service in the designated system upon receipt. 6) The Care Coordinator tracks the status of the referral in the designated system until completed. 7) The Care Coordinator follows up with the referral provider within 3 business days of the scheduled appointment. (See "Documentation/Tracking of all Referrals")
2) Community Resource Referrals	1) When the needs of the patient require non-clinical support, the patient is referred to community resources. 2) The patient is given a copy of the referral form, which contains the contact information for the community resource. 3) The Care Coordinator files a copy of the referral form, notes, or other documentation about the status or outcome of the referred service in the designated system upon receipt. 4) Community resource referrals are reviewed at each clinical appointment, including past referrals, utilization of referrals, and the need for any additional referrals.

	6) The Care Coordinator tracks the status of the referral in the designated system until completed (See "Documentation/Tracking of all Referrals")
5) Documentation/Tracking of all Referrals	1) All referrals are documented electronically in the designated system. a. A copy of the referral and consult report is maintained in the patient's electronic health record (EHR). 2) Referrals are tracked by the Care Coordinator until completed. a. Completed is defined as the care or service was received or all communication attempts with the provider and/or patient have been exhausted, yet the care or service was not received. 3) The Care Coordinator makes documented efforts to follow up with patients who miss referral appointments. a. First attempt: within 72 hours of a missed appointment, the patient is contacted via phone. b. Second attempt: 5-7 days of a missed appointment, the patient is contacted via phone. c. Third attempt: 10-12 days of a missed appointment, the patient is contacted via written notification sent with electronic delivery confirmation receipt. d. All three attempts will be documented in the EHR. 4) The Care Coordinator reviews all open referrals daily. The Care Coordinator will close the referral upon: a. Receipt of verification that the referral appointment was completed. Verification must include a referral report from the referral provider. The referral report will be filed in the patient's EHR. The referral report will also be sent to the clinical staff member to ensure clinical follow-up. b. Verification that a patient who has missed their referral received three attempts at contact, including two verbal and one written per Health Center A policy.

APPROVAL:



Dr. Philip Chandler, Board President

07/28/2025

Date

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Health Center A	**ORIGINAL DATE:** April 28, 2016 **LATEST REVISION DATE:** July 28, 2024
SUBJECT: Hospitalization Tracking Procedure	**APPLICABLE TO:** Clinical Staff, Care Coordinators

POLICY:

The purpose of this policy is to ensure all Health Center A patients who have been hospitalized or recently treated at the Emergency Department (ED) receive a timely follow-up visit to ensure continuity of care.

Clinicians should also ask patients at the beginning of each visit whether they have had a hospital admission or emergency department visit since their last health center appointment.

Nursing staff - Additionally, the nursing staff shall ask patients during the triage process (document in social history) whether they have been hospitalized or evaluated by an emergency department since their last visit

PROCEDURE:

Step	Process
1) ED/Hospital Visit Follow Up	1) Support staff will track all Health Center A patients that have used any hospital ER/inpatient services daily via the designated tracking system. 2) Support staff will obtain all medical records including the hospitalization summary, all consult reports, and all labs and diagnostic results related to the hospitalization or ED visit. All relevant documentation will be maintained in the patient's EHR. 3) Support staff will call all Health Center A patients that utilized hospital services to schedule a continuity of care visit with the patient's primary care provider. 4) Patients will be scheduled with their primary care provider within 48-72 hours of hospital discharge. 5) In the event of urgent need, patients needing a follow-up continuity of care visit with their primary care provider will be seen as an "open- access/walk-in" visit or will be sent to a local urgent care clinic. 6) If not already received via electronic communication, the medical assistant or nurse will contact the hospital for the hospital stay or visit documentation including the results of all laboratory, radiology, and diagnostic testing. All these records will be maintained in the patient's electronic health record. 7) If a patient does not keep their follow-up visit, Health Center A support staff (center receptionist, nurse or medical assistant) will attempt to contact the patient via telephone or mail to reschedule a follow-up appointment. The patient's primary care provider will be informed of all missed follow-up appointments. 8) All information and follow-up are to be documented in the patient's electronic health record and tracked for follow-up via the task list/orders tracking

3) Internal Referrals	1) When the patient requires assistance from a specialty provider within Health Center A, such as Dental Care, OB/GYN, or Social Work, an internal referral is made. 2) The clinical staff member discusses the referral with the patient and enters the referral in the designated system. The referral should include the patient's name, DOB, date of the referral, relevant information regarding the patient's medical condition, reason for referral, current assessment, and treatment/services requested. 3) The Care Coordinator schedules an appointment with the internal provider. 4) The Care Coordinator notifies the patient of the appointment date and time. 5) The Care Coordinator files a copy of the referral form, notes, or other documentation about the status or outcome of the referred service in the designated system upon receipt. 6) The Care Coordinator tracks the status of the referral in the designated system until completed. 7) The Care Coordinator follows up with the referral provider within 1 business day of the scheduled appointment. (See “Documentation/Tracking of all Referrals”)
4) Behavioral Health Referrals	1) When the needs of the patient require mental health services, the patient is referred to a Behavioral Health provider. a. This includes internal and external referrals 2) The clinical staff member discusses the referral with the patient and enters the referral in the designated system. The referral should include the patient's name, DOB, date of the referral, relevant information regarding the patient's medical condition, reason for referral, current assessment, and treatment/services requested. a. For medication management, patients will need a referral from their primary care provider. b. If they do not have a primary care provider, offer them an appointment with Health Center A. c. For counseling services, they can self-refer. 3) The Care Coordinator schedules an appointment with the external provider. 4) The Care Coordinator notifies the patient of the appointment date and time. 5) The Care Coordinator files a copy of the referral form, notes, or other documentation about the status or outcome of the referred service in the designated system upon receipt.

2) Documentation/Tracking of all Hospitalizations	1) All hospitalizations are documented electronically in the designated system. a. A copy of the hospitalization summary and all consult reports are maintained in the patient's electronic health record (EHR). 2) Post-hospitalization appointments are tracked by the Care Coordinator until completed. a. Completed is defined as the care or service was received or all communication attempts with the patient have been exhausted, yet the care or service was not received. 3) The Care Coordinator makes documented efforts to follow up with patients who miss post-hospitalization appointments. a. First attempt: within 72 hours of a missed appointment, the patient is contacted via phone. b. Second attempt: 5-7 days of a missed appointment, the patient is contacted via phone. c. Third attempt: 10-12 days of a missed appointment, the patient is contacted via written notification sent with electronic delivery confirmation receipt. d. All three attempts will be documented in the EHR. 4) The Care Coordinator reviews all post-hospitalization appointments daily. The Care Coordinator will cease tracking upon: a. Verification that the post-hospitalization appointment was completed. b. Verification that a patient who has missed their post-hospitalization appointment received three attempts at contact, including two verbal and one written per Health Center A policy.

APPROVAL:

Dr. Philip Chandler, Board President

07/28/2024
Date

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Health Center A	**ORIGINAL DATE:** March 28, 2018 **LATEST REVISION DATE:** October 10, 2024
SUBJECT: Diagnostic Services	**APPLICABLE TO:** Clinical Staff

POLICY

It is the policy of Health Center A to utilize reasonable and customary diagnostic testing to aid with the diagnosis or detection of disease, injury, or any medical condition.

POLICY STATEMENT

Diagnostic testing is provided as part of the patient assessment process and testing and procedures are performed as ordered.

When a center has x-ray, laboratory, and other diagnostic services on-site, these facilities are sufficient for patient assessments and are utilized as appropriate.

If any or al of these facilities are not on-site, contractual procedural agreements with off-site laboratories and/or radiology providers are established in writing, and the center provides the use of these services as part of patient assessment.

If the center maintains on-site laboratory facilities, these facilities are in compliance with Federal regulations, (CLIA-88).

PROCEDURE

Step	Process
1. Diagnostic Tests	1) The results of diagnostic tests are interpreted in a timely manner by qualified professionals, who may be part of the center staff, or who are provided to the center by means of established and written contract. Pathology examinations of tissue samples are reported to the center staff quickly without delay. All results of diagnostic testing are recorded in the patient medical record. 2) Documentation of compliance with federal regulations and documentation that testing provides the quality and accuracy to support clinical and medial decisions is supplied by all in-house or contracted referent facilities. 3) The use of test results is defined in patient care and delineates tests for which results are used as a screening device. 4) Staff who may perform supervised waived testing are identified. 5) Staff who may perform supervised waived testing have adequate training and demonstrate consistent competence. 6) All testing facilities and procedures are subject to individual quality control checks, and to organizational quality control evaluations and activities. 7) Records of quality control activities are maintained and current. 8) When a test report requires clinical interpretation, relevant information is provided with the request. 9) Documentation of testing requests and results are included in the patient's medical record

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Health Center A	**ORIGINAL DATE:** March 28, 2018 **LATEST REVISION DATE:** October 10, 2024
SUBJECT: 2024 All Staff Annual Risk Management Training Plan	**APPLICABLE TO:** All Staff

2024 All Staff Annual Risk Management Training Plan

1. Annual HR Manual Review
2. Bloodborne Pathogens and Standard Precautions
3. HIPAA: Basics
4. HIPAA: Do's and Don'ts of Social Media and Electronic Communication
5. HIPAA: Privacy Rule
6. Password Policy
7. Health Center HIPAA Policy
8. Elective of your choice
9. Nursing Policy (completed only by certain clinical staff, check your learning portal assignment)
10. Obstetrics (completed only by certain clinical staff because we don't provide OB services, check your learning portal assignment)

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HRSA
Health Resources & Services Administration

FTCA Educational Training Tracking Form

TRAINING INFORMATION	
1. Topic Area	Obstetrics Training (Health Center A)
2. Training Title	Postpartum Complications
3. Brief Description	Cardiovascular disease, venous thromboembolism, postpartum preeclampsia, postpartum hemorrhage, postpartum infec□on and sepsis, postpartum depression

If you need more rows beyond page 2, complete an additional FTCA Educational Training Tracking Form.

STAFF MEMBER INFORMATION

4. First Name *	5. Last Name *	6. Staff Type *	7. Date Training Completed *	8. Comments
Donald	Westphall	Clinical	2/21/2024	In house training
Mark	Craig	Clinical	2/21/2024	In house training
Victor	Ehrlich	Clinical	2/21/2024	In house training
Daniel	Auschlander	Clinical	2/21/2024	In house training
Wayne	Fiscus	Clinical	2/21/2024	In house training
Ben	Samuels	Non-Clinical	2/21/2024	In house training
Annie	Cavanero	Clinical	2/21/2024	In house training
Jack	Morrison	Clinical	2/21/2024	In house training
Peter	White	Clinical	2/21/2024	In house training
Helen	Rosenthal	Non-Clinical	2/21/2024	In house training
Lucy	Papandreo	Clinical	2/21/2024	In house training
Elliot	Axelrod	Clinical	2/21/2024	In house training
Cathy	Martin	Clinical	2/21/2024	In house training
Philip	Chandler	Clinical	2/21/2024	In house training
Carol	Novino	Clinical	2/21/2024	In house training
Ellen	Craig	Clinical	2/21/2024	In house training
Marcie	Ravelle	Clinical	2/21/2024	In house training
		(Selection)		
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Health Center

A

Plan-Do-Study-Act & Action Plan

TOOL: Cervical Cancer Screening Rate
STEP: Percentage Screened to Percentage Goal
CYCLE: **1st Quarter 2024**

Aim Statement

1. Specific- targeted population: Patients eligible for cervical cancer screening (21 years old through 64 years old) who are set up to receive text reminders.
2. Measurable- what to measure and clearly stated goal: Of the number of eligible patients sent reminders to be screened, 51% of patients will be screened.
3. Achievable- brief plan to accomplish: Using the patient portal, eligible patients will be sent reminders to make an appointment for a screening.
4. Relevant- why is it important to do now: **Increased screening of cervical cancer in women results in earlier detection which in turn produces greater treatment choices and better outcomes/ survival rates for patients with a cervix. Cervical cancer is a critical health concern in Louisiana, with one of the highest mortality rates in the nation, although 80% of cervical cancer cases and deaths can be prevented through regular Pap screenings.**
5. Specific- anticipated length of cycle: January 2024 – March 2024

Plan

Track cervical cancer screenings in eligible patient population and meet or exceed 51% goal.

Target 1. Enhance provider and patient awareness and education.

- Ensure providers understand the current recommended guidelines for CRC screening and different screening methods.
- Use patient portal (new texting platform) to send messages to eligible patients.
- Optimize social media for messaging

Target 2. Organizational policies and procedures

- Review, and update if needed, current policies and procedures for tracking and follow-up of screening results
- Designate a provider to be the physician champion.
- Designate an individual responsible for tracking women aged 21-64 who had cervical cytology performed within the last 3 years and women aged 30-64 who had cervical human papillomavirus (HPV) testing performed within the last 5 years

Target 3. Measure performance improvement

- Establish baseline screening rates and set health center goals that align with UDS quality of care measures
- Collect and analyze data.

Implementation Plan:

1. Educate providers of screening recommendation for patient population
2. Identify target population
3. Create Patient portal reminder message
4. Send message reminders to eligible population
5. Create and publish social media posts
6. Track and identify testing rate
7. Compare to goal

Prediction: Patient reminders will encourage the majority of patients to have a cervical cancer screening over 3 months.

Data Collection Plan:

1. Identify physician champion.
   - Peter White, MD
2. What data/measures will be collected?
   - Number of reminders sent to eligible patient population
   - Number of cervical screenings performed
3. Who will collect this data?
   - Quality Manager
4. When will the collection of data take place?
   - Monthly, from January 2024 to March 2024
5. How will the data (measures or observations) be collected and displayed?
   - Using Relevant reports
6. What decisions will be made based on this data?
   - How to optimize patient portal to send recommended preventative care messages
   - Future patient satisfaction survey questions

DO

Activities/Observations: The 51% goal was never achieved in the months observed.

	January 2024	February 2024	March 2024
# patients screened (numerator)	1661	1653	1686
total eligible (denominator)	3636	3628	3624
% screened	46%	46%	47%
% goal	51%	51%	51%

STUDY

Prediction: Patient reminders will encourage a majority of patients who receive the message to have a cervical cancer screening within the time frame

Learning:

- Patient feedback included placing "Health Center A" in the body of the text message. Patients expressed concern over spam messaging.
- Social media posts may encourage patients to be screened but not necessarily at Health Center A, not necessarily within the time frame being reviewed, and not necessarily as the sole reason for the appointment scheduled.
- Sending appointment reminders via mailers was time consuming and data collection on effectiveness was inconsistent.
- No-show rates for cervical cancer screenings remained consistent.

Summary: Patient reminders will encourage a majority of patients who receive the message to have a cervical cancer screening

- **No month met or exceeded 51% goal**

ACT

Conclusions:

1. Quarter tracking does not reflect overall success of effort. Extend and expand data collection and compare to prior numbers for full picture of possible improvements.
2. Continue to determine staffing needs.

Successes

- **Increased the number of primary care providers proficient in conducting Pap tests through education and training.**
- **Improved the process flow for providers unable to conduct Pap tests, enabling them to schedule patients directly with OB/GYN specialists.**
- **Held "Pap Fest" screening events during non-traditional clinic hours to offer Paps and related services.**
- **Fostered multiple opportunities for cervical cancer screening conversations, including cervical screening reminders to both patients and providers.**
- **5% increase in screenings last year.**
- **Significantly, the eligible patient population more than doubled in the last 3 years, while the number of cervical cancer screenings tripled from 533 to 1693.**

	2021	2022	2023	2024
Number of patients screened	533	485	1513	1693

Health Center

A

2nd Quarter 2024

Identified High Risk Clinical Questionnaire & Action Plan
Diagnostic Test Tracking, Referral Tracking, Hospitalization Tracking, Infection Control & Sterilization Confidentiality (HIPAA), Obstetrics, Preventing Sexual Misconduct, & Cybersecurity

Conducted by: Risk Manager on May 2, 2024

Diagnostic Test Tracking

Question	Yes	No	Needs Improvement
ls there a process in place that ensures laboratory and x-ray results are tracked, received, acknowledged by the practitioner, and reported to the patient ln a timely manner?	X		
Is there a policy/procedure that differentiates between normal, abnormal, and critical test results and includes resources that specify laboratory test reference ranges?		X	Create separate policy/procedure for test result ranges and actions based on ECRI's "Reporting Test Results" procedure
Is there a process for reporting critical results to the practitioner immediately?	X		
Is there a policy/procedure that requires patient notification of lab results and other tests, even if results are within normal limits?	X		

Referral Tracking

Question	Yes	No	Needs Improvement
Is there a process in place that ensures referrals and associated consultation reports are tracked, received, acknowledged by the practitioner, and reported to the patient in a timely manner?	X		
Is there a mechanism in place to ensure the consulted provider's findings have been incorporated into the patient's plan of care?	X		
Is there a policy/procedure to follow up with patients who do not complete a referral within the timeframe specified by the ordering physician?			Internal procedure needs update to state clinic recommended minimum time frames for open referrals and steps for referral closings when patients do not complete a referral with a certain timeframe

Hospitalization Tracking

Question	Yes	No	Needs Improvement
Is there a tracking system in place for receiving information regarding hospital or emergency department (ED) admissions?	X		

Is there a mechanism in place to follow up with the patient, provider, or outpatient facility to request pertinent medical information (e.g., diagnostic studies, discharge summary) related to a hospital or ED visit?	X		

Infection Control and Sterilization

Question	Yes	No	Needs Improvement
Do written infection control policies and procedures address: identifying infection risks, preventing infection, reporting results to health authorities, and providing a plan to implement measures to reduce infection risks?	X		
Do cleaning procedures adhere to manufacturer's guidelines, state and federal guidelines and acceptable standards of practice regarding the cleaning, disinfection and sterilization of instruments, equipment, and supplies?	X		

Confidentiality (HIPAA)

Question	Yes	No	Needs Improvement
Are there in place (for example, certified electronic health records and corresponding standard operating procedures) for protecting the confidentiality of patient information and safeguarding this information against loss, destruction, or unauthorized use, consistent with federal or state requirements?	X		
Is there a designated individual, such as a privacy officer, to oversee HIPAA-related training, policies and procedures, self-assessments, and other HIPAA compliance measures?	X		

Obstetrics

Question	Yes	No	Needs Improvement

Does the organization include obstetrical training as part of the health center risk management training plan?	X		Expand training to all medical providers, all nurses, all behavior health providers, and all dental staff.
Are pregnant patients assessed for high-risk factors, common medical complications, and mental health status, including screening for depression or history of depression?	X		
Is there a written escalation protocol identifying when and what type of abnormal findings require prompt reporting to a provider and the thresholds for patient transfer to another care?		X Create	
Is there a tracking process in place to ensure that pregnant patients attend their scheduled appointments and that complete testing and referral results are communicated to them?	X		
Are clinicians and staff trained on postpartum complications such as cardiovascular disease, venous thromboembolism, postpartum preeclampsia, postpartum hemorrhage, postpartum infection and sepsis, and postpartum depression?		X	*Update training for CY2025*
Is there a postpartum follow-up process in place that ensure ongoing care as needed including contact with a healthcare provider within weeks of giving birth (or sooner for patients considered high risk or who experienced pregnancy-related postpartum visit no later than 12 weeks after birth?	X		

Cybersecurity

Question	Yes	No	Needs Improvement
Does the organization have policies and procedures in place to prevent, detect, and respond to security incidents?	X		*Update current training to include practical tips on maintaining professional boundaries with patients/ clients*
Is there a designated individual such as a security officer to oversee IT security-related training, policies and procedures, self-assessments, and other related processes?	X		
Does the organization have general liability insurance that covers impermissible use or disclosure of protected health information (e.g., breach of unsecured health information)?	X		

Action Plan

High Risk Area	Action Item	Responsible Party	To Do List	Completed Date
*Diagnostic Test Tracking	Create policy/ procedure based on ECRI's "Reporting Test Results" to address normal, abnormal, and critical test results and resources that specify laboratory test reference ranges	**Risk Manager** *working with Chief Medical Officer, Chief Nursing Officer*	1. Draft new SOP - Reporting Test Results 2. Senior leadership review and approval 3. Publish to Knowledge Hub	5/27/2024
*Referral Tracking	Update SOP "Referral Tracking" policy/procedure to include guidelines follow-up with patients who do not complete a referral within the timeframe specified by the ordering physician	**Risk Manager** *working with Chief Medical Officer, Chief Nursing Officer*	1. Update SOP "External Referral Tracking"; renamed "External Referral Initiation &Tracking" 2. Senior leadership review and approval 3. Publish to Knowledge Hub	4/10/2024
Obstetrics	Expand obstetrical training to GYN medical providers and dental staff; use FTCA Deeming Clinic trainings	**Risk Manager** *working with Training Manager*	1. Update CY2023 Training Plan 2. Identify providers 3. Track progress to completion	5/31/2024
	Create written escalation protocol based on MEW thresholds identifying when and what type of abnormal findings require prompt reporting to a provider and the thresholds for patient transfer to another care	**Risk Manager** *working with Chief Medical Officer, OB/GYN medical providers*	1. Draft Obstetrics Escalation Protocol 2. Medical provider review and approval 3. Publish to Knowledge Hub	3/27/2024
	Update training plan for all medical staff to include postpartum medical complications such as cardiovascular disease, venous thromboembolism, postpartum preeclampsia, postpartum hemorrhage, postpartum infection and sepsis, and postpartum depression	**Risk Manager** *working with Training Manager and Clinical Leadership*	1. Update CY2023 Training Plan 2. Identify training content and method 3. Conduct in-person training	4/08/2024

**Indicates priority*

Health Center

A

Plan-Do-Study-Act & Action Plan

ASSESSMENT: IUD Procedures
CYCLE: **3rd Quarter 2024**

Aim Statement

1. Specific- targeted population: Identify patients who were issued orders for IUDs and determine if the procedure was performed and if a follow-up visit occurred.
2. Measurable- what to measure and clearly stated goal: Of the number of patients for whom an IUD order was issued, 100% will have a signed procedure consent form and documented device lot number in their medical record and 80% will have scheduled a subsequent follow-up visit by December 31, 2024.
3. Achievable- brief plan to accomplish: A sample of patient records will be identified and audited.
4. Relevant- why is it important to do now: **IUD procedures are performed in clinic. There is an increased malpractice risk when patients do not undergo an informed consent process, when the lot number of the device is not documented, and when a surveillance visit does not occur after insertion.**
5. Specific- anticipated length of cycle: July 2024 – September 2024

Plan

For patients for whom an IUD order was issues, track order issued to required documentation and follow-up appointment.	
Target 1: Required Documentation	• Identify required documentation elements. • Designate an individual responsible for reviewing the medical records. • Review medical records for presence of required documentation.
Target 2: Measure Performance	• Collect and analyze data
Target 3: Educate Staff	• Provide feedback to staff
Implementation Plan	1. Identify required elements of documentation for IUD procedures 2. Identify sample population 3. Create audit tool 4. Review medical records 5. Identify passing rate 6. Compare to goal
Prediction	• 100% of patients who receive IUDs will have an informed consent • 100% of patients who receive IUDs will have the lot number documented

	• 80% of patients who receive an IUD will have a subsequent surveillance visit
Data Collection Plan	1. What data/measures will be collected? a. All orders for IUDs b. Number of visits where IUD was inserted and/or removed c. Number of visits where informed consent was document d. Number of visits where lot number was documented e. Number of subsequent surveillance visits 2. Who will collect this data? a. Risk Manager 3. When will the collection of data take place? a. Weekly, from July to September 2023 4. How will the data (measures or observations) be collected and displayed? a. Using Relevant and internal tracking table 5. What decisions will be made based on this data? a. Additional provider education b. Additional auditing

DO

Observations: *Although four (4) providers are privileged to perform the procedure, during the review period, only one provider actively inserted and/or removed IUDs.*

Patient	Signed Informed Form Present?	Visit Date	Informed Consent Documented in Visit Note?	Checklist Documented in Visit Note?	Lot number?	Expiration date?	IUD Surveillance
Patient 1	N/A	N/A	Visit notes do not indicate it was implanted	N/A	N/A	N/A	N/A
Patient 2	Yes	7/19/2023	Yes	Yes	Yes/ form + visit note	Yes/ form + visit note	None scheduled
Patient 3	No	**5/10/2023**	Yes + Nexplanon removal	Yes	No	No	6/12/2023
Patient 4	N/A	6/7/2023/ Canceled	N/A	N/A	N/A	N/A	N/A
Patient 5	N/A	N/A	Visit notes do not indicate it was implanted	N/A	N/A	N/A	N/A
Patient 6	No	8/23/2023	Yes	Yes	No	No	9/5/2023
Patient 7	No	9/20/2023	Yes+ Mirena removal	Yes	Yes/ visit note	Yes/ visit note	10/23/2023
Patient 8	No	8/9/2023	Yes	Yes	Yes/ visit note	Yes/ visit note	9/11/2023
Patient 9	No	9/28/2023	Yes	Yes	Yes/ visit note	Yes/ visit note	10/27/2023
Patient 10	Not filled at Avita/ Duplicate to Patient 11						
Patient 11	No/ 2023 general consent missing as well	**10/18/2023**	Yes	Yes	Yes/ visit note	Yes/ visit note	11/20/2023

STUDY

Prediction:	• 100% of patients who receive IUDs will have a signed informed consent • 100% of patients who receive IUDs will have the lot number documented • 100% of patients who receive IUDs will have the expiration date documented • 80% of patients who receive an IUD will have a subsequent surveillance visit

Learning:	• Patient sample number is seven (7).
	  ○ 3 patients were issued ICD orders but did not have them inserted. They are excluded from the summary findings.
	
	<u>Informed Consent</u>
	• Only 1 of 7 patients had a signed informed consent in their patient chart.
	  ○ The physician documents in the visit note that informed consent was obtained 100% of the time.
	
	<u>Procedure Checklist</u>
	• The physician documents in the visit note that the procedure checklist was followed 100% of the time.
	  ○ Note - The checklist details are not documented in the patient chart.
	
	<u>Device Lot Number</u>
	• The device number was documented 5 times.; in two charts, no lot number was documented.
	  ○ The informed consent form contained it once; while the visit note contained it 5 times.
	
	<u>Device Expiration Date</u>
	• The expiration date was documented 5 times.; in two charts, it was undocumented.
	  ○ The informed consent form contained it once; while the visit note contained it 5 times.
	
	<u>Subsequent Follow-Up Visit</u>
	• Six of the seven patients had follow-up visits.

Summary	• 100% of patients who receive IUDs will have a signed informed consent form
	  ○ 14% of patients have a signed informed consent form in the patient chart
	• 100% of patients who receive IUDs will have the lot number documented
	  ○ 71% of IUD lot numbers were recorded
	• 100% of patients who receive IUDs will have the expiration date documented
	  ○ 71% of IUD lot numbers were recorded
	• 80% of patients who receive an IUD will have a subsequent surveillance visit
	  ○ 85% of patients were scheduled and attended a subsequent visit
	  ○ 14% of patients did not have a subsequent visit scheduled

ACT

1. Nursing leads to review and monitor/audit procedure visits to ensure that needed documentation is in chart, including Informed Consent forms, device lot numbers, and device expiration dates, when procedures with implantable/removable devices are performed.
2. Nursing leads to stress these requirements during new-hire nursing staff training.
3. Nursing leads to conduct in-service training for current nursing staff.
4. Risk Manager to review documentation requirements with providers privileged to perform IUD procedures for consistency between providers and between patients.
    a. Identify the checklist and possibly incorporate into EHR as a built-in template.
    b. Assist Training Manager with clinical staff EHR training materials.
5. Risk Manager to re-assess within 1 year.

Health Center

A

Plan-Do-Study-Act & Action Plan

ASSESSMENT: Critical Lab Results
CYCLE: **4th Quarter 2024**

Aim Statement

1. Specific- targeted population: Patients with abnormal or critical level findings that resulted after hours.
2. Measurable- what to measure and clearly stated goal: Of the number of patients with abnormal or critical level findings, the on-call provider was notified by nursing triage vendor timely, the on-call provider communicated the value to the PCP, the patient was contacted and a treatment plan initiated – all of which is documented in the designated system.
3. Achievable- brief plan to accomplish: Using AnsweringServiceOne call log, actions taken for identified patients will meet standard operating procedure expectations for follow up.
4. Relevant- why is it important to do now: **Abnormal and critical level testing levels received after hours must be communicated in a timely fashion and treatment initiated as required for positive patient outcomes and to reduce malpractice risk.**
5. Specific- anticipated length of cycle: October 2024 – December 2024.

Plan

Review and report on turnaround times from afterhours notification to documented in medical record patient treatment plan to determine if critical and abnormal results are being communicated to the provider (immediate attempt to contact) and the patient (at least 3 attempts made).	
Target 1: Required Workflow	• Identify required documentation elements. • Review medical records for presence of required documentation. • Designate an individual responsible for reviewing the medical records.
Target 2: Measure Performance	• Collect and analyze data
Target 3: Educate Staff	• Provide feedback to staff
Implementation Plan	1. Review after hours abnormal and critical level results communication protocol 2. Identify target population 3. Create audit tool 4. Review records and logs 5. Identify passing rate 6. Compare to goal
Prediction	• Abnormal and critical test results communication will follow the workflow identified in the procedures 90% of the time

Data Collection Plan	1. What data/measures will be collected? a. Instances of abnormal or critical results received afterhours b. What measurement was reported c. Whether AnsweringServiceOne is notifying the providers in a timely manner d. Whether the on-call provider is following up in a timely manner e. Whether the PCP, if identified, is alerted in a timely manner f. Whether the patient is spoken to a timely manner g. Whether the treatment plan is documented in a timely manner. 2. Who will collect this data? a. Risk Manager 3. When will the collection of data take place? a. Weekly, from October to December 2024 4. How will the data (measures or observations) be collected and displayed? a. Using call records and telephone encounters 5. What decisions will be made based on this data? a. Whether to retain the designated calling system as afterhours triage b. Whether additional auditing is necessary for on-call providers c. Whether AcentraLab needs to be contacted for negative feedback

DO

Observations: *AcentraLab and AnsweringServiceOne made the appropriate number of repeated attempts; on-call providers did not engage AnsweringServiceOne as expected.*

After Hours Call Log	Critical Lab Value	Documented in EHR?	Patient Contacted?	Closing the Loop?
11/10/2024 05:57 AM	Hgb 5.7/Hct 22.1	Yes - 11/10 @ 9 am (Alex Karev)	Yes - 11/10 @ 9:30 am (Alex Karev); Advised patient to present to ER for infusion	On-call provider notified PCP; Derek Shephard spoke with patient on 11/13/2024; Patient received blood transsfusion and has a hematology appointment on 11/22/2024; *patient was previously scheduled on* ***11/09/2024*** *for 02/08/2024 hematology appt*
11/10/2024 08:03 AM	low glucose level at 31	Yes - AcentraLab called **2nd time** at 8:42 am & CAR initiated TE to Cristina Yang; CY forwarded TE to PCP (Addison) at 9:07 am	Yes - Addison advised patient of emergency signs and symptoms and to go to Urgent Care/ED (patient was in Baltimore) and to eat 3 big or 6 small meals daily at 9:33 am	Appt scheduled for 11/16/2024 (1st day patient back in NOLA) and patient was seen on 11/16/2024

11/10/2024 08:17 AM	**Duplicate** to 11/10/2024 05:57 AM - 2nd call; on-call provider initiated documentation at 9 am Note - Afterhours staff spelled patient's first name incorrectly			
11/12/2024 07:47 PM	Unknown (ED visit)	No - Appointment & medical follow up not needed	11/13/2024 appt scheduled with Meredith Grey	Seen for HIV management (only) by O'Malley; 11/30/2024 appointment scheduled on ***05/2024*** and patient arrived
11/18/2024 01:34 AM	low glucose 23	Yes - AcentraLab called **a 4th time** on 11/20 at 8:59 am & CAR initiated TE to Sheryl Wilson; SW sent to Addison at 11:13 am	Yes - 11/20 at 11:27 (Addison); Type 2 DM- Following with Miranda Bailey, MD - seen last week - reports off Ozempic in July, on mounjaro end Oct; not on any other DM meds; Reports day of labs, had just done mounjaro injection and ate, did not feel bad that day; no hx of lows; reports checking home BG almost daily and average in the high 90s, reported home BG this am 98; eating regular meals. Feels well. Continue with scheduled f/u with PCP, advised on hypoglycemic s/s and go to ER if any occur.	Seen for HIV management (only) on 11/30/2024 (Lexie Grey); appointment was made on ***08/04/2024***
11/19/2024 02:09 PM	**Duplicate** to 11/18/2024 1:34 am - 2nd call by AcentraLab; staff responded at 9 am on 11/20/2024			
11/20/2024 09:13 AM	**Duplicate** to 11/18/2024 at 1:34 am - 3rd call by AcentraLab; staff responded at 9 am on 11/20/2024 Note - Afterhours staff Addison posed numbers of reference number			
11/22/2024 08:19 AM	Lithium <0.1 ; normal range 0.5 - 1.2 mmol/L	Yes - AcentraLab called **a 2nd time** on 11/20 at 3:44 pm & CAR initiated TE to Elizabeth Holcomb; EH documented that she was in touch with AcentraLab at 9:00 am, that patient did not appear as toxic during 11/21/2024 visit and requested that lab be rerun	Patient scheduled on 11/22 for lab draw to re-run test but did not show	Holcomb at 4:22 pm that on-call Dr. Webber is aware of pending lab; blank TE timed at 4:13 pm; On 11/27 CAR sends TE at 10:58 that AcentraLab is calling about repeat labs & sends to Alex Karev; patient seen on 12/22/2024; no documentation of lab value in question

STUDY

Prediction:	• Abnormal and critical test results communication will follow the workflow identified in the procedures 90% of the time
Learning:	• 5 calls were eligible for review.
Summary	• Abnormal and critical test results communication will follow the workflow identified in the procedures 90% of the time ○ 100% appropriate documentation of call in the medical record ○ 100% patient contact ○ 100% PCP contact, when appropriate ○ 100% patient appointment and/ or visit follow-up, when appropriate ○ 80% of the time, the provider did not immediately communicate with AcentraLab, prompting multiple calls from them; eventually internal Call Center staff initiated the documentation thread in the patient record

ACT

1. Clinical Practice Director will communicate quality expectations with AnsweringServiceOne to address misspelling of patient name and incorrect lab reference number.
2. Chief Medical Officer to determine whether delayed staff response/ documentation as evidenced by the multiple AcentraLab attempts and when documentation was initiated in the medical record.
3. Review for updates
    a. SOP – Reporting Test Results needs review and clarification
        i. AcentraLab communicated results to Call Center staff rather than directly to the provider twice. II.E.d. of the SOP states Critical results must not be communicated over voicemail, e-mail, or to administrative assistants or other unlicensed staff members.
4. AnsweringServiceOne protocol for Critical and Abnormal Results
    a. Recommend a third-tier notification in case on-call provider is not spoken to after first two attempts.

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Health Center

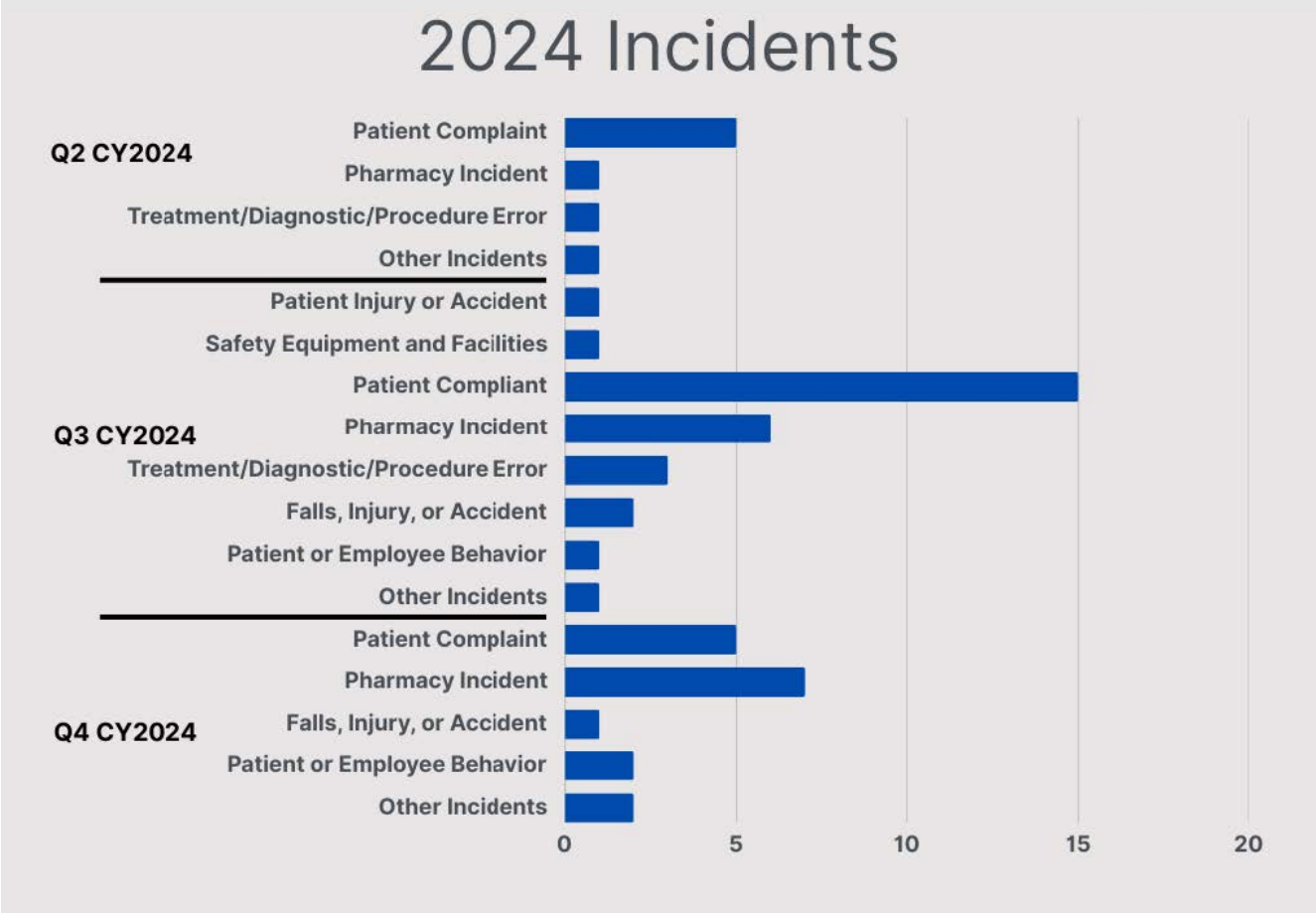
A

2024 Annual Risk Management Report to the Board

January 30, 2025

Introduction

This report describes Health Center A performance relative to the risk management plan, and evaluates the effectiveness of risk management activities including the response to identified areas of high risk. Topics presented include review of incident reporting dashboards, risk management training, risk and patient safety activities, and claims management, as well as planned activities for the calendar year.



Health Center

A

2024 Risk Management Report

1. **Patient Satisfaction / Grievances**
    a. Year in Review:
        i. SWOT Analysis completed which assisted in directing further activities.
        ii. Relevant policies were reviewed and updated:
            1. Patient Satisfaction Survey. Updated Q3 2024
            2. Patient Advocacy/Patient Grievance. Updated Q3 2024
    b. Planning:
        i. Ongoing PDSA with goal of assessing and ensuing adequacy in surveying unique patient sub populations (ethnicity, primary language, etc.)
        ii. Ongoing PDSA with goal of improved consistency in addressing/responding to patient complaints from all origins (in-person, online, survey, etc.)
        iii. Planned PDSA with goal of improving patient experience, patient awareness of their wait time, and cost of their visit
    c. Measure/Key Performance Indicator:
        i. Patient survey reports and dashboard

2. **Incident Management**
    a. Year in Review:
        i. Transition Q2 to portal for incident report submission, review, and tracking
        ii. Review of Accident/Incident Investigation Report policy
    b. Planning:
        i. Ongoing PDSA with goal of increasing number of incidents reported and increase in number of incidents submitted
            1. Planned training for all staff on incident reporting and portal at upcoming staff meeting
            2. Ongoing PDSA with goal of reducing time to complete investigation of incidents
    c. Measure/Key Performance Indicator:
        i. Number of incidents
        ii. Time to complete investigation of incidents

3. **Health Information Management/Confidentiality of Patient Records/HIPAA**
    a. Year in Review:
        i. Transition to new EHR system Q2 2023
        ii. HIPAA Training Q4 2023
        iii. No HIPAA incidents
    b. Measure/Key Performance Indicator:
        i. Number of incidents

4. **Infection control, Sharps Injury, Exposure Prevention, and Sterilization**
    a. Year in Review:
        i. Post Exposure Protocol and Policy and HR Policy Updated Q1 2024
        ii. Training
            1. Blood borne pathogens training for all staff Q4 2024
            2. Autoclave and sanitization training of relevant staff Q4 2024
    b. Planning:
        i. Ongoing PDSA with goal of improved compliance with post-exposure protocol
    c. Measure/Key Performance Indicator:
        i. Number of incidents
        ii. Compliance with sterilization schedule
        iii. Medical waste disposal audit findings

5. **Patient Care Process: Referral, Diagnostics, Hospitalization Tracking, and Clinic-Administered Medications:**
    a. Year in Review:
        i. Transition to new EHR system Q2 2023
        ii. Improved access to outside records since transition to new EHR system (hospitalizations, referrals, consults, etc.)
    b. Planning:
        i. planned SWOT and FMEA of processes
    c. Measure/Key Performance Indicator
        i. Number of incidents
        ii. Metrics for timeliness of medical record documentation completion
        iii. Metrics for completion of referral tracking and results
        iv. Metrics for timeliness of completion for lab results tracking

6. **Access to Care, After Hours, Low English Proficiency**
    a. Year in Review:
        i. Transition to same day/next day scheduling
        ii. Focus on access for patients with low English proficiency
            1. Walkthrough to review appropriate signage at all locations Q4 2024
    b. Planning:
        i. Covert surveillance to monitor access to care for patients with low English proficiency
        ii. Ongoing contract review with translation service to ensure competitive pricing, timely access to quality translation services
    c. Measure/Key Performance Indicator:
        i. Metrics for access to care
        ii. Covert surveillance findings
        iii. Patient satisfaction data review by ethnicity and language

7. **Claims Management / Litigation Review**
    a. Year in Review:
        i. FTCA Claim, originated from care provided Q4 2021, case settled Q3 2024
    b. Planning:
        i. Clinical review and education session on topic completed Q1 2024
    c. Measure/Key Performance Indicator:
        i. Number of claims

8. **Safety, Equipment and OSHA**
    a. Year in Review:
        i. Accident / Injury Response Protocol updated Q4 2024
        ii. Staff training Q4 2024
        iii. Mock OSHA inspection Q3 2024
    b. Planning:
        i. Ongoing PDSA with goal of improved compliance with Accident / Injury Response Protocol and standardization of response actions
        ii. Establishing a formal subcommittee to meet regularly and report to QI and Risk management regarding safety issues
    c. Measure/Key Performance Indicator:
        i. Number of incidents

9. **Obstetrics/Prenatal Care**
    a. Year in Review:
        i. Meetings with staff stakeholders to review current care and processes
        ii. SWOT analysis completed
        iii. Staff training on prenatal care topics Q2 2024
    b. Planning:
        i. OB Team meetings to have protected time for planning and review
            1. Review/Development of policy
            2. Development of patient panels and dashboard
        ii. Annual Staff Education on care for women of reproductive age and prenatal care.
    c. Measure/Key Performance Indicator:
        i. Development of relevant clinical care metrics and dashboard for ongoing evaluation

10. **Cybersecurity**
    a. Year in Review:
        i. No incidents
    b. Measure/Key Performance Indicator:
        i. Number of incidents

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Health Center A	**ORIGINAL DATE:** March 28, 2021 **LATEST REVISION DATE:** July 28, 2024
SUBJECT: Credentialing and Privileging Procedure	**APPLICABLE TO:** Clinical Staff

POLICY:

Health Center A has developed its provider Credentialing and Privileging process both to meet industry and government requirements for health center practices, and to ensure that the Organization's staff provide the highest quality of care to patients and clients. Credentialing and Privileging involves evaluating a practitioner's eligibility to provide clinical or other professional services at the health center.

SCOPE:

The SOP process described herein is intended to guide the work of staff responsible for credentialing and privileging processes and files and to inform those staff who are credentialed and privileged by that staff as new hires and on a recurrent basis as needed. Credentialing and Privileging files are updated at least every two years, and throughout the year as needed to maintain current licensures and certifications.

RESPONSIBILITIES:

Health Center A personnel that have a primary role in the SOP include:

- the Credentialing and Privileging staff and their supervisor for the creation and maintenance of complete Credentialing and Privileging files
- Licensed Independent Practitioners and Other Licensed or Certified Health Care Practitioners for presenting, earning, and maintaining licensures and certifications, as described here in
- the Environment of Care Nurse, Nursing Supervisors, Human Resources Department, and Quality Department staff for obtaining and maintaining specific supportive documentation, as described here in
- the Compliance Department for quality assurance, inclusion of language adhering to these principles in needed contracts, when applicable, and updates to this SOP based on new HRSA requirements. The Compliance Director performs an annual internal audit of the credentialing and privileging process by reviewing and confirming or updating the ECRI tool "FTCA Application Procedural Demonstration of Compliance Tool: Credentialing & Privileging Edition".

DEFINITIONS:

Credentialing and Privileging are two parts of a process that allows providers to work with Health Center A patients at Health Center A sites. Credentialing and Privileging applies to all health center practitioners, employed, or contracted, volunteers or locum tenens, at all Health Center A sites who fall into the HRSA Compliance Manual defined categories of licensed independent providers, other licensed clinical staff or other clinical staff.

Level 1 or Level 2 OSHA Job Categories are identified in the Occupational Safety and Health Administration's (OSHA) Blood borne Pathogen Standard 29 CFR1910.1030. At Health Center A, these are: Physician, Physician Assistant, Nurse Practitioner, Registered Nurse, Licensed Practical Nurse, Medical Assistant, Phlebotomist, Dental Assistant, Dental Hygienist, and

Dentist. Based on these categories, staff are required to participate in the Hepatitis B immunization process.

"Emergency" or "Disaster": An event affecting the overall health center target population and/or the health center's community at large, which precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official such as a governor, the Secretary of the Department of Health and Human Services, or the President of the United States. Examples include but are not limited to hurricanes, floods, earthquakes, tornadoes, widespread fires, and other natural/environmental disasters; civil disturbances; terrorist attacks; collapses of significant structures within the community (e.g., buildings, bridges); and infectious disease outbreaks or other public health threats.

Credentialing is similar to a background check for employment, in that license, education and other pertinent pieces of information are verified. The difference is that for Licensed Independent Practitioners (LIPs) and Other Licensed or Certified Practitioners (OLCPs) clinical staff, Health Center A must assure that all licenses always remain current and are updated prior to their expiration dates. Health Center A queries the Office of the Inspector General's (OIG) debarment list monthly for all LIPs and OLCPs.

Privileging is a process that verifies a licensed individual's skill and ability to deliver the quality of service expected of Health Center A providers. It includes verification of fitness of duty, clinical competence (via training, education, and, as

Primary Source Verification is the process by which the organization verifies credentialing information directly from the entity that originally issued the credential to the practitioner (e.g., state licensing board, state board of social work, etc.). Data sources may include oral, written, Internet, cumulative reports, and agents of approved sources (e.g., Federation of State Medical Boards). State Licensing Boards in Louisiana primary source verify education elements of individuals, making the holding of a current license evidence of education validation if there is annual confirmation from the individual board of this practice.

Secondary Source Verification is used when primary source verification is not required. Examples include, but are not limited to, presenting an original or notarized copy of the credential or a copy of the credential (when the copy is made by approved Organization staff employees from an original).

Licensed Independent Practitioners (LIPs): LIPs include any individual permitted by law and the organization to provide care and services independently, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. These individuals include, but are not limited to:

- physicians, psychiatrists, dentists
- physician assistants, advanced practice nurses
- psychologists
- licensed clinical social workers (LCSWs)
- licensed practical counselors (LPC)

Other Licensed or Certified Health Care practitioners (OLCPs): OLCPs are individuals licensed, registered, or certified but are not permitted by law to provide patient care services without direction or

- medical or dental assistants
- laboratory technicians

Timeframes: The credentials and privileges of LIPs and OLCPs are reviewed and granted at the time of hire and are reviewed and renewed, at a minimum, once every two years

PROCEDURE:

Item	Initial Appointment/ Upon Hire/ Prior to First Day of Employment			Re-appointment		
	LIPs	OLCPs	OSCs	LIPs	OLCPs	OSCs
Government Issued Photo ID	X	X	X			
Primary Source Current Professional License, Certification	X	X	X	X	X	X
Primary Source Education (Highest Degree) *(Or confirmation from Licensing Board)*	X	Copy of Degree OK	Copy of Degree OK			
Current DEA Registration Certificate *(DOs, MDs, PAs, NPs, DDS)*	X			X		
National Provider Data Bank Query *(At least once every 2 years)*	X	X	X	X	X	X
Current Basic Life Support Training	X	X	X	X	X	X
Fitness of Duty Attestation *(At least once every 2 years)*	X	X	X	X	X	X
Clinical Competency *(Examples may include: Reference checks/interviews [initial], Peer Review [LIPs], 90-day or Annual Performance Evaluation [all], or Clinical Checklists [nursing staff] depending on the applicant and job position within the category; a minimum of 1 item is needed)*	X	X	X	X	X	X
**Immunization – COVID/ or Declination *(Per CDC recommendations)*	X	X	X	X	X	X
**Immunization – TB/ PPD or Declination *(Per CDC recommendations)*	X	X	X	X	X	X
**Immunization – Hep B/ or Declination *(Level 1 or 2 job under the OSHA risk determination guidelines)*	X (if Level 1 or 2)	X (if Level 1 or 2)	X (if Level 1 or 2)	X (if Level 1 or 2)	X (if Level 1 or 2)	X (if Level 1 or 2)
**Immunization – Annual Flu/ Or Declination *(Per CDC recommendations)*	X	X	X	X	X	X

** *Acceptable evidence of immunization status includes, but is not limited to, copies of medical records, vaccination cards, in-house administration documentation, and declination forms.*

CREDENTIALING & RE-CREDENTIALING:

Licensed Independent Practitioners (LIPs):

Step 1. Health Center A new hires that are LIPs receive an application for credentialing and clinical privileges from the HR department. The packet includes information required for hire, credentialing (both for the Organization and for third-party payers) and a privileges application specific to their scope of practice.

Privilege applications vary depending on the type of specialty or scope of practice being requested.

Step 2. Individuals will return completed application along with all requested documents within the requested timeframe.

Step 3. Applications will be reviewed and processed by Credentialing staff. All completed packets are processed within 10 days after they have been received by the Credentialing staff. Staff will verify and upload the following documentation into the electronic credentialing software system MD Staff:

A. Primary Source Verification:
   1. Government-issued photo identification
   2. Evidence of current Louisiana professional licensure
      a. As applicable, medical or dental board certifications
   3. Evidence of relevant education, training, or experience (current State of Louisiana licensure is acceptable evidence of education and training verification);
   4. Drug Enforcement Administration (DEA) certificate (if applicable based on licensure)
   5. Current competency (including, but not limited to, interviews/responses from employment or educational references)
   6. Annual Fitness of Duty Attestation statement completed by the individual and reviewed by the Health Center A designated physician or its CMO (required)

B. Secondary Source Verification:
   1. Query documentation from National Practitioner Data Bank (NPDB)
   2. Basic Life Support (BLS) certificate (current or evidence of completed training)
   3. Hospital admitting privileges (if applicable)
   4. Immunization and communicable disease status (acceptable evidence of status includes, but is not limited to, copies of medical records, vaccination cards, in-house administration documentation, or declination forms)
      Note: BLS and disease status documentation is maintained in the electronic credentialing application by the Environment of Care Nurse

Step 4. At recredentialing (at least every 2 years), the following will be reviewed. Unless otherwise noted, all supporting documents are uploaded into the electronic credentialing system MD Staff.
   1. Primary Source evidence of current state licensure status and any board certifications
   2. Current DEA certificate status, if applicable

3. NPDB Query
4. Annual Fitness of Duty Attestation statement completed by the individual and reviewed by the Health Center A designated physician or its CMO (required)
5. BLS training (current or evidence of completed training)
6. Clinical Competency, which may consist of, but is not limited to: peer review, 90-day or annual performance evaluations along with any performance improvement plan, clinical checklists, etc., but at least one must be obtained, and review of any other known external actions or complaints against clinical licensure or clinical performance
7. Immunization and communicable disease status (acceptable evidence of status includes, but is not limited to, copies of medical records, vaccination cards, in- house administration documentation, or declination forms)

Note: Annual performance evaluation and performance improvement plans is maintained in Human Resources files

Note: Peer review data is maintained in the files of the Quality Department

Note: Known external or internal clinical complaints or suits against a LIP is maintained in Compliance Department files

Other Licensed or Certified Health Care Practitioners (OLCPs):

Step 1. The initial and re-credentialing of OLCPs requires the following:

A. Primary source verified documentation:
   1. Government issued photo identification
   2. Current state professional licensure

B. Secondary source verified documentation:
   1. Relevant education, training, or experience (copy of diploma or certificate is acceptable)
   2. Fitness of Duty statement signed by the individual and signed by the Health Center A designated physician or its CMO with a date in the prior or current year;
   3. Current competency (including, but not limited to, for **initial applicants**, interviews/ responses from employment or educational supervisory references; for **renewals**, at least one of the following: an annual performance evaluation along with any performance improvement plans, clinical checklists; and review of any other known external actions or complaints against clinical licensure or clinical performance)
   4. NPDB Query
   5. BLS training (current or evidence of completed training)
   6. Immunization and communicable disease status (acceptable evidence of status includes, but is not limited to, copies of medical records, vaccination cards, in-house administration documentation, or declination forms

Note: Annual performance evaluation and performance improvement plans is maintained in Human Resources files

Note: BLS and disease status documentation is maintained in the electronic credentialing application by the Environment of Care Nurse

Note: Known external or internal clinical complaints or suits against a OCLP is maintained in Compliance Department files

Other Clinical Staff (OCS):

Step 1. The initial and re-credentialing of OCS requires the following:

A. Primary source verified documentation:
   1. Government issued photo identification

B. Secondary source verified documentation:
   1. Relevant education, training, or experience (copy of diploma or certificate is acceptable)
   2. Annual Fitness of Duty statement signed by the individual and signed by the Health Center A designated physician or its CMO
   3. Clinical competency (including, but not limited to, for **initial applicants**, interviews/ responses from employment or educational supervisory references; for **renewals**, at least one of the following: an annual performance evaluation along with any performance improvement plans, clinical checklists; and review of any other known external actions or complaints against performance)
   4. NPDB Query
   5. BLS training (current or evidence of completed training)
   6. Immunization and communicable disease status (acceptable evidence of status includes, but is not limited to, copies of medical records, vaccination cards, in-house administration documentation, or declination forms

Note: Annual performance evaluation and performance improvement plans is maintained in Human Resources files

Note: BLS and disease status documentation is maintained in the electronic credentialing application by the Environment of Care Nurse

Note: Known external or internal clinical complaints or suits against a OCLP is maintained in Compliance Department files

INITIAL PRIVILEGING:

Step 1. Once the credentialing process is complete, the health care professional's application form is checked for errors and is forwarded to the privileging committee for privileging review and approval, based on category of professional.

Step 2. Privileging Committees convene as needed to review, discuss, and make recommendations on LIP privileging (re)applications.

Step 3. After review and discussion, the appropriate Committee makes a recommendation to approve,

deny or modify applications based on a consensus of Committee members present for the discussion. If approved, the Committee will recommend a specific scope and content of patient care services based on an evaluation of the practitioner's clinical qualifications and competence. Privileges are appropriate to the specialty of the practitioner and appropriate for the scope of services that are offered by Health Center A as circumscribed by the health center's license, available medical equipment, and staff. The Committee Chair, or designee, will attest to the recommendations.

Step 4. The application, along with the Committee's recommendations regarding privileging will be submitted to the CMO for review. The CMO will review the file and come to an independent decision to accept or reject its recommendation. The CMO will sign the application.

Step 5. Individuals are notified of the Committee's decision in writing. In the event that privileges are denied, the applicant will be informed of his/her/their ability to appeal the decision to the Board of Trustees by submitting a written request to the Co-Chairs of the Board explaining the reasons behind the request for reconsideration. The Board shall review and provide a written response to the appeal to the LIP or OLCP within 30 days. The Compliance Director will assist the applicant with this process.

Step 6. The Board of Trustees will be notified at least at least twice yearly of the privileges granted to LIPs.

Step 7: Completed applications and supporting materials will be organized, compiled, and retained in the individual's file within MD Staff, unless otherwise noted in this SOP.

Step 8: All records will be retained for seven (7) years following any individual's separation from the Organization.

REPRIVILEGING & REAPPOINTMENT:

Step 1. The health care professional's re-privileging application form is forwarded to the Privileging Committee to review the individual's competence to perform the duties based on category of professional. Documentation may include:

1. Board certification in appropriate discipline
2. Continuing education requirements of their particular license and discipline (for example, all Health Center A employed MD/DOs are required to complete 20 hours yearly of CME in order to maintain their medical license with the State of Louisiana, therefore current licensure is evidence of the CEU requirements) and/or any assignment and/ completion of internal clinically related training
3. Peer review and/or supervisory performance reviews
4. Performance improvement plans
5. Known patient/client complaints / litigation / medical incidents

Step 2. After review, the Privileging Committee makes a recommendation to approve, deny or modify applications based on a consensus of Committee members present for the discussion. The Committee will recommend a specific scope and content of patient care services based on an evaluation of the practitioner's clinical qualifications and competence. Privileges are appropriate to the specialty of the practitioner and appropriate for the scope of services that are offered by St. Elsewhere Community Health

Center as circumscribed by the health center's license, available medical equipment, and staff. The Committee Chair, or designee, will attest to the recommendations.

Step 3. The completed application, along with the Committee's recommendations regarding privileging will be submitted to the CMO for review. The CMO will review the file and come to an independent decision to accept or reject its recommendation. The CMO will sign the application.

Step 4. Individuals are notified of the Committee's decision in writing. In the event that privileges are denied, the individuals will be informed of his/her/their ability to appeal the decision to the Board of Trustees by submitting a written request to the Co-Chairs of the Board explaining the reasons behind the request for reconsideration. The Board shall review and provide a written response to the appeal to the LIP within 30 days. The Director of Compliance will assist the applicant with this process.

Step 5. The Board of Trustees will be notified at least twice yearly of the privileges granted to specific LIPs.

Step 6: Completed application and all supporting documents will be organized, compiled, and retained in the individual's file within MD Staff, unless otherwise noted in this SOP.

Step 7: All records will be retained for seven (7) years following any individual's separation from the Organization.

TEMPORARY PRIVILEGES:

1. For all practitioners responding to declared public health emergencies at impacted FTCA deemed health centers, including volunteers, temporary privileges (also known as expedited credentialing and privileging) may be granted by the CMO, upon expedited review and verification of the professional credentials, references, claims history, fitness, professional review organization findings, and license status of providers.

2. Such expedited review and verification may take into account signed, written findings of the impacted health center's applicable clinical department head and/or the Chief Medical Officer, as to the following items:
    a. **Identity**: This may be done by verifying the individual's government issued ID. This may include state or federal ID (i.e., driver's license, passport).
    b. **Professional Credentials**: Licensure verification must be done by primary source verification. In the event that primary source cannot be obtained, the health center must document its attempts to obtain primary source verification and may accept a secondary source document (i.e., a copy from the provider). These references should also include information related to any negative professional organization findings, if applicable.
    c. **Claims History**: This may be done by obtaining a secondary source copy from the applicant of the most recent National Practitioner Data Bank (NPDB) query. If not possible, the applicant may attest that they have had no claims within the last 12 months, or if such claims exist, the applicant should provide information for each.
    d. **Fitness/References**: This must be assessed by reviewing privileging forms and/or at

least one reference from the current or most recent employer, which demonstrates the individual can perform the duties and services that will be requested. The reference may be provided in the form of an email or other electronic correspondence that clearly states the individual can perform the duties that are requested. If an individual cannot produce privileging forms from a current or recent employer (for example, if the individual is a 3 recent graduate), the applicant may provide secondary sources such as a statement or other documentation from the degree issuing institution

3. Temporary privileges can be granted for no more than 90 days. After the 90-day period, all the necessary verification for standard credentialing and privileging and granted full privileges based on that information should be completed.

PRIVILEGE RESTRICTION:

1. The CMO, or the Chief Executive Officer, may summarily suspend, restrict, or place conditions or requirements on all or any portion of the clinical privileges of any practitioner in accordance with this section. Any such suspension, restrictions, conditions, or requirements shall be effective immediately and shall remain in effect until terminated by the CMO, CEO or the Board of Trustees after considering the recommendations.
2. Grounds for imposition of summary suspension, restriction or conditions shall include, but not be limited to, the following:
    a. the conduct of a practitioner creates a reasonable possibility of injury or damage to any patient, employee or person present in the Centers or to Health Center A,
    b. a practitioner is convicted with the commission of a felony which may relate to the practitioner's suitability to practice under his/her license,
    c. a practitioner is charged with the commission of a misdemeanor which may relate to the practitioner's suitability to practice under his/her license,
    d. a practitioner engages in unlawful or unethical activity related to the practice of medicine, dentistry, or social work,
    e. a practitioner engages in any dishonest, unprofessional, abusive, or inappropriate conduct which is or may be disruptive of health center operations and procedures,
    f. the practitioner has had any medical staff clinical privileges, certification, licensure, or registration terminated, suspended, restricted, limited, reduced, or modified in any way,
    g. the practitioner has voluntarily surrendered or agreed not to exercise any clinical privileges while under investigation or to avoid an investigation,
    h. it is determined that the practitioner made a material misstatement or omission on any pre- application or application for appointment or reappointment, or at any time provided incorrect information or otherwise deceived or attempted to deceive or mislead the clinical staff and/or Health Center A,
    i. a practitioner has falsified or inappropriately destroyed or altered any medical record,
    j. a practitioner refuses to submit to evaluation or testing relating to the practitioner's mental or physical status, including refusal to submit to any testing related to drug or alcohol use.
    k. a practitioner abandons a patient or wrongfully fails or refuses to provide care to a

patient,

l. a practitioner engages in clinical activities outside the scope of the practitioner's approved clinical privileges.

AUDIT:

Annually, credentialing and privileging records will be audited by Compliance staff for completeness

REFERENCES:

This SOP will be updated, as needed, and its processes governed by the most recent versions of the following documents:

External:

- The HRSA Health Center Program Site Visit Protocol, Chapter "Clinical Staffing" ECRI tool "FTCA Application Procedural Demonstration of Compliance Tool:

- Credentialing & Privileging Edition".

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Health Center

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Credentialing and Privileging List						
FTCA ID	First Name	Last Name	Most Recent Credentialing Date	Most Recent Privileging Date	Needs Attention	Options
FTCA00088888	Donald	Westphall	12/14/2022	12/14/2022		View Individual Details
FTCA00088888	Mark	Craig	04/10/2022	04/10/2022		View Individual Details
FTCA00088888	Victor	Ehrlich	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Daniel	Auschlander	07/11/2022	07/11/2022		View Individual Details
FTCA00088888	Wayne	Fiscus	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Ben	Samuels	08/14/2022	08/14/2022		View Individual Details
FTCA00088888	Annie	Cavanero	07/20/2022	07/20/2022		View Individual Details
FTCA00088888	Jack	Morrison	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Peter	White	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Helen	Rosenthal	12/14/2022	12/14/2022		View Individual Details
FTCA00088888	Lucy	Papandreo	04/10/2022	04/10/2022		View Individual Details
FTCA00088888	Elliot	Axelrod	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Cathy	Martin	07/11/2022	07/11/2022		View Individual Details
FTCA00088888	Philip	Chandler	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Carol	Novino	08/14/2022	08/14/2022		View Individual Details
FTCA00088888	Ellen	Craig	07/20/2022	07/20/2022		View Individual Details
FTCA00088888	Marcie	Ravelle	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Luther	Hawkins	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Shirley	Daniels	12/14/2022	12/14/2022		View Individual Details
FTCA00088888	Timothy	Hodges	04/10/2022	04/10/2022		View Individual Details
FTCA00088888	Joan	Halloran	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Nina	Morrison	12/14/2022	12/14/2022		View Individual Details
FTCA00088888	Mark	Tork	04/10/2022	04/10/2022		View Individual Details
FTCA00088888	Andrew	Schroeder	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Cora	Huffman	07/11/2022	07/11/2022		View Individual Details
FTCA00088888	Barbara	Majer	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Alan	Poe	08/14/2022	08/14/2022		View Individual Details
FTCA00088888	Rachel	Greenspan	07/20/2022	07/20/2022		View Individual Details
FTCA00088888	Samuel	King	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Harold	Alden	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Beth	Chan	12/14/2022	12/14/2022		View Individual Details
FTCA00088888	Gerald	McCabe	04/10/2022	04/10/2022		View Individual Details
FTCA00088888	Sandra	Kelly	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Leonard	Franklin	07/11/2022	07/11/2022		View Individual Details
FTCA00088888	Doris	Gibson	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Patrick	Wilson	08/14/2022	08/14/2022		View Individual Details
FTCA00088888	Elizabeth	Carr	07/20/2022	07/20/2022		View Individual Details
FTCA00088888	Michael	Doyle	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Franklin	Michaels	03/11/2024	03/11/2024		View Individual Details

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Health Center

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2(A). Has the health center had any history of claims under the FTCA?

Note: Health centers must provide any medical malpractice claims or allegations that have been presented during the past 5 years.

[X] Yes [_] No

If Yes, list each claim below.

Date of occurrence: 11/10/2021

Names of Provider(s) involved:	Mark Craig, M.D.
Role(s) in Health Center:	Podiatric Medicine and Service Providers
Specialty:	Podiatrist
Others:	
Nature of Allegations:	Claims - Treatment Related
Date of Occurrence:	11/10/2021
Date Claim Filed:	11/15/2021
Summary of allegations:	The patient presented with a foot infection and claims Dr. Vuong failed to provide timely and adequate treatment, resulting in a severe non-healing wound, pain, and permanent scarring on the left foot. Dr. Vuong states the patient reported prior antibiotic treatment from their PCP and presented with foot pain, redness, and swelling but no open wound or elevated temperature. Dr. Vuong prescribed Ibuprofen for pain and advised rest.
Has this claim or allegation been resolved or settled?	[X] Yes [_] No
Summary of health center internal analysis and implemented steps to mitigate the risk of such claims in the future (Only submit a summary if the case is closed. If the case has not been settled, do not include the summary.)	The allegation was not pursued further following the Patient Compensation Fund's review, which identified federal government involvement.

Supporting Claims Documentation (Only For Closed or resolved Claims and Allegations) (Maximum 10)

No documents attached

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Health Center B	**ORIGINAL DATE:** October 13, 2016 **LATEST REVISION DATE:** October 15, 2024
SUBJECT: Referral Tracking Policy	**APPLICABLE TO:** Case Management Staff

Purpose: To ensure all referrals are tracked and documented.

POLICY

Health Center B maintains a coordinated process for patient referrals to ancillary and specialty services. Health Center B tracks referrals to facilitate a closed loop process whenever possible.

PROCEDURE

Step	Process
1. Initiating Referrals	Any Health Center B provider may initiate a referral for specialty care, radiology, specialty labs, or other ancillary services. Referrals are typically initiated while a patient is at Health Center B for an appointment, although at times they may be initiated following a patient phone call or when a previous referral requires renewal. To initiate a referral, the provider electronically "drops" the referral into the EHR, generating an electronic message to the nurse or medical assistant (MA) who is responsible for setting up the referral. Although most Health Center B referrals are made to the Local Hospital, the provider may request another referral source as appropriate to the individual patient's needs.
2. Setting Up Referrals	Based on staffing at the time a referral is made, any nurse or MA may set up a referral as directed by the provider. For Local Hospital referrals, the Case Management Staff drops the referral electronically to Local Hospital's EHR. Once the referral is set up, the Local Hospital notifies Health Center B of any supporting documentation needed prior to seeing the patient (e.g. lab test

	results, radiology test results, medical record documentation, demographic information). The Case Management Staff sets up the referral electronically forwards the needed information to the Local Hospital. For non-Local Hospital referrals, the provider writes the referral information as a prescription, which the Case Management Staff faxes to the referral provider along with relevant patient information. Once a referral has been set up, the Case Management Staff documents in the patient's EHR the referral date and source.
3. Urgent Referrals	Providers may electronically mark a referral as urgent when clinically necessary. Urgent referrals are displayed in the electronic message to the Case Management Staff in red to assist clinical support staff with prioritizing daily tasks.
4. Scheduling Referral Appointments	In most cases, the referral provider contacts the patient directly to schedule the referral appointment. If a patient has not scheduled/ kept a referral appointment and is seen at Health Center B for a follow-up appointment, the Case Management Staff may assist the patient with scheduling.
5. Referral Reminders	Health Center B Case Management Staff logs into Local Hospital's electronic system daily to review referral appointments that have been scheduled. The Health Center B Case Management Staff places reminder calls to patients with Local Hospital referral appointments in the upcoming month. Patients with non-Local Hospital referrals typically receive reminder calls directly from the referral provider.
6. Referral Results	The Case Management Staff logs into the Local Hospital's electronic system daily to search for completed referral reports. Any available referral reports are printed, given to the referring Health Center B provider for review/sign-off, and scanned into the patient's Grey Sloan Memorial Health Center EHR. For non-Local

	Hospital referrals, the referral provider forwards the referral result/report to Health Center B, which is then signed off on by the provider and scanned into the patient's EHR.
7. Referral Tracking/Follow-Up	To maximize the number of referrals that are closed loop (meaning that the referring Health Center B provider receives follow-up information back from the referral source), Health Center B utilizes the referral tracking module of their EHR. Health Center B referral staff regularly review open referrals, following up with the patient as needed to ensure their referral appointments have been scheduled and kept. As needed, Health Center B referral staff follow up with the referral source to obtain any missing referral reports.
8. Case Management Backup	All Case Management Staff are trained in referral management, as detailed throughout this policy. In the event that a member of Case Management Staff is out of the office, any other Case Management Staff member may fulfill the Case Management Staff's referral management tasks.

TRAINING

All clinical staff (providers and clinical support staff) are trained in referral management as part of new staff orientation, and whenever significant changes are implemented.

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Health Center B	**ORIGINAL DATE:** April 28, 2016 **LATEST REVISION DATE:** October 15, 2024
SUBJECT: Hospitalization Tracking Policy	**APPLICABLE TO:** Program Coordinator

PURPOSE

This policy outlines the process of tracking hospital and emergency department (ED) visits for established primary care patients seen in the health center within the past 24 months.

POLICY:

It is the policy of Health Center B to provide comprehensive care coordination/case management services including the tracking of hospitalizations and emergency department visits. Tracking hospital and emergency visits as close as possible to when they happen can enhance follow-up, prevent readmission, and improve monitoring, which may prevent the condition from worsening. Health center staff must educate patients and family members to contact the health center after a hospital admission or emergency department visit. Health Center B will distribute patient education materials instructing patients to notify the health center when they go to the emergency department or are admitted to the hospital.

PROCEDURE

Health Center staff assumed different responsibilities in the tracking and follow-up process. Patients may present to the hospital either by a referral from their PCP as a result of an office visit or may present to the hospital upon self-referral. Depending on the patient's condition the patient may have been seen and treated in the ER or admitted to the hospital for further evaluation and treatment.

Step	Process
1. Nursing Staff	The nursing staff shall review the hospitalization or emergency room records for patients following up from an emergency room visit or a hospital discharge.
2. Front Office Staff	Upon notification of a hospital admission or emergency department visit from either a patient/family member or facility during scheduling, the following steps should be taken and documented on the reason for visit. a) Request the patient, at time of appointment scheduling, to bring all discharge documentation from hospital or emergency department where treatment was received Front office staff will request records via phone or fax and document “records requested” in reason for visit.

Health Center B	**ORIGINAL DATE:** April 28, 2016 **LATEST REVISION DATE:** October 15, 2024
SUBJECT: Hospitalization Tracking Policy	**APPLICABLE TO:** Program Coordinator

APPROVAL:

Dr. Richard Webber, Board President

07/28/2024
Date

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Health Center B	**ORIGINAL DATE:** October 28, 2014 **LATEST REVISION DATE:** June 15, 2024
SUBJECT: Diagnostic Tracking Policy, Reporting Test Result Policy	**APPLICABLE TO:** Ordering providers, clinical staff

POLICY

Diagnostic Tracking

PURPOSE

Health Center B recognizes the importance of tracking the results of diagnostic tests and informing patients of their results in a timely manner. This policy outlines the process for responding to critical, abnormal, and normal diagnostic results.

PROCEDURE

Step	Process
1. Imaging/Diagnostics	1) When a provider orders diagnostic test(s), including X-rays (or other imaging) for a patient, the provider will document the date the test was ordered and the ordering provider in the EHR. 2) All ordered diagnostic test(s) are documented electronically in the designated tracking system. 3) Ordered diagnostic test(s) are tracked by the Care Coordinator until completed. a. Completed is defined as the care or service was received or all communication attempts with the patient have been exhausted, yet the care or service was not received.
2. Laboratory Tests/Labs	1) When a provider orders laboratory test(s), including STAT labs for a patient, the provider will document the date the test was ordered and the ordering provider in the EHR. 2) All ordered laboratory test(s) are documented electronically in the designated tracking system. 3) To order STAT labs, the nurse must call AcentraLab at 888-888-8888 and request the STAT lab. If a provider would like to be called when the lab results are ready, the nurse indicates the provider's number on the order. Providers must give a phone number if the lab results will not be available until after hours. At this time, AcentraLab will send a courier to take the specimen to a designated stat lab facility. 4) Ordered laboratory test(s) are tracked by the Care Coordinator until completed.

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	a. Completed is defined as the care or service was received or all communication attempts with the patient have been exhausted, yet the care or service was not received.
5) ***Documentation and Timelines***	1) The Care Coordinator makes documented efforts to follow up with patients who miss appointments to complete ordered diagnostic test(s). a. First attempt: within 72 hours of a missed appointment, the patient is contacted via phone. b. Second attempt: 5-7 days of a missed appointment, the patient is contacted via phone. c. Third attempt: 10-12 days of a missed appointment, the patient is contacted via written notification sent with electronic delivery confirmation receipt. d. All three attempts will be documented in the EHR. 2) The Care Coordinator reviews all ordered diagnostic test(s) daily. The Care Coordinator will cease tracking upon: a. Verification that the ordered diagnostic test(s) was completed. b. Verification that a patient who has missed their appointment received three attempts at contact, including two verbal and one written per Health Center B policy.

Health Center B	**ORIGINAL DATE:** October 28, 2014 **LATEST REVISION DATE:** June 15, 2024
SUBJECT: Diagnostic Tracking Policy, Reporting Test Result Policy	**APPLICABLE TO:** Ordering providers, clinical staff

POLICY

Reporting Test Results

PURPOSE

Health Center B recognizes the importance of prompt review and communication of test results to ensure accurate diagnoses, effective attention and treatment, and optimal patient care.

Test results must be communicated to the ordering provider, or a surrogate provider if the ordering provider is unavailable, within a period of time that allows prompt clinical action to be taken. The ordering provider must communicate all test results, including normal results, to patients within specified time frames (see the discussion, Procedures) to ensure patients are active participants in their healthcare. This policy applies to all types of test results, such as laboratory, cardiology, radiology, and other diagnostic tests.

PROCEDURE

Step	Process
1. General Procedure for Receiving and Communicating All Test Results	1) Laboratory reference ranges are provided by the laboratory facility and included with electronic and paper laboratory results. If results are communicated by telephone (typically critical labs) reference ranges are available on request. 2) Depending on the type of test result, ordering providers may receive results from laboratories or outside testing centers by either direct verbal communication or electronic communication (see specific procedures for critical, abnormal, and normal test results below). a. Ordering providers must personally acknowledge receipt of the results via phone or written documentation. b. When results are reported by telephone, the person receiving the information must read back the information to the person calling with the results. The following process should be followed: i. The recipient of the result writes down the result. ii. The result is read back to the caller. iii. The caller verifies the accuracy of the result as the recipient reads it back.
2. Communicating Normal Test Results	1) Ordering providers may communicate results to patients in-person, through the patient portal or by letter, telephone, or

	encrypted e-mail. While the designated system sends test results automatically to the patient through their patient portal, this does not substitute for direct communication initiated by the provider. 2) Ordering providers may request that another licensed or certified staff member contact the patient with results; the name of the person contacting the patient with results should be documented. Normal lab results may be communicated to patients during their next visit to the clinic. 3) When the patient must take action in response to the results (e.g., change medications, schedule a visit to the office), providers should use direct verbal communication and document that the information was received and understood by the patient. Providers must not include any identifiable patient information in unencrypted e-mails or on voicemail/answering machines. 4) If the patient is not competent to make medical decisions, test results will be communicated to the patient's designated guardian or representative. 5) When the patient cannot be reached (e.g., phone number is disconnected), reasonable attempts should be made to contact the patient or his/her/their emergency contact and attempts should be documented in the patient's EHR. a. First attempt: within 24 hours of receipt of results, the patient is contacted via phone. b. Second attempt: 72 hours of receipt of results, the patient is contacted via phone. c. Third attempt: 5-7 days of receipt of results, the patient is contacted via written notification sent with electronic delivery confirmation receipt. d. All three attempts will be documented in the EHR.
3. Communicating Abnormal Test Results	1) Ordering providers may communicate results to patients in-person, through the patient portal or by letter, telephone, or encrypted e-mail. While the designated system sends test results automatically to the patient through their patient portal, this does not substitute for direct communication initiated by the provider. 2) Ordering providers may request that another licensed or certified staff member contact the patient with results; the name of the person contacting the patient with results should be documented. 3) When the patient must take action in response to the results (e.g., change medications, schedule a visit to the office), providers should use direct verbal communication and document

Health Center B	**ORIGINAL DATE:** October 28, 2014 **LATEST REVISION DATE:** June 15, 2024
SUBJECT: Diagnostic Tracking Policy, Reporting Test Result Policy	**APPLICABLE TO:** Ordering providers, clinical staff

	that the information was received and understood by the patient. Providers must not include any identifiable patient information in unencrypted e-mails or on voicemail/answering machines. 4) If the patient is not competent to make medical decisions, test results will be communicated to the patient's designated guardian or representative. 5) When the patient cannot be reached (e.g., phone number is disconnected), reasonable attempts should be made to contact the patient or his/her/their emergency contact and attempts should be documented in the patient's EHR. a. First attempt: within 24 hours of receipt of results, the patient is contacted via phone. b. Second attempt: 72 hours of receipt of results, the patient is contacted via phone. c. Third attempt: 5-7 days of receipt of results, the patient is contacted via written notification sent with electronic delivery confirmation receipt. d. All three attempts will be documented in the EHR.
4. *Communicating Critical Test Results*	1) Critical results must be communicated immediately by direct verbal communication from the outside laboratory or testing center to the ordering provider or surrogate provider. a. In cases in which the ordering provider and surrogate are not available, results must be communicated following the established chain of responsibility. b. The following steps should be taken when the ordering provider does not respond to notification of a critical test result: i. If the ordering provider does not respond within 10 minutes, call/ page the provider a second time. ii. If the ordering provider does not respond within 15 minutes of the second call, call/page the surrogate provider or the patient's primary care physician (if not the ordering provider). iii. If the surrogate provider does not respond within 15 minutes, call/page the surrogate provider a second time.

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SUBJECT: Diagnostic Tracking Policy, Reporting Test Result Policy	**APPLICABLE TO:** Ordering providers, clinical staff

	iv. If the surrogate provider does not respond within 15 minutes of the second call, call/page the executive director or medical director. c. Critical results should never be communicated over voicemail or e-mail. d. Critical results and necessary actions (e.g., come to the office, go to the ED) should also be communicated to patients immediately by direct verbal communication. 2) Health Center B may engage internal social services staff, patient's emergency contact(s), other known support professionals at external agencies and/or U.S. postal mail. Patient contacts should only be asked to communicate to the patient that and Health Center B provider is trying to reach them. 3) Critical lab results are flagged in the EHR. When providers see critical lab results, they assess the results (ensuring there was no laboratory error or issue with the specimen) and will immediately (no more than one hour of receipt) contact the patient by phone to notify him/her/them of the results. The provider then explains to the patient, what he/she/they should do as a result of critical lab results. This content is documented immediately in the EHR. a. First attempt: within 1 hour of receipt of critical lab result(s), the patient is contacted via phone. b. Second attempt: if the patient cannot be reached within 1.5 hours of receipt of critical lab result(s), the patient's emergency contact is contacted via phone. c. Third attempt: if the patient/emergency contact has not responded, the patient is contacted again via phone within 3-4 hour of receipt of critical lab result(s). d. Fourth attempt: if the patient/emergency contact has not responded, the patient's emergency contact is contacted again via phone within 3-4 hours of receipt of critical lab result(s). e. Fifth attempt: if patient/emergency contact has not responded, the nurse will contact the local police department and provide brief description of the situation, last known address for the patient, and request a welfare check. f. All attempts will be documented in the EHR.
5. ***Documentation***	1) The ordering provider must document:

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SUBJECT: Diagnostic Tracking Policy, Reporting Test Result Policy	**APPLICABLE TO:** Ordering providers, clinical staff

	a. Acknowledgment of receipt of results b. Actions taken related to the patient c. Patient notification, including date and time of notification, means used to communicate results (e.g., phone call, letter), and person spoken to (if applicable) d. All attempts to contact the patient if the patient cannot be reached e. Other clinical information as appropriate

APPROVAL:

Dr. Richard Webber, Board President

07/28/2024
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Health Center B	**ORIGINAL DATE:** December 28, 2007 **LATEST REVISION DATE:** September 15, 2024
SUBJECT: Orientation and Mandatory Education/Meetings	**APPLICABLE TO:** All Departments

PURPOSE

Health Center B has established an orientation program as well as a variety of annual employee education/training courses to ensure that staff are knowledgeable in departmental processes and the organization's overall policies and procedures, such as risk management, safety, and corporate compliance.

POLICY

All employees are required to satisfactorily complete an orientation program, our annual training program, as well as other orientation requirements on an annual basis. New hires are required to satisfactorily complete the orientation and annual training programs during their orientation period of employment as scheduled by Human Resources.

Full Time (FT) employees are to satisfactorily complete all assigned annual education and/or training programs within 30 days of assignment. Part Time (PT) and PRN employees (working less than 20 hours per pay period) will be allowed to complete their assigned education and/or training programs on a quarterly basis, at a paid rate of 30 minutes per training assignment. Failure to satisfactorily complete assigned annual education and/or training programs at or before the deadline will count as non-compliant at the time of the employee's annual evaluation.

The ability to deliver, support, and promote the mission, vision, and values of Health Center B is vital to our healthcare organization and dependent upon ongoing education and training. At times, employees may be assigned other mandatory educational meetings, such as annual employee updates, organizational in-services, departmental (staff) meetings, etc. Employees are required to attend such events. Employees are compensated for mandatory educational meetings coordinated by Human Resources, Administration, and/or their supervisor.

- Tardiness for mandatory educational meetings will not be tolerated. Every element of a mandatory educational meeting is essential; therefore, tardiness will be counted as an absence.
- For further details regarding compensation for mandatory educational meetings, reference Compensation for Employee Meetings policy.

The Director of Human Resources is responsible for coordinating and tracking mandatory annual education and/or training programs as defined in this policy. Documentation of the completed training shall be maintained in the employee's employment file for the duration of their employment.

ORIENTATION PROGRAM

The orientation program is conducted to acquaint new employees to the organization and their assigned department, as well as assist existing employees who may be assigned new duties. It is expected that employees will be trained in all required duties before they are expected to perform such duties independently. A procedure manual will be maintained to assist employees with duties when practical.

The orientation program will include, at a minimum, education and/or training in the following areas:

- Employee Handbook
- Health Center Compliance Manual (formerly PIN 98-23)
- Standards of Behavior

- Review of job description
- Annually Assigned Trainings (Risk Management, Corporate Compliance, Safety, etc.)
- Other such training as assigned

ANNUAL EDUCATION/TRAINING PROGRAM

The annual education/training program is designed to provide employees (clinical and non-clinical staff) with ongoing education related to the overall policies and procedures of the organization, such as:

- Corporate Compliance
- Risk Management
- Safety (such as: Hazard Communications; Emergency Preparedness: Safety Drills; etc.)
- Standard Precautions/Infection Control
- HIPAA & Privacy Policies

CLINICAL EDUCATION/TRAINING PROGRAM

In addition, all clinical employees are to satisfactorily complete education and/or training in the following areas within 30 days of hire and annually thereafter:

Health Center B	**ORIGINAL DATE:** December 28, 2007 **LATEST REVISION DATE:** September 15, 2024
SUBJECT: Orientation and Mandatory Education/Meetings	**APPLICABLE TO:** All Departments

- Immunization Education & Training
- Infection Control & TB Basics
- Universal Precautions
- Obstetrics Training
- Nursing Skills & Competencies
- Clinical Policies

MANDATORY EDUCATION PLAN FTCA SUMMARY

The policy outlines the Health Center B overall training program, as well as the expectation of the program. This policy is reviewed and approved by the Board of Directors. Further details include:

- Mitigation Plan for Completion:
    - Full time employees are to satisfactorily complete all assigned annual education and/or training programs within 30 days of assignment. Part-time and PRN employees will be allowed to complete their assigned education and/or training programs on a quarterly basis, paid at a rate of 30 minute per training assignment. Failure to satisfactorily complete assigned annual education and/or training programs at or before the deadline will count as non-compliant at the time of the employee's annual evaluation.

- Staff on temporary leave (such as FMLA) are allowed to complete assignments as “PRN employees” on a quarterly basis.

- Selection of Courses:

  - Courses assigned to Health Center B staff are reviewed annually for appropriateness. All items are updated on an annual basis to include Health Center B policy and procedure, as well as best practices (as identified via ECRI, HRSA, or other educational opportunities such as FTCA workshop). For 2024, the following items were chosen for FTCA applicability:

  - **Standard Precautions/Infection Control:** The course is a standardized catalog course from the Health Center B learning portal. It also contains applicable Health Center B policy/procedure. (*This training is assigned to all staff.*)

  - **Dental Risk Management (FTCA) Training**: The Dental Risk-specific training for 2024 was obtained via ECRI. ECRI’s Risk-specific dental training was chosen to acclimate dental staff to common risk-associated events within the dental program. (*This training is assigned only to dental staff.*)

  - **HIPAA/Confidentiality:** The course is a standardized catalog course from the Health Center B learning portal. It also contains applicable Health Center B policy/procedure. The training also identifies routine EMR and on-site auditing measures, as well as social media usage and the Health Center B Information Security Program. (*This training is assigned to all staff.*)

  - **OB Training:** The course chosen for 2024 was from the Improving Maternal Care course. (*This training is assigned only to clinical staff.*)

Health Center B	**ORIGINAL DATE:** December 28, 2007 **LATEST REVISION DATE:** September 15, 2024
SUBJECT: Orientation and Mandatory Education/Meetings	**APPLICABLE TO:** All Departments

2024 Mandatory Education Schedule					
Start Date	**Completion Date**	**Title of Training**	**Topic Area**	**Brief Description**	**Training Method**
January 8, 2024	February 8, 2024	Corporate Compliance & Risk Management	Risk Management	• Corporate Compliance policies, including education related to Conflict of Interest & Secondary Jobs • Risk Mgmt. policies, including incident reporting, driver's safety, etc.	Learning portal (all staff)
March 1, 2024	March 31, 2024	Standard Precautions/Infection Control	Infection Control	• This course will teach you about the serious nature of infection control in health care. By knowing the chain of infection, you can better prepare yourself for possible hazards. You will also learn about the ways you can protect yourself and those around you in your organization.	Learning portal (all staff)
March 18, 2024	April 18, 2024	Dental Risk Mgmt. (FTCA) Training	Areas of High-Risk	Dental Risk-specific training (ECRI). (1) Discuss the relationships between risk management, quality improvement, and patient safety,	Email (dental staff only)

				(2) Identify risks in the dental healthcare setting, (3) Review strategies that prevent or decrease risks to patients and dental personnel, (4) Review strategies for raising awareness and developing the culture of safety.	
May 1, 2024	May 30, 2024	HIPAA/Confidentiality	HIPAA	• EMR & Site Audits • Social Media Policy • Information Security Policy	Learning portal (all staff)
May 6, 2024	June 6, 2024	OB Training	OB	• Improving Maternal Care	Learning portal (all staff)
September 1, 2024	September 30, 2024	Emergency Preparedness (in-person)		• EPP & Communication • Emergency Codes • Drills & Participation	In person, all sites

Health Center B	**ORIGINAL DATE:** December 28, 2007 **LATEST REVISION DATE:** September 15, 2024
SUBJECT: Orientation and Mandatory Education/Meetings	**APPLICABLE TO:** All Departments

2024 Scheduled Acknowledgements			
Month	**Subject**	**Disperse Method**	**Special Consideration/Notes**
February 19-23	Corporate Compliance & Risk Management	Learning portal (all staff)	• Ensure updated policy stays in rotation
April 8-12	COI Acknowledgement COI Disclosure Secondary Jobs Disclosure	Learning portal (all staff)	COI Acknowledgement (all staff); COI Disclosure (contract providers, providers, C suite, board).
June 17-21	Confidentiality Acknowledgement Social Media Policy Information Security Program Policy	Learning portal (all staff)	
August 5-9	Patient Portal Usage	Learning portal (all staff)	
October 14-18	Employee Handbook	Learning portal (all staff)	
December 16-20	TB Symptom Screen	Learning portal (all staff)	

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FTCA Educational Training Tracking Form

HRSA
Health Resources & Services Administration

TRAINING INFORMATION	
1. Topic Area	Obstetrics Training (Health Center B)
2. Training Title	Effective Obstetric Case Management: Ensuring Maternal and Neonatal Safety
3. Brief Description	Manage obstetric cases, focusing on high-risk pregnancies, labor complications, and postpartum emergencies. Through case studies and hands-on workshops, participants will enhance their ability to ensure safe, patient-centered care for mothers and newborns.

If you need more rows beyond page 2, complete an additional FTCA Educational Training Tracking Form.

STAFF MEMBER INFORMATION

4. First Name *	5. Last Name *	6. Staff Type *	7. Date Training Completed *	8. Comments
Meredith	Grey	Clinical	3/19/2024	In house training
Derek	Shepherd	Clinical	3/19/2024	In house training
Cristina	Yang	Clinical	3/19/2024	In house training
Alex	Karev	Clinical	3/19/2024	In house training
Izzie	Stevens	Clinical	3/19/2024	In house training
George	O'Malley	Non-Clinical	3/19/2024	In house training
Miranda	Bailey	Clinical	3/19/2024	In house training
Richard	Webber	Clinical	3/19/2024	In house training
Callie	Torres	Clinical	3/19/2024	In house training
Arizona	Robbins	Non-Clinical	3/19/2024	In house training
Mark	Sloan	Clinical	3/19/2024	In house training
Lexie	Grey	Clinical	3/19/2024	In house training
April	Kepner	Clinical	3/19/2024	In house training
Jackson	Avery	Clinical	3/19/2024	In house training
Teddy	Altman	Clinical	3/19/2024	In house training
Owen	Hunt	Clinical	3/19/2024	In house training
Jo	Wilson	Clinical	3/19/2024	In house training
Andrew	DeLuca	Clinical	3/19/2024	In house training
Maggie	Pierce	Clinical	3/19/2024	In house training
Amelia	Shepherd	Clinical	3/19/2024	In house training
Nathan	Riggs	Clinical	3/19/2024	In house training

Catherine	Fox	Clinical	3/19/2024	In house training
Erica	Hahn	Clinical	3/19/2024	In house training
Stephanie	Edwards	Clinical	3/19/2024	In house training
Preston	Burke	Clinical	3/19/2024	In house training
Addison	Montgomery	Clinical	3/19/2024	In house training
Levi	Schmitt	Clinical	3/19/2024	In house training
Miranda	Bailey	Clinical	3/19/2024	In house training
Carina	DeLuca	Clinical	3/19/2024	In house training
Lucas	Adams	Clinical	3/19/2024	In house training
Tom	Koracick	Clinical	3/19/2024	In house training
Eliza	Minnick	Clinical	3/19/2024	In house training
Sadie	Harris	Clinical	3/19/2024	In house training
Finn	Dandridge	Clinical	3/19/2024	In house training
Reed	Adamson	Clinical	3/19/2024	In house training
Charles	Percy	Clinical	3/19/2024	In house training
Denny	Duquette	Clinical	3/19/2024	In house training
Ben	Warren	Clinical	3/19/2024	In house training
Kyle	Diaz	Clinical	3/19/2024	In house training
Susan	Grey	Clinical	3/19/2024	In house training
Thatcher	Grey	Clinical	3/19/2024	In house training
Ellis	Grey	Clinical	3/19/2024	In house training
Henry	Burton	Clinical	3/19/2024	In house training
Heather	Brooks	Clinical	3/19/2024	In house training
Sloan	Riley	Clinical	3/19/2024	In house training
Megan	Hunt	Clinical	3/19/2024	In house training
Paul	Stadler	Clinical	3/19/2024	In house training
Joey	Phillips	Clinical	3/19/2024	In house training
Taryn	Helm	Clinical	3/19/2024	In house training
		(Selection)		
		(Selection)		
		(Selection)		
		(Selection)		
		(Selection)		
		(Selection)		
		(Selection)		
		(Selection)		

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Health Center B		Date: 02/07/2024
Assessment	**Answer**	**Notes**
Risk Factors for Workplace Violence		
Do employees have contact with the public?	Yes	
Do employees exchange money with the public?	Yes	
Do employees work alone?	Yes	
Do employees work late at night or during early morning hours?	Yes	
Is the workplace often understaffed?	No	Still in the process of hiring more staff
Do employees have a mobile workplace (patrol vehicle, work van, etc.)	Yes	
Do employees deliver passengers or goods?	Yes	
Do employees perform jobs that might put them in conflict with others?	Yes	
Do they ever perform duties that could upset people (deny benefits, confiscate property, terminate child custody, etc.)	Yes	
Do employees or supervisors have a history of assault, verbal abuse, harassment, or other threatening behavior?	Yes	

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Inspecting Work Areas		
Are nametags or ID cards required for employees (omitting personal information such as name and home address)?	Yes	
Are trained security and counseling personnel accessible to workers in a timely manner?	Yes	
Do security and counseling personnel have sufficient authority to take all necessary action to ensure worker safety?	Yes	
Is there an established liaison with state police and/or local police and counseling agencies?	Yes	
Are bullet-resistant windows or similar barriers used when money is exchanged with the public?	Yes	
Are areas where money is exchanged visible to others who could help in an emergency? (i.e. can you see cash registers areas from the outside?)	Yes	
Is a limited amount of cash kept on hand, with appropriate signs posted?	Yes	
Could someone hear a worker who calls for help?	Yes	
Can employees observe patients or clients in waiting areas?	Yes	
Are waiting areas and work areas free from objects that could be used as weapons?	Yes	

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Is furniture in waiting areas and work areas arranged to prevent entrapment of workers?	Yes	
Are patient or client waiting areas designed to maximize comfort and minimize stress?	Yes	
Are patients or clients in waiting areas clearly informed how to use the department's services so they will not become frustrated?	Yes	
Are waiting times for patient or client services kept short to prevent frustration?	Yes	
Inspecting Exterior Building Areas		
Do workers feel safe walking to and from the workplace?	Yes	
Are the entrances to the building clearly visible from the street?	Yes	
Is the area surrounding the building free of bushes or other hiding places?	Yes	
Is lighting bright and effective in outside areas?	Yes	
Are security personnel provided outside the building?	N/A	Still in the process of installing cameras
Is video surveillance provided outside the building?	N/A	Still in the process of installing cameras
Are all exterior walkways visible to security personnel?	N/A	Will be once cameras are installed

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Inspecting Parking Areas		
Is the parking lot free of blind spots and landscaping trimmed back to prevent hiding places?	No	Need maintenance to come trim bushes around facility
Is there enough lighting to see clearly in the parking lot and when walking to building?	Yes	
Security Measures		
Physical barriers (plexiglass, bullet-resistant customer window, Etc.)?	Yes	
Security cameras or closed-circuit TV in high risk areas?	No	Still in the process of installing cameras
Panic buttons?	Yes	Installed in December 2023
Alarm systems?	No	Need to be looked at had issue in February which disabled system.
Door locks?	No	Had to remove dead bolts due to non-compliance by employees unlocking during the day we have a meeting set up to correct this workflow at the end of May 2024
Internal telephone system to contact emergency assistance?	Yes	
Two-way radio, pagers, or cellular telephones?	Yes	
Security mirrors?	N/A	Not needed
Secured entry?	Yes	

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"Drop safes" to limit the amount of cash on hand? Broken windows repaired promptly?	No Yes	Still need to be discussed in S&S Committee
Workplace procedures		
Are employees given maps and clear directions in order to navigate the areas where they will be working?	Yes	
Is public access to the building controlled?	Yes	
Are floor plans posted showing building entrances, exits,	Yes	
Is other emergency information posted, such as telephone numbers?	Yes	
Are special security measures being taken to protect people who work late at night?	N/A	Employees do not work nights here.
Are visitors escorted to offices or exam rooms for visits?	Yes	
Are authorized visitors in the building required to wear some sort of ID badge?	Yes	
Are ID badges required for employees omitting personal information?	Yes	

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Risk Assessment – Action Plan

Activity	Action Needed	Priority	Responsibility	Target Date	Date Completed
1. Review the Point of Care Clinical Policy.	1. Review current Point of Care test results clinical policy, update, and define Critical Laboratory Results.	High	CMO	4/15/2024	5/30/2024
2. Generate a monthly critical Laboratory results report.	1. Utilize EHR to generate critical laboratory results reports. 2. Review the current clinical workflow and implement a revised one for timely communication to providers and patients of critical laboratory results.		Lead Medical Assistant QI Director	5/21/2024 5/21/2024	5/30/2024 5/30/2024

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Hazard Identification Checklist

FACILITY NAME AND LOCATION: Health Center B	DATE: 7/11/24
WORK AREA INSPECTED: Whole facility	

	Area	Yes	No	Comments/Action
1	**General Facility Safety**			
1.1	Are lighting levels sufficient in all work areas?	X		
1.2	Are emergency exit signs clearly visible and functioning?	X		
1.3	Are walkways clear of any obstructions or trip hazards?		X	Walkway near reception has loose carpet; needs fixing.
2	**Fire and Emergency Preparedness**			
2.1	Are fire extinguishers available and properly maintained?	X		
2.2	Are fire exits clearly marked and free from obstruction?		X	Exit near back door is partially blocked by equipment; needs clearing.
2.3	Are smoke detectors and alarms regularly tested?	X		
3	**Electrical and Equipment Safety**			
3.1	Are all electrical cords and wiring in good condition?		X	Frayed wiring found near reception desk; needs immediate repair.
3.2	Are backup generators tested periodically?	X		
3.3	Is medical equipment maintained according to schedule?	X		
4	**Hazardous Material and Chemical Safety**			

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4.1	Are all hazardous substances clearly labeled?	X		
4.2	Are chemical spill kits readily available?		X	Spill kits need to be restocked.
4.3	Are staff trained in handling hazardous materials?	X		
5	**Workplace Ergonomics and Physical Hazards**			
5.1	Are workstations ergonomically designed?	X		
5.2	Are step stools and ladders in good condition?	X		
5.3	Are walkways free from wet or slippery surfaces?		X	Water spill found in hallway; needs immediate clean-up.
6	**Gas and Oxygen Cylinder Safety**			
6.1	Are oxygen and gas cylinders properly secured?		X	One oxygen cylinder was found unsecured; needs correction.
6.2	Are gas tanks stored separately from flammable materials?	X		
6.3	Are emergency shut-off valves easily accessible?	X		
7	**Security and Access Control**			
7.1	Are covered metal waste cans used for oily and paint-soaked waste? Are they emptied daily?	X		
7.2	Are exhaust ducts cleaned regularly?		X	Visitor logs are maintained but need review.
7.3	Is there planned preventive maintenance practiced?	X		

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Health Center B		Date: 11/8/2024
Assessment	**Answer**	**Notes**
Preventative Care		
Does Health Center B patient education materials cover the following topics:		
a. Disease-specific screenings?	Yes	
b. Substance abuse prevention?	Yes	
c. Smoking cessation?	Yes	
d. Promotion of healthy eating?	Yes	
e. Diabetes prevention and management?	Yes	
f. Violence prevention?	Yes	
g. Promotion of physical fitness?	Yes	
h. Stress management and relaxation techniques?	Yes	
Inspecting Work Areas		
Does the facility have written infection control policies and procedures?	Yes	
Are policies and procedures similar to other nationally recognized guidelines?	Yes	

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Do policies and procedures address:		
a. Identifiying infection risks?	Yes	
b. Preventing infection?	Yes	
c. Reporting results to public health or other authorities, when appropriate?	Yes	
d. Providing a plan of action to implement measures to reduce infection risks?	Yes	
Are infection control systems implemented that address:		
a. Hand hygiene in line with WHO and CDC guidelines?	Yes	
b. Separation of infected and uninfected patients?	Yes	
Health and Safety		
Does the facility take vitals on every patient for office visit appointments?	Yes	
Does Clinical staff check two identifiers when calling patients with any medical record information?	Yes	
Does the facility have an active safety and health program in operation that includes safety and health programs elements as well as the management of hazard specific to the work-site?	Yes	
Is one person clearly responsible for the health	Yes	QI Director

and safety program?		
Do you have a safety committee made up of management and labor representatives that meets regularly?	Yes	
Does the facility have a working procedure to handle in-house employee complaints regarding safety and health?	Yes	
Prenatal Care		
Are HCG test being done on patients of child bearing age (11-50)	Yes	
Is HIV tested completed on women of child bearing age? (15-50)	Yes	
Are Prenatal Referrals being tracked from start to finish?	Yes	

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2024 Annual Risk Management Report to Health Center B Governance Board

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

Submitted by:

Jane Doe, MSN, RN, Director of Quality/Risk Manager

John Doe, MBA/HRM, PHR, Human Resources Director/Risk Manager

Jean Doe, MS, MPH, Chief Operations Officer/Risk Manager

Reviewed/Approved by:

Justin Doe, MD, Chief Medical Officer

Julie Doe, Chief Executive Officer

Date submitted to the Board of Directors CQI Committee & Board of Directors:

May 15, 2024

Date recorded in the board minutes: May 25, 2024

Introduction

The purpose of this report is to provide an account of Health Center B annual performance relative to the risk management plan and evaluate the effectiveness of risk management activities aimed at mitigating risks and respond to identified areas of high-risk. Topics presented include high-risk and quarterly risk assessments, adverse event reporting, risk management training, risk and patient safety activities, and claims management. Each topic includes:

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

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

High-Risk and 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. Risk assessment tools include self-assessment questionnaires, failure modes and effects analysis (FMEA), and safety walk arounds and inspections —in which members of management or Risk Management committee walk around the building 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.

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Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Completed annual high-risk assessments	Health Center B has determined that the following areas are at high clinical risk: dental, overall sterilization, overall infection control, OBGYN, tracking (referrals) and pharmacy. Health Center B goal is to conduct a comprehensive risk assessment on at least two high-risk areas annually. For 2024, Infection control, Referrals, and Pharmacy were selected for comprehensive risk assessment. Health Center B completed the 2024 Infection Event Risk Matrixes across the organization, departments, and locations. Health Center B conducted a referral process audit reviewing implementation and compliance of protocol and practices in referral management. Lastly, a review was conducted within the 3 operational pharmacies.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Completed quarterly assessments	Health Center B at minimum conducts one risk assessment quarterly. Currently, the Quality department conducts those. The assessments are reviewed for opportunities for improvement by the RM/EOC committee, a corrective action plan is developed and disseminated to responsible parties to correct and follow through and report back on progress in resolving deficiencies. Concerns may be elevated to the CMO, CEO, COO, senior management, and/or the board as appropriate. Additional quarterly risk assessments are conducted as new risks are identified or processes implemented, equipment upgraded and on an ongoing basis. In 2024, audits were conducted in the areas of employee grievance and complaints, culture of safety, IT security, policy and procedures assessment, emergency panic button testing and general site/departmental risk indicators

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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.

Person Responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
RM - Quality	# Completed annual high-risk assessments	≥ 2 per year	Infection Event Risk Matrices 1	Referral Audit 1	Pharmacy Ops and Procedures 1		3
RM - Quality	# Completed quarterly assessments	Min 1/qtr.	11	9	16	8	44

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
High-risk areas identified, and assessments completed. Have designated staff to serve as main point of contact for assessments. Have a process for vetting policies, standing operating procedures, protocols, standing orders	A central plan of assessments to be conducted does not exist.	Collaborating with other managers/teams to conduct quarterly risk assessment	Staff may haphazardly conduct activities without thought to contingencies and follow-up actions

Follow-up Actions

Q2, 2024: Rolled out work order request and PPE request forms.

Q3, 2024: Drafted additional pharmacy policies.

Q4, 2024: Trained staff on Equipment Management module of new compliance management system.

Conclusion

An inventory tracking system will be acquired to track Health Center B equipment and manage PPE and work order requests.

Proposed Future Activities

Ensure equipment user guides are readily available and accessible. Develop a schedule of high-risk assessments. Develop or adopt departmental and/or programmatic checklists to perform risk assessments and engage more staff in the process of conducting assessments for their area(s).

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Adverse Event Reporting

Introduction

Event reporting is an essential component of the risk management program and is part of the performance and quality improvement process. Each provider, employee, or volunteer is responsible for reporting all adverse events, including sentinel events, incidents, and near misses at the time they are identified to his or her immediate supervisor and/or the Director of Nursing, Director of Operations or HR Director depending on incident type. The risk manager, in conjunction with the manager of the service (as applicable), is responsible for conducting follow-up investigations. The manager's investigation is a form of self-critical analysis to determine the cause of the incident, analyze the process, and make improvements.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Adverse events or incident	An adverse event or incident is defined as an undesired outcome or occurrence, not expected within the normal course of care or treatment, disease process, condition of the patient, or delivery of services. Health Center B monitors the number of events reported per quarter. Low volumes of reports may indicate barriers to reporting, such as fear of personal blame for events. The goal is to report all events so no minimum, nor maximum threshold is set.
Near miss	A near-miss is defined as an event or situation that could have resulted in an accident, injury, or illness but did not, either by chance or through timely intervention (e.g., a procedure almost performed on the wrong patient due to a lapse in verification of patient identification but caught at the last minute by chance). Health Center B monitors the number of near misses reported per quarter. Near misses are viewed as opportunities for learning and for developing preventive strategies and actions. The goal is to report all events so no minimum, nor maximum threshold is set.

Data Summary

See the dashboard below for completed risk management activities and status of Health Center B performance relative to established risk management goals.

Person responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
Staff	# Adverse events	Total #/qtr	1	0	1	0	2
Staff	# Near miss	Total #/qtr	1	1	0	0	2
Staff	# Medication errors	Total #/qtr	1	1	2	0	4
Staff	# Peer reviews	Total #/qtr	4	7	14	6	31

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SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
After training, monitoring, and coaching, decreased number of adverse events (i.e., needle sticks in Q1)	Event reporting could decrease if staff does not see systematic improvements because of reporting	Hold face-to-face staff training quarterly to address potential risk areas and processes	Event reporting could decrease if staff does not see systematic improvements as a result of reporting

Follow-up Actions

Q1/Q2 2024: Launched required staff training across organization. Continued staff training days across the organization.

Q3, 2024: Continued risk management and safety training and staff check-offs.

Q4, 2024: Continued risk management and safety training and staff check-offs. Relaunched Culture of Safety Survey across the organization.

Conclusion

About 76% of staff responded to the culture of safety survey. Many the responses were favorable. Significant improvements have been or will be made to processes, channels of communication, sharing of results and training. The surveys will be relaunched to compare results to gauge change.

Proposed Future Activities

Health Center B will roll out the incident reporting module of a new compliance management system. Develop and launch the culture of safety survey to re-measure employees' perception of safety to identify or measure change. We will include the following new measures: unsafe conditions reported and timeliness of completion.

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. The risk manager identifies areas of highest risk within the context of Health Center B risk management plan and selects risk management training topics.

Health Center B

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
# Risk Management education sessions/all staff trainings	Health Center B annual mandatory training to all Health Center B staff on the following topics: event reporting, basic infection control and prevention issues, medical record confidentiality requirements, workplace safety, customer service and the Health Insurance Portability and Accountability Act (HIPAA). Training is offered at minimum once a year online throughout the year.
# Risk Management education sessions/clinical staff trainings	Health Center B provides annual mandatory training to all Health Center B staff on the following topics: event reporting, basic infection control and prevention issues, medical record confidentiality requirements, workplace safety and the Health Insurance Portability and Accountability Act (HIPAA). This training is offered at minimum once a year online throughout the year.
Annual training completion rate	The annual training completion rate is reported as a cumulative total quarterly. Each staff member must complete all mandatory training by assigned due date (all staff training, clinical staff training, and other specialty clinical staff training) as assigned based on role. The goal is to have 80% of all staff complete annual training by the end of the calendar year. Training is offered at minimum once a year online through the year.
Obstetrics electronic fetal monitoring (EFM) training completion rate	Health Center B identified that staff working servicing women of childbearing age should complete electronic fetal monitoring (EFM). This training is in addition to all other required training. This training is available online.

Data Summary

See the dashboard below for completed risk management activities and status of Health Center B performance relative to established risk management goals.

Person responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
RM – HIPAA Privacy Officer	# Staff HIPAA educational training	1x/year		C			completed

RM – Quality Director and Director of Nursing	# Risk Management Education sessions or clinical staff trainings	1x/year	C	C	C	C	completed
RM - HR	Annual training completion rate	≥90%					93%
RM – HR	Obstetrics electronic fetal monitoring (EFM) training completion	100%					100%

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Online learning management system has made delivery of training sessions and tracking manageable. The system also provides due date reminders	Inconsistent in holding staff, providers and managers accountable	Hold staff and managers accountable. Educate everyone on the importance of completing training timely	Lack of adherence to due dates

Follow-up Actions

Q1 – Q4, 2024 Risk Management training is assigned to all existing staff and assigned to new staff during onboarding.

Q3, 2024 Staff check offs were completed across departments and job classifications.

Conclusion

The annual training completion goals were met. Managers and teams were held accountable for completing training timely and training was rolled out in smaller increments. Staff were educated on the importance of completing training on time.

Proposed Future Activities

Health Center B will continue to evaluate and update learning tracks annually and add additional training as needed. Increase reminders related to training due dates. Continue to hold managers accountable for not ensuring that staff complete training on time. Also, hold staff accountable for not completing training timely.

Health Center

B

Risk and Patient Safety Activities

Introduction

Health Center B patient safety and risk management program aims to continuously improve patient safety and minimize and/or prevent the occurrence of errors, events, and system breakdowns leading to harm to patients, staff, volunteers, visitors, and others through proactive risk management and patient safety activities.

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Patient satisfaction - overall satisfaction with service (Great/Good)	Health Center B routinely analyzes patient satisfaction surveys as part of its quality assurance/quality improvement (QA/QI) program. Health Center B goal is to receive an overall score of (Great/Good) on at least 90% of all returned patient satisfaction surveys during the calendar year.
Referral completion rate (internal)	Routine internal specialty referrals are tracked by the health center for timely completion in order to reduce the risk of missed or delayed diagnosis.
Referral completion rate (external)	Routine external specialty referrals are tracked by the health center for timely completion to reduce the risk of missed or delayed diagnosis.
Patients discharged	Health Center B ensures the safety and well-being of all individuals. Occasionally, a patient is discharged due
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. Health Center B monitors the number of grievances opened per quarter. No minimum nor maximum threshold is set.
Grievances – resolved rate	Health Center B responds to and resolves grievances in a timely manner. A complaint and grievance policy and procedures are in place and is reviewed annually. Health Center B goal is to resolve a grievance within ten business days from initial receipt of notification.
Attorney requests for Medical Records	Health Center B responds to requests for medical records in a timely manner. The volume and types of requests are tracked and monitored for trends.
Credentialing and Privileging files reviewed	Health Center B maintains files for all clinical staff that contain documentation of licensure, credentialing verification, and applicable privileges, consistent with the health center's operating procedures as required by the Health Center Program Compliance Manual. The health center monitors for timely renewal of privileges.

Health Center B

Data Summary

See the dashboard below for completed risk management activities and status of Health Center B performance relative to established risk management goals.

Person responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
RM - Quality	Patient satisfaction - overall satisfaction with service (Great/Good)	≥90%	97%	93%	94%	95%	95%
RM – Quality	Referral completion rate (internal)	≥90%	91%	87%	75%	60%	80%
RM – Quality	Referral completion rate (external)	≥85%	89%	81%	75%	60%	77%
RM - Operations	# Patients discharged	#/qtr	2	3	2	8	15
RM – Operations	# Grievances (patients)	#/qtr	0	0	0	2	2
RM – Operations	Grievances (patients) – resolved rate	100%	0	0	0	100%	100%
RM – HIM/HIT	# Attorney requests for Medical Records	#/qtr	69	50	52	40	-
RM - HR	# Credentialing and Privileging files reviewed	#/qtr	7	14	31	5	-

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Training, training, training Maintenance of facilities Reiterating expectations Patient Portal Policies and Procedures	Inconsistent customer service practice. Lack of decision-making skills in a favorable direction	Continuous training on complete, timely and accurate documentation in the medical record Training and reporting on hazards Culture of improvement Add appropriate signage	Potential litigation Unsatisfied consumers Loss of patients

Follow-up Actions

Q1- Q4, 2024 Patient complaints are addressed timely. As a last resort, several patients have been discharged from receiving services due to bad behavior (i.e., irate, uncontrollable, foul language, threats, etc.).

Conclusion

Customer service training has been ongoing. Patients' rights and responsibilities are posted, visitor policy is posted and the Lynne Truxillo Act (RS 40:2199.11) signage is posted. Copies are made available.

Proposed Future Activities

The incident reporting module of our new compliance management system, will be implemented to electronically to manage grievances. Encourage patients to adopt portal creation and usage to assist with transfer of information.

Claims Management

Introduction

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

Risk Activity Focus Area/Measure	Summary Description of Assessment/Methodology/Indicators
Claims submitted to HHS	Health Center B immediately sends court complaints or notices of intent to the HHS Office of the General Counsel. Health Center B monitors the number of claims sent per quarter. No minimum nor maximum threshold is set.
Claims settled or closed	Health Center B monitors the number of claims settled or closed per quarter. No minimum nor maximum threshold is set.
Lawsuits filed	Health Center B monitors the number of lawsuits resulting from a claim that are filed per quarter. No minimum nor maximum threshold is set.
Lawsuits litigated	Health Center B monitors the number of lawsuits litigated per quarter. No minimum nor maximum threshold is set.
Lawsuits settled	Health Center B monitors the number of lawsuits settled per quarter. No minimum nor maximum threshold is set.
Licensure board inquiries	Health Center B monitors the number and type of licensure board inquiries received 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 B performance relative to established risk management goals.

Person responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
RM – HR*	# Claims submitted to HHS	NA	0	0	0	0	0
RM - HR	# Claims settled or closed	NA					1
RM – HR/Legal	# Lawsuits filed	NA	0	0	0	0	0

RM – HR/Legal	# Lawsuits litigated	NA	0	0	0	0	0
RM – HR/Legal**	# Lawsuits settled	NA	0	0	0	0	0
RM - HR	# Licensure board inquiries	NA					1

SWOT Analysis

Strengths	Weaknesses	Opportunities	Threats
Training, training, training Maintenance of facilities Reiterating expectations Credentialed staff	Address public reviews and comments timely Chart closure rate	Continuous training on complete, timely and accurate documentation in the medical record Training and reporting on hazards Culture of improvement	Potential litigation Malpractice suit Untimely chart completion Potential Facility hazards Potential social media comments and reviews

Follow-up Actions

In 2024, there were no follow-up actions related to claims management.

Conclusion

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. Deploy transcribing technology to all providers to improve chart closure rated and monitor chart closure rate monthly.

Report Submission

The 2024 Annual Risk Management Report to Health Center B Governance 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.

Health Center B Risk Management Dashboard Calendar Year 2024

Person Responsible	Measure/ Key Performance Indicator	Threshold	Q1	Q2	Q3	Q4	Annual Total
Risk Assessments							
RM - Quality	# Completed annual high-risk assessments	≥2/year	3rd party sterilization evaluation 1	Referrals Audit 1	Infection Event Risk Matrixes 1	0	3
RM - Quality	# Completed quarterly assessments	Min 1/qtr	13	11	13	10	47
Adverse Events/ Incident Reports							
Staff	# Adverse events	Total #/qtr	1	0	0	0	1
Staff	# Near miss	Total #/qtr	1	0	0	0	1
Staff	# Medication error	Total #/qtr	1	1	1	0	3
CMO/HR*	# Peer Reviews	Total #/qtr	0	7	13	3	23
Training and Education							
RM – HIPAA Privacy Officer	# Staff HIPAA educational training	1x/year		completed			Completed
RM – HR/Quality Director/Infection Control Coordinator	# Risk Management education sessions/all staff trainings	1x/year	completed	completed	completed	completed	Completed
RM – Quality Director/Director of Nursing/Infection Control Coordinator	# Risk Management education sessions/clinical staff trainings	1x/year	completed	completed	completed	completed	Completed
RM - HR	Annual training completion rate	≥90%					93%
RM – HR	Obstetrics electronic fetal monitoring (EFM) training completion	100%					100%

Risk and Patient Safety Activities							
RM - Quality	Patient satisfaction - overall satisfaction with service (Great/Good)	≥90%	97%	93%	94%	95%	95%
RM - Quality	Referral completion rate (internal)	≥90%	91%	87%	75%	60%	80%
RM - Quality	Referral completion rate (external)	≥85%	89%	81%	75%	60%	77%
RM - Operations	# Patients discharged	#/qtr	2	3	2	8	15
RM - Operations	# Grievances	#/qtr	0	0	0	2	2
RM - Operations	Grievances – resolved rate	100%	0	0	0	100%	100%
RM – HIM/HIT	# Attorney requests for Medical Records	#/qtr	69	50	52	40	-
RM - HR	# Credentialing and Privileging files reviewed	#/qtr	7	14	31	5	-
Claims Management							
RM – HR	# Claims submitted to HHS	#/qtr	0	0	0	0	0
RM - HR	# Claims settled or closed	#/qtr					1

Health Center

B

Person responsible	Measure/Key Performance Indicator	Threshold/ Goal	Q1	Q2	Q3	Q4	Annual Total
RM – HR/Legal	# Lawsuits filed	NA	0	0	0	0	0
RM – HR/Legal	# Lawsuits litigated	NA	0	0	0	0	0
RM – HR/Legal**	# Lawsuits settled	NA	0	0	0	0	0
RM - HR	# Licensure board inquiries	NA					1
Dashboard Key – Performance Threshold							
*Improved/exceeded expectations (green shading or *)*							
*Acceptable/needs improvement (yellow shading or **)*							
*Not meeting target, action needed (red shading or ***)*							

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Health Center B	**ORIGINAL DATE:** June 15, 2020 **LATEST REVISION DATE:** May 10, 2024
SUBJECT: Credentialing and Privileging Procedure	**APPLICABLE TO:** Clinical Staff

PURPOSE:

To establish policies and procedures for Health Center B credentialing/privileging program to ensure continued compliance with state/federal regulations and standards set forth by accrediting bodies to drive continuous improvement of quality, patient care and mitigate risk.

POLICY:

This policy applies to all Health Center B Licensed Independent Practitioners (LIP) whether employed directly or contracted; volunteers; and/or locum tenens.

Credentialing and privileging will be performed on all LIPs before assuming patient care activities.

Responsibility: The Board of Directors (BOD) has the ultimate authority for the approval or denial of credentialing and privileging decisions for all Licensed Independent Practitioners (LIP). The BOD delegates oversight of this Policy to the Credentialing Committee, which consists of executives or leaders from all primary service lines and the Chief Financial Officer (CFO). The Credentialing Committee delegates responsibility for creating and maintaining current and active LIP credentialing and privileging files to the Credentialing Department.

Licensed Independent Practitioners (LIP):

A. Licensed Independent Practitioner (LIP): An individual permitted by law to provide care and services without direction or supervision, within the scope of the individual's license, and consistent with individually granted clinical privileges. Health Center B defines LIPs as including, but not limited to:
    - Physicians
    - Dentists
    - Nurse Practitioners
    - Physician Assistants
    - Behavioral Health Providers

B. Applications: During the inquiry and interview process, an LIP candidate will submit the following:
    - Curriculum vitae or resume

C. LIP contracts: Upon an offer being extended to a LIP, a contract is created and provided to the LIP for signature. The contract will be voided or postponed if the full credentialing and privileging process is not satisfactorily completed by the date of hire.

D. Initial Collection of Information: Following offer execution by Grey Sloan Memorial Health

Center, Human Resources will notify the Credentialing Department and will provide necessary information for credentialing/privileging to occur.

a. The following information is collected from the applicant during the initial credentialing and privileging process.
    - Government-issued identification, such as a driver's license or passport
    - State Health Care Professional Credentialing and Business Data Gathering Form
    - Diplomas of medical school, dental school, Behavioral Health Degree
    - Certificates from any training programs
    - Evidence of medical board certification, if applicable
    - Active State license
    - Active DEA license
    - Active CPR card
    - Fitness for Duty Form that verifies the physical and cognitive ability of the individual to perform their responsibilities in a safe, secure, and effective manner.
    - Self-attestation in the State of Illinois Health Care Professional Credentialing and Business Data Gathering Form
    - Professional/peer references will be contacted regarding the specific competencies of the applicant. These contacts will be kept in the candidate's credentialing and privileging file.

b. The Health Center B Credentialing Department will open a listing with the database maintained by the Council on Affordable Quality Healthcare (CAQH) and begin populating the database with the LIP's information. The LIP is expected to fully cooperate with this process.

c. The Human Resources Director will ensure that collaborative agreements are signed and maintained for all Advanced Practice Medical Providers (APP), prior to patient care.

E. Primary Source Verification: Primary Source Verification (PSV) is verification by the original source of a specific credential to determine the accuracy of a qualification reported by an individual health care practitioner. PSV is completed, at a minimum, for the following:
    - Current Licensure
    - Board Certification (if applicable)
    - Relevant education, training, or experience
    - Current competence
    - Fitness for Duty
    - National Practitioner Data Bank (NPDB) Query
    - Drug Enforcement Administration Licensure (as applicable)

    a. The American Medical Association (AMA) Physician Profile may serve as primary source verification for any Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or Physician Assistant.

    b. For Dentists and Behavioral Health Providers, the Credentialing Department will query the National Student Clearing House for the professional school or

training program of the applicant. If the information is not available through the query, the Credentialing Department will obtain a written verification of the degree or training either on the school's letterhead stationery or via email from the registrar's office.

c. The Credentialing Department will maintain a tracking system to follow and report on progress for each LIP for all source verification. Periodic reports of Credentialing/Recredentialing status will be provided to the Credentialing Committee, as requested.

F. Secondary Source Verification: Secondary Source Verification (SSV) uses methods to verify credentials when PSV is not required. SSV is completed for the following:
   - Government-issued photo identification
   - Hospital Admitting Privileges (as applicable)
   - Immunization and PPD status; and
   - Life Support Training

Initial Privileging:

A. Privileging is required of each LIP specific to the services being provided. Health Center B verifies its LIPs possess the requisite skills and expertise to manage and treat patients and to perform the medical procedures that are required to provide the authorized services. It is the responsibility of Health Center B to assure practitioners have met standards of practice and training that enable them to manage and treat patients and/or perform procedures and practices with a level of proficiency which minimizes the risk of causing harm or injury. Verification procedures are appropriate to the specialty of each practitioner, the breadth of clinical services offered by Health Center B, and the particular circumstances of the center's accessibility to ancillary and tertiary medical practitioners. The initial granting of privileges to LIPs is performed by Health Center B with ultimate approval authority vested in the BOD and based on recommendations by the Credentialing Committee.

B. The LIPs completed Credentialing and Privileging packets containing application, verifications, and other relevant documentation will be reviewed by the Chief Medical Officer, Lead Dentist, or Chief Behavioral Health Officer, as applicable based on the provider type, who will then make a recommendation to the Credentialing Committee to approve or deny the applicant or staff member.

C. The Credentialing Committee will present to the Board of Directors (BOD) the recommendations to grant or deny the requested privileges for all LIPs based upon a thorough review of the practitioner's credentials and evaluation of clinical qualifications.

Hospital Privileges (if applicable):

A. Hospital Privileges: The Credentialing Department will initiate the enrollment of new

medical providers with all Health Center B-designated hospitals, as applicable. As additional information, form completion, or provider signatures become necessary, the Credentialing Department will work with the provider to complete the requested documentation.

B. Health Plan Enrollment: The Credentialing Department will initiate the enrollment of the new LIP with all Health Center B-designated carrier plans. The Finance Department will maintain the list of applicable carrier plans. As additional information, form completion or LIP signatures become necessary, the Credentialing Department will work with the LIP to complete the requested documentation.

C. The Credentialing Department will maintain a tracking system to follow and report on progress for each LIP with each plan. Periodic reports will be given to the Credentialing Committee.

D. The Credentialing Department will maintain a tracking system to follow and report on progress for each provider with each hospital. Periodic reports will be given to the Credentialing Committee.

Renewal and Appeal:

A. At least every two years, all LIPs will be reviewed for recredentialing and reappointment of privileges. This process includes verification of expiring or expired credentials using the appropriate source, NPDB Query, Fitness for Duty, verification of annual PPD status and a synopsis of at least peer review or performance results for the 2-year period. All reappointment activity is reviewed by the CMO, Lead Dentist or Chief Behavioral Health Officer as applicable and the CEO and presented to the BOD for determination.

B. Any LIP that is denied or discontinued Health Center B clinical privileges may appeal this determination, in writing, within 10 days of notification. To initiate the appeal process, the LIP must submit a written appeal request to the BOD. The BOD reviews the appeal request and decides to uphold or reverse its previous decision. The appeal decision made by the BOD is final

PROCEDURE:

A credentialing and privileging checklist is used to document and track completeness of the credentialing and privileging process. The checklist becomes a part of the permanent practitioner file. Criteria include:

A. Primary verification of state licensure will be performed via the Internet through the appropriate licensing agency (i.e., IDFPR or DEA).

B. Primary verification of the highest degree attained will be performed via the Internet through the National Student Clearinghouse or the registrar’s office of the appropriate

university and/or via background check completed by Human Resources. Residency and Board Certification will be verified through the American Medical Association. Certification for Advanced Practice Registered Nurses (APRN) will be verified through the American Nurses Credentialing Center (ANCC) or the American Academy of Nurse Practitioners Certification Board (AANPCB).

C. If the applicant is not Board or Nationally Certified, competency to practice will be evaluated by a review of the past 2 years of CME's or CEU's.

D. References will be completed by sending forms directly to the identified References from the Health Center B Credentialing Department or Human Resources.to be completed and returned.

E. Hospital affiliations are verified directly with the Hospital Facility where the practitioner identifies they are on staff. The verification received back from the facility is acceptable as source for documentation of such credential.

F. The National Practitioner Data Bank (NPDB) will be queried by Health Center B for review.

G. A Fitness for Duty Form is collected for each LIP at the time of initial credentialing and privileging and renewal.

H. A copy of the applicant's tuberculosis test results, Hepatitis B immunity, rubella immunity, varicella immunity, influenza immunity, pertussis immunity and pre- employment drug screen.

I. A copy of the current professional license, DEA license (if applicable), and current and appropriate life support training card (i.e., CPR, ACLS, BCLS).

J. A copy of a current government-issued photo ID, such as driver's license, military ID, state ID, or passport.

K. A copy of the applicant's current malpractice insurance.

L. Health Center B will query the Office of Inspector General Exclusion List in respect to Applicants Full Name and "also known as" names, if applicable.

M. Evidence of privileging: The privileging process may involve the following:
   - primary source verification of a course of study from a recognized and certifying educational institution showing that the clinician met or passed a level of training required to perform a defined procedure or management protocol.
   - delineation of privileges form signed by provider.
   - direct, first-hand one-on-one documentation by a supervising clinician who possesses the privilege of the particular procedure or management protocol; and/ or

- direct proctoring by a qualified clinician possessing a degree of expertise in a particular procedure or protocol beyond the level of expertise of most primary care providers.

Temporary Privileges:

Temporary privileges may be granted for the following circumstances:

A. In the event of an emergency or disaster which is defined as an event affecting the overall health center target population and/or the health center's community at large, which precipitates the declaration of a state of emergency at a local, state, regional, or national level by an authorized public official, i.e. State Governor, Secretary of the Department of Health and Human Services, or the President of the United States.
   i. Examples include but are not limited to:
      - Hurricanes, floods, earthquakes, tornadoes, widespread fires, and other natural/environmental disasters
      - civil disturbances, terrorist attacks, collapses of significant structures within the community (e.g., buildings, bridges) and infectious disease outbreaks or other public health threats.
   ii. In these circumstances, temporary privileges may be granted by the CEO of the impacted health center upon expedited review and recommendation of the Credentialing Committee, provided there is verification of credentials, current licensure, references, claims history and current competence.

B. The CEO determines when temporary privileging will occur on a case-by-case basis and whether extraordinary circumstances justify a determination that the situation faced by the health center constitutes an emergency.

Modification and/or Revocation of Privileges

At any time, if the CMO, Lead Dentist or Chief Behavioral Health Officer recognizes an area of clinical privileging concern, they may immediately and temporarily limit the privileges of an LIP. This action would then trigger an occurrence-based peer review process around the area of concern. Based on findings of this peer review, the CMO, Lead Dentist or Chief Behavioral Health Officer may recommend to the CEO and Board one of the following actions:

A. Continued limitation of specific privilege until satisfactory competence in that area is demonstrated.
B. A revocation of a specific privilege
C. Reinstatement of the temporarily limited privilege.
D. The Board of Directors will notify the LIP, in writing, of their decision.

Any LIP who has had a privilege limited as above may appeal that decision within 30 days by submitting a written appeal request to the CEO and Board. The Board will review the appeal and uphold or reverse its decision to limit a clinical privilege. The appeal decision made by the Board is final and will be communicated via a written response to the LIP.

Health Center B	**ORIGINAL DATE:** June 15, 2020 **LATEST REVISION DATE:** May 10, 2024
SUBJECT: Credentialing and Privileging Procedure	**APPLICABLE TO:** Clinical Staff

Separation of employment at Health Center B equates to a voluntary relinquishment of all clinical privileges.

Disaster Privileges: Our privileging document recognizes the ability of any LIP to act to the best of their ability in the event of a clinical emergency.

Documentation and Monitoring

Primary and Secondary source verification is documented on a credentialing. checklist which is maintained as part of the practitioners' file.

BOD decisions are documented in the BOD minutes as well as on the credentialing and privileging checklist.

Each LIP is responsible for maintaining the current and active status of licensing, DEA, if applicable, immunizations, hospital privileges, if applicable and life support training, as appropriate.

REFERENCES:

Sections 330(a)(1) and (b)(1), (2) of the PHS Act

Joint Commission Comprehensive Accreditation Manual for Ambulatory Care: HR HRSA Health Center Program Compliance Manual

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Health Center

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Credentialing and Privileging List

FTCA ID	First Name	Last Name	Most Recent Credentialing Date	Most Recent Privileging Date	Needs Attention	Options
FTCA00088888	Meredith	Grey	12/14/2023	12/14/2023		View Individual Details
FTCA00088888	Derek	Shepherd	04/10/2023	04/10/2023		View Individual Details
FTCA00088888	Cristina	Yang	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Alex	Karev	07/11/2023	07/11/2023		View Individual Details
FTCA00088888	Izzie	Stevens	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	George	O'Malley	08/14/2023	08/14/2023		View Individual Details
FTCA00088888	Miranda	Bailey	07/20/2023	07/20/2023		View Individual Details
FTCA00088888	Richard	Webber	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Callie	Torres	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Arizona	Robbins	12/14/2023	12/14/2023		View Individual Details
FTCA00088888	Mark	Sloan	04/10/2023	04/10/2023		View Individual Details
FTCA00088888	Lexie	Grey	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	April	Kepner	07/11/2023	07/11/2023		View Individual Details
FTCA00088888	Jackson	Avery	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Teddy	Altman	08/14/2023	08/14/2023		View Individual Details
FTCA00088888	Owen	Hunt	07/20/2023	07/20/2023		View Individual Details
FTCA00088888	Jo	Wilson	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Andrew	DeLuca	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Maggie	Pierce	12/14/2023	12/14/2023		View Individual Details
FTCA00088888	Amelia	Shepherd	04/10/2023	04/10/2023		View Individual Details
FTCA00088888	Nathan	Riggs	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Catherine	Fox	12/14/2023	12/14/2023		View Individual Details
FTCA00088888	Erica	Hahn	04/10/2023	04/10/2023		View Individual Details
FTCA00088888	Stephanie	Edwards	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Preston	Burke	07/11/2023	07/11/2023		View Individual Details
FTCA00088888	Addison	Montgomery	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Levi	Schmitt	08/14/2023	08/14/2023		View Individual Details
FTCA00088888	Miranda	Bailey	07/20/2023	07/20/2023		View Individual Details
FTCA00088888	Carina	DeLuca	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Lucas	Adams	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Tom	Koracick	12/14/2023	12/14/2023		View Individual Details
FTCA00088888	Eliza	Minnick	04/10/2023	04/10/2023		View Individual Details
FTCA00088888	Sadie	Harris	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Finn	Dandridge	07/11/2023	07/11/2023		View Individual Details
FTCA00088888	Reed	Adamson	03/11/2024	03/11/2024		View Individual Details
FTCA00088888	Charles	Percy	08/14/2023	08/14/2023		View Individual Details
FTCA00088888	Denny	Duquette	07/20/2023	07/20/2023		View Individual Details
FTCA00088888	Ben	Warren	04/15/2024	04/15/2024		View Individual Details
FTCA00088888	Kyle	Diaz	03/11/2024	03/11/2024		View Individual Details

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2(A). Has the health center had any history of claims under the FTCA?

Note: Health centers must provide any medical malpractice claims or allegations that have been presented during the past 5 years.

Health Center B

[X] Yes [_] No

If Yes, list each claim below.

Date of occurrence: 03/10/2020

Names of Provider(s) involved:	Levi Schmitt, M.D.; Tom Koracick, M.D.; Andrew DeLuca, M.D.
Role(s) in Health Center:	Physicians
Speciality:	Family Medicine
Others:	
Nature of Allegations:	Claims - Obstetrics Related
Date of Occurrence:	03/10/2020
Date Claim Filed:	04/15/2020
Summary of allegations:	It is alleged that employees and staff failed to accurately diagnose the patient, allowing the lymphoma to remain undiagnosed and progress until it was finally identified in March 2020.
Has this claim or allegation been resolved or settled?	[X] Yes [_] No
Summary of health center internal analysis and implemented steps to mitigate the risk of such claims in the future (Only submit a summary if the case is closed. If the case has not been settled, do not include the summary.)	An analysis of this claim was conducted with the Medical Director and Risk Manager thoroughly reviewing the medical record. Upon review, it was determined that the providers involved demonstrated due diligence by referring the patient for further testing and conducting appropriate follow-up. Staff education regarding proper tracking and timely documentation was reinforced with both case managers and medical providers. On July 23, 2023, I contacted Robert Murphy, Attorney with the Office of the General Counsel, via email. He responded, stating, "Claim 2023-0234 was denied and closed because the claimant filed a Complaint in the United States District Court for the Western District of Washington."

Supporting Claims Documentation (Only For Closed or resolved Claims and Allegations) (Maximum 10)

No documents attached

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