THE QUALITY-COMPLIANCE COLLABORATIVE IN FQHCs

Illustrating the Evolving Model for American Healthcare

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PRESENTERS

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SURVEY

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

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WHAT IS AN FQHC?

- Under the Social Security Act, FQHC means:

(1) An entity that is receiving a PHSA Section 330 grant or is receiving funding through a contract with a PHSA Section 330 grant recipient;

(2) An entity that meets the requirements to receive a PHSA Section 330 grant as determined by HRSA;

(3) An entity that was treate4d by the Secretary of HHS as a comprehensive funded health center for the purposes of Medicare Part B as of 1/1/1990; or

(4) An outpatient program or facility operated by an Indian Tribe, Tribal Operations, or Urban Indian Organization receiving funds authorized in the Indian Health Care Improvement Act.

Source: § 18611(aa) of the Social Security Act, 42 U.S.C. §1395x and §1905(1)(2)(B), 42 U.S.C. §1396d.

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TYPES OF HEALTH CENTERS

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

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THE AFFORDABLE CARE ACT

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

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

How does that impact community health centers?

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IMPACT ON COMMUNITY HEALTH CENTERS

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

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WHAT WE ARE HERE TO TALK ABOUT…

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COMPLIANCE

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

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

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

8. The Quality-Compliance Collaborative.

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330 COMPLIANCE – QUALITY FOCUS

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

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COMPLIANCE → QUALITY

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

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

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

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WHEN IT GOES SIDEWAYS….

Rideout CEO to face charges

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

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

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

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

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

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WHAT CAME OUT OF IT

The Bad

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

The Good

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

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GARP'S THEORY TESTED

Department of Justice

U.S. Attorney's Office

Eastern District of California

SHARE

FOR IMMEDIATE RELEASE — Tuesday, December 6, 2016

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

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

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THE BEST OF THE GOOD

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

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COMPLIANCE FOCUS

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

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QUALITY/COMPLIANCE COLLABORATIVE

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

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HRSA EFFORTS TO EXPAND AND ACCELERATE QUALITY IMPROVEMENT

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

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

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QUALITY IMPROVEMENT

OBJECTIVES

1. American Healthcare System at a glance
2. Understanding Quality Improvement
3. Building a Culture of Quality
   - Moving to Value Based Care
   - SCHC example

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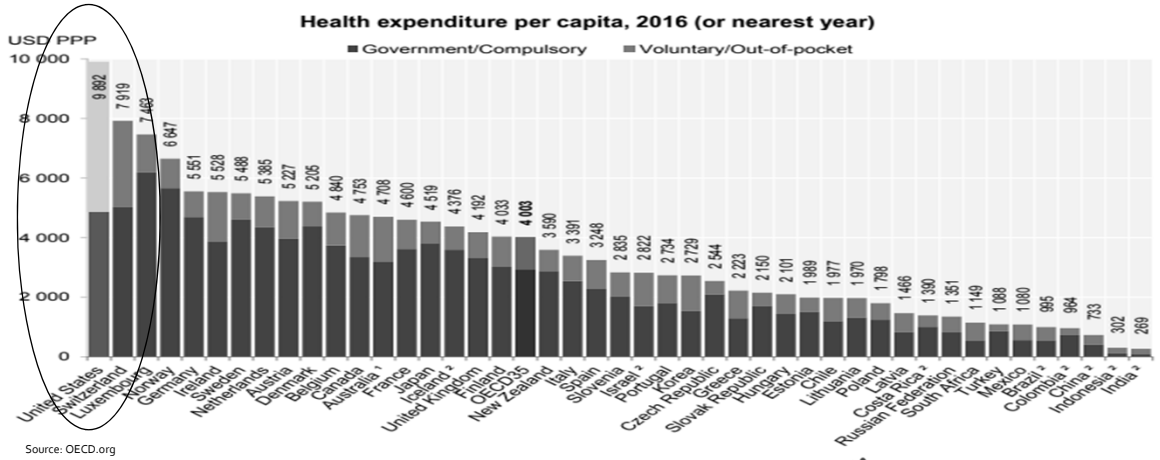
AMERICAN HEALTHCARE SYSTEM

HEALTHCARE EXPENDITURE

(COMPARED TO OTHER OECD COUNTRIES)



Source: OECD.org

- **Health spending averages $9,892 per person in the US (adjusted for local costs), much higher than in all other countries (the OECD average is $4,003).**
- **Health spending amounted to 17.2% of GDP, more than eight percentage points above the OECD average**

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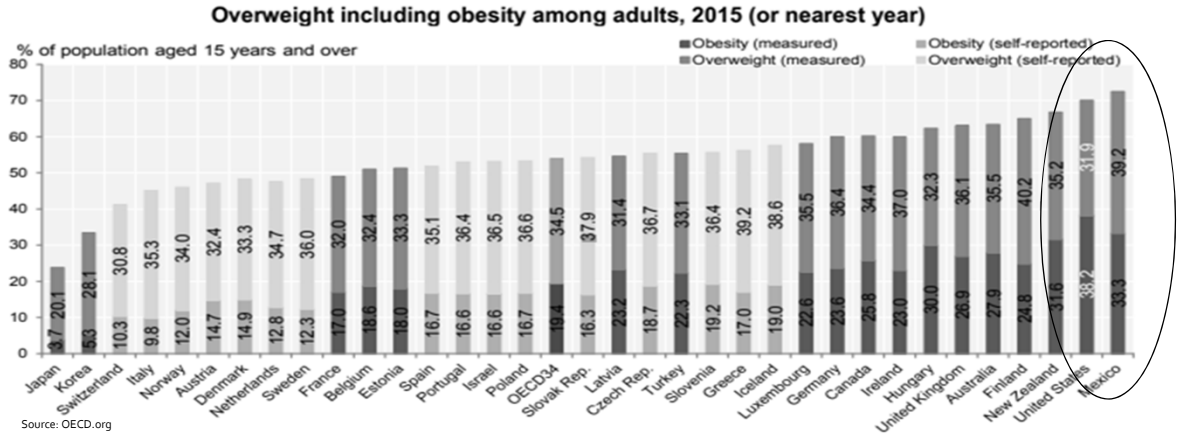
OBESITY RATES

(COMPARED TO OTHER OECD COUNTRIES)



Source: OECD.org

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

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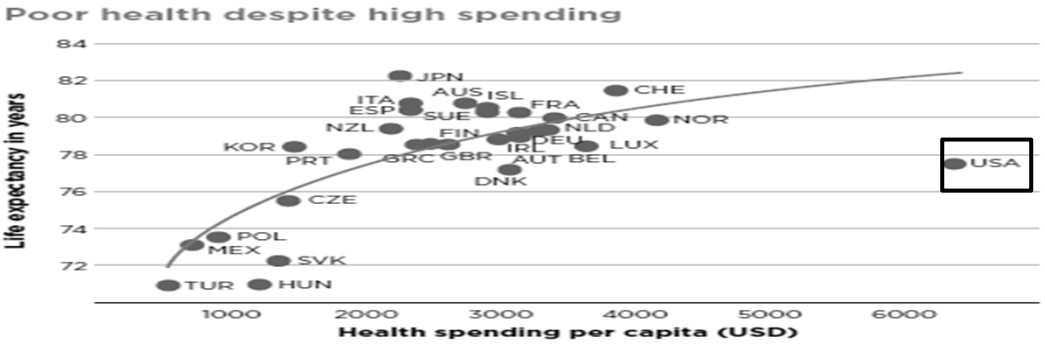
POOR HEALTH DESPITE HIGH SPENDING



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

Source: OECD.org

WASTE IN AMERICAN HEALTHCARE

Systemic waste across the board

Excess Cost Estimates	
Unnecessary Services	$210 B
Inefficiently Delivered Services	$130 B
Excess Administrative Costs	$190 B
Prices That Are Too High	$105 B
Missed Prevention Opportunities	$55 B
Fraud	$75 B
Total Excess Costs:	**$765 B**

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

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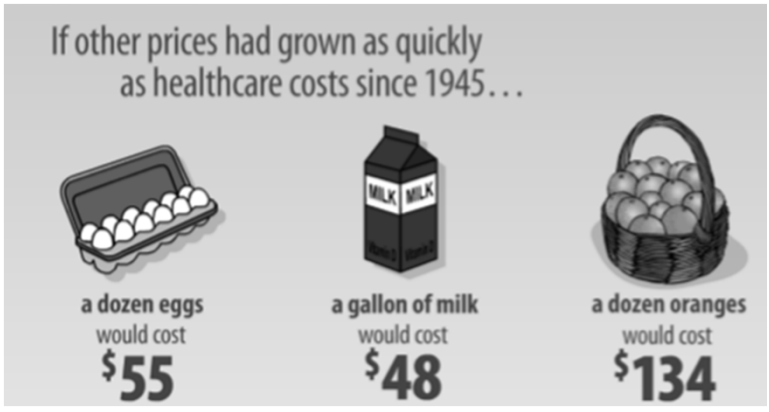
CONTEXT OF US HEALTHCARE COST GROWTH



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

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SCIENCE-PRACTICE GAP
(UNIVERSAL CHALLENGE)

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

Source: Mindy Tinkle, Richard Kimball, Emily A. Haozous, George Shuster, and Robin Meize-Grochowski, "Dissemination and Implementation Research Funded by the US National Institutes of Health, 2005–2012," Nursing Research and Practice, vol. 2013, Article ID 909606, 15 pages, 2013. https://doi.org/10.1155/2013/909606.

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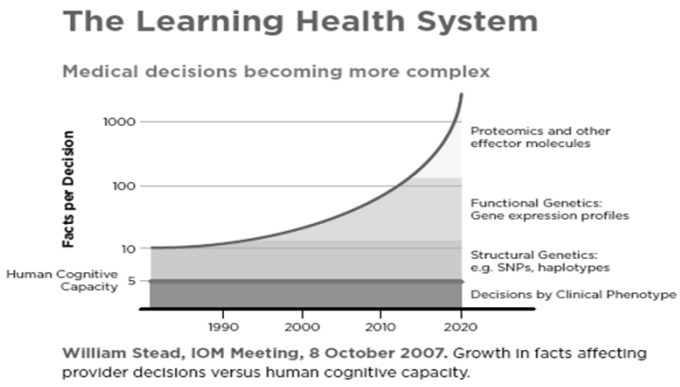
MEDICAL DECISION BECOMING MORE COMPLEX (UNIVERSAL CHALLENGE)



William Stead, IOM Meeting, 8 October 2007. Growth in facts affecting provider decisions versus human cognitive capacity.

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

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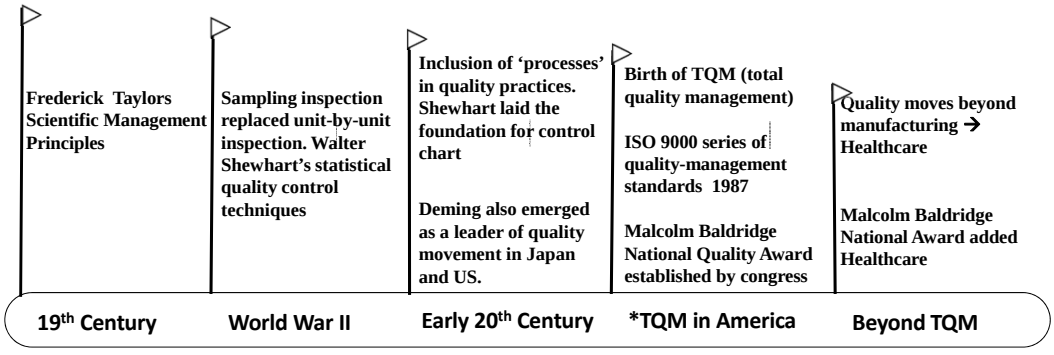
UNDERSTANDING QUALITY IMPROVEMENT

THE HISTORY OF QUALITY



Source: ASQ

Taiichi Ohno- Toyota Production System (Lean)

Deming cycle→ PDSA

Six Sigma developed by Motorola

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

DEFINING QUALITY IMPROVEMENT?

Health Resources and Service Administration (HRSA)

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

Institute of Healthcare Improvement

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

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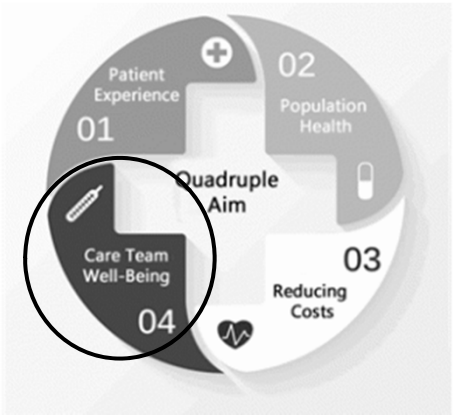
GUIDING PRINCIPLES OF QI

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

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

TRIPLE AIM →QUADRUPLE AIM



Source: From triple to quadruple aim: care of the patient requires care of the provider. *Annals of family medicine*

Quadruple Aim

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

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ADDRESSING THE QUADRUPLE AIM

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

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Source: From triple to quadruple aim: care of the patient requires care of the provider. *Annals of family medicine*

QUALITY IMPROVEMENT MODELS

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

1. **Model for Improvement (Plan-Do-Study-Act [PDSA] cycles) aka Deming Wheel:** The Institute for Healthcare Improvement's Model for Improvement combines two popular QI models: Total Quality Management (TQM) and Rapid-Cycle Improvement (RCI). The result is a framework that uses PDSA cycles to test interventions on a small scale.
2. **Six Sigma**: Six Sigma is a method of improvement that strives to decrease variation and defects. It's a strategy for process improvement and problem reduction by using the DMAIC methodology (define, measure, analyze, improve, control).
3. **Lean**: is an approach that drives out waste and improves efficiency in work processes so that all work adds value. This model defines value by what a customer (i.e., patient) wants. It maps how the value flows to the customer (i.e., patient), and ensures the competency of the process by making it cost effective and time efficient. Toyotas 4P model.
4. **Many more……..**

Source: American Academy of Family Physicians

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BUILDING A CULTURE OF QUALITY

MOVING TO VALUE BASED CARE
(QUALITY AN INTEGRAL PART)

SHASTA COMMUNITY HEALTH CENTER EXAMPLE

BUILDING QUALITY IMPROVEMENT INFRASTRUCTURE

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COLLABORATIVE TEAM APPROACH

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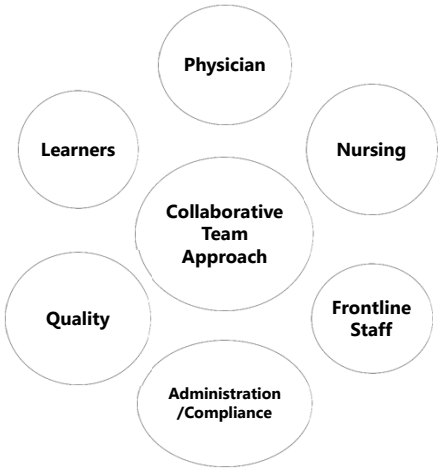

- Physician and administrative chair leads
- Multidisciplinary committee membership
- Yearly committee goals aligned with PCMH, HRSA and SCHC strategic priorities
- Shared decision making

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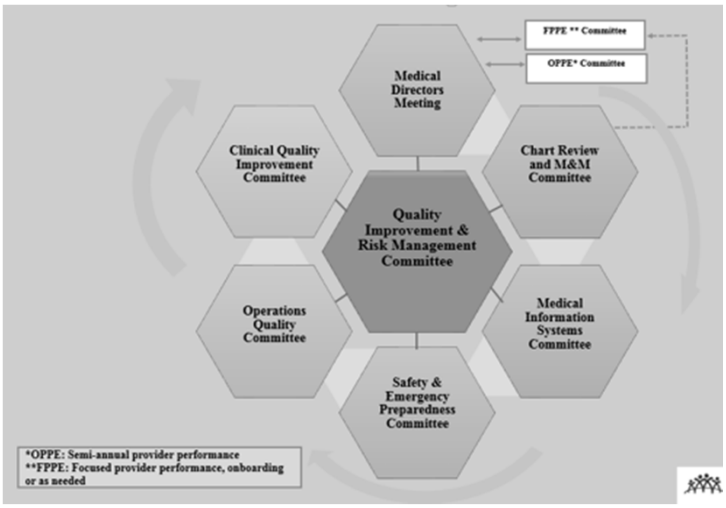
QUALITY IMPROVEMENT STRUCTURE AT SCHC



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

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QUALITY/COMPLIANCE COLLABORATIVE

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

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CENTRALIZED REPOSITORY

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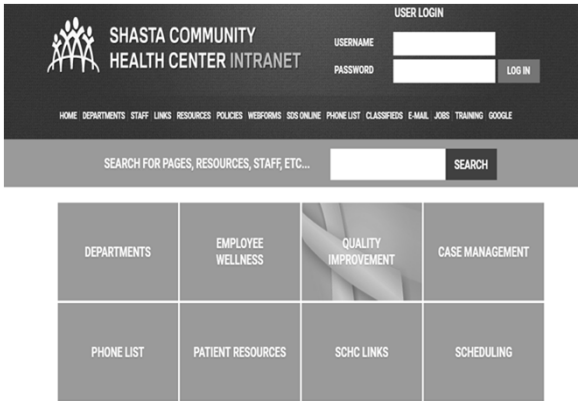
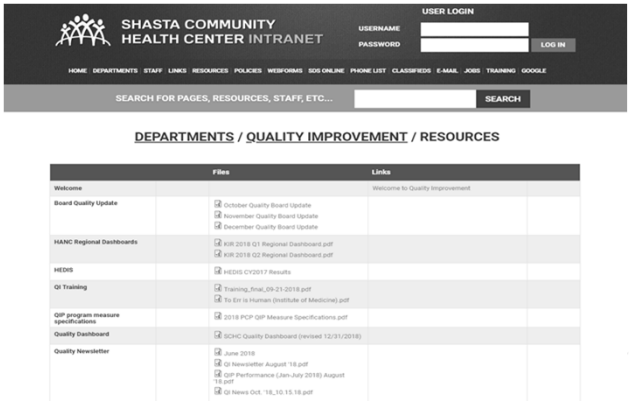
To create transparency and a centralized location to store all SCHC Quality efforts, a collaborative web library is available to staff



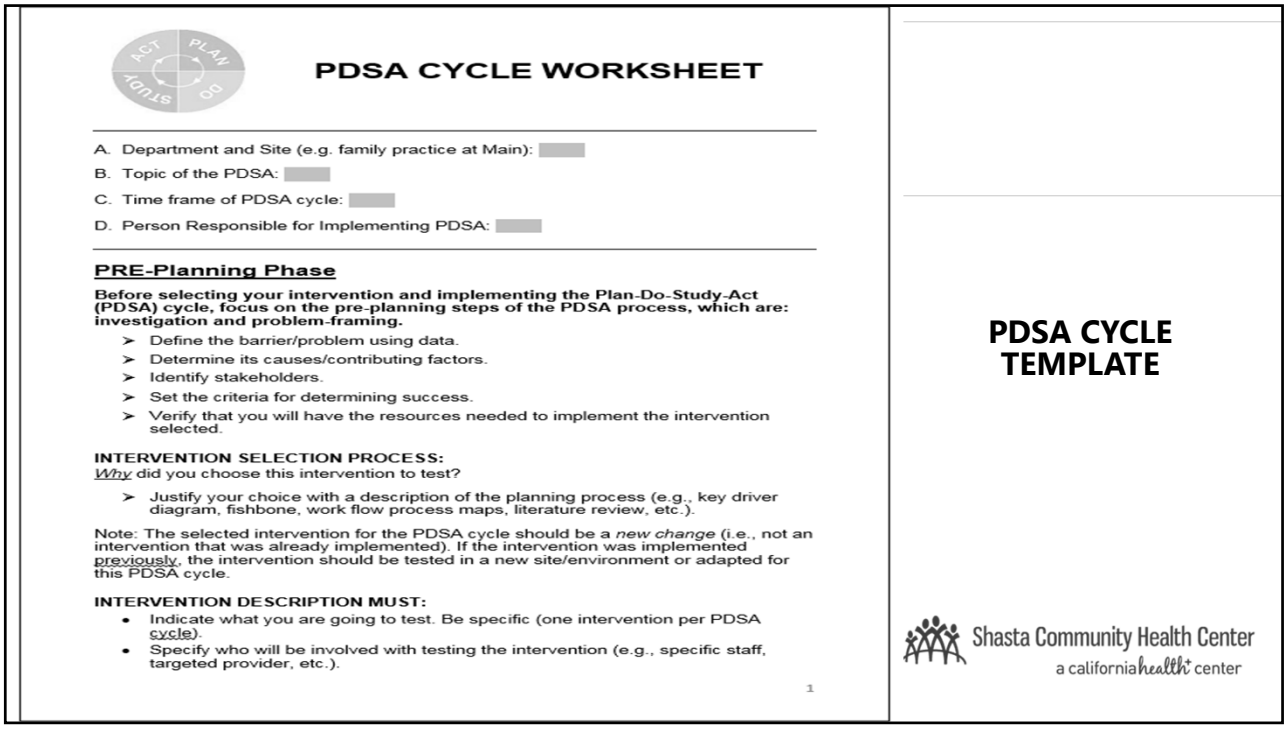


QUALITY DASHBOARD

SHASTA COMMUNITY HEALTH CENTER

Shasta Community Health Center Dashboard

Indicator	SCHC Baseline (CY2017)	Target Source	Target	Indicator Source	Priority	CY18 YTD June	CY18 YTD July	CY18 YTD Aug	Action (Next Steps) Active projects
Main Site									
Diabetes Management- HbA1c Good Control (<or=9) (age18-75)	71.3%	PHC 90th percentile	70.9%	Eagle dream	Tier 1				
Diabetes Management- Retinal Eye Exam (age 18-75)	58.9%	PHC 90th percentile	68.3%	Eagle dream	Tier 1				
Diabetes Management- Nephropathy (age 18-75)	87.7%	PHC 90th percentile	93.3%	Eagle dream	Tier 1				
Controlling High Blood Pressure (age 18-75)	81.4%	PHC 90th percentile	71.7%	Eagle dream	Monitoring				
Cervical Cancer Screening (age 21-64)	65.8%	PHC 90th percentile	70.8%	Eagle dream	Tier 1				
Breast Cancer Screening (age 50-74)	New measure in 2018	PHC 50th percentile	59.0%	Eagle dream	Tier 1				
Colorectal Cancer Screening (age 51-75)	45.7%	PHC 90th percentile	56.8%	Eagle dream	Tier 1				
Well Child Visits (age 3-6)	72.4%	PHC 90th percentile	82.8%	Eagle dream	Tier 1				
Immunizations for Adolescents (age 9-13)	New measure in 2018	PHC 50th percentile	19.8%	Eagle dream	Tier 1				
Childhood Immunizations Status (age 0-2)	New measure in 2018	PHC 50th percentile	71.6%	Eagle dream	Tier 1				
Anderson									
Diabetes Management- HbA1c Good Control (<or=9) (age18-75)	70.8%	PHC 90th percentile	70.9%	Eagle dream	Tier 1				
Diabetes Management- Retinal Eye Exam (age 18-75)	76.9%	PHC 90th percentile	68.3%	Eagle dream	Tier 1				
Diabetes Management- Nephropathy (age 18-75)	87.7%	PHC 90th percentile	93.3%	Eagle dream	Tier 1				



PDSA CYCLE WORKSHEET

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

PRE-Planning Phase

Before selecting your intervention and implementing the Plan-Do-Study-Act (PDSA) cycle, focus on the pre-planning steps of the PDSA process, which are: investigation and problem-framing.

- Define the barrier/problem using data.
- Determine its causes/contributing factors.
- Identify stakeholders.
- Set the criteria for determining success.
- Verify that you will have the resources needed to implement the intervention selected.

INTERVENTION SELECTION PROCESS:
Why did you choose this intervention to test?

- Justify your choice with a description of the planning process (e.g., key driver diagram, fishbone, work flow process maps, literature review, etc.).

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

INTERVENTION DESCRIPTION MUST:

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

1

PDSA CYCLE TEMPLATE

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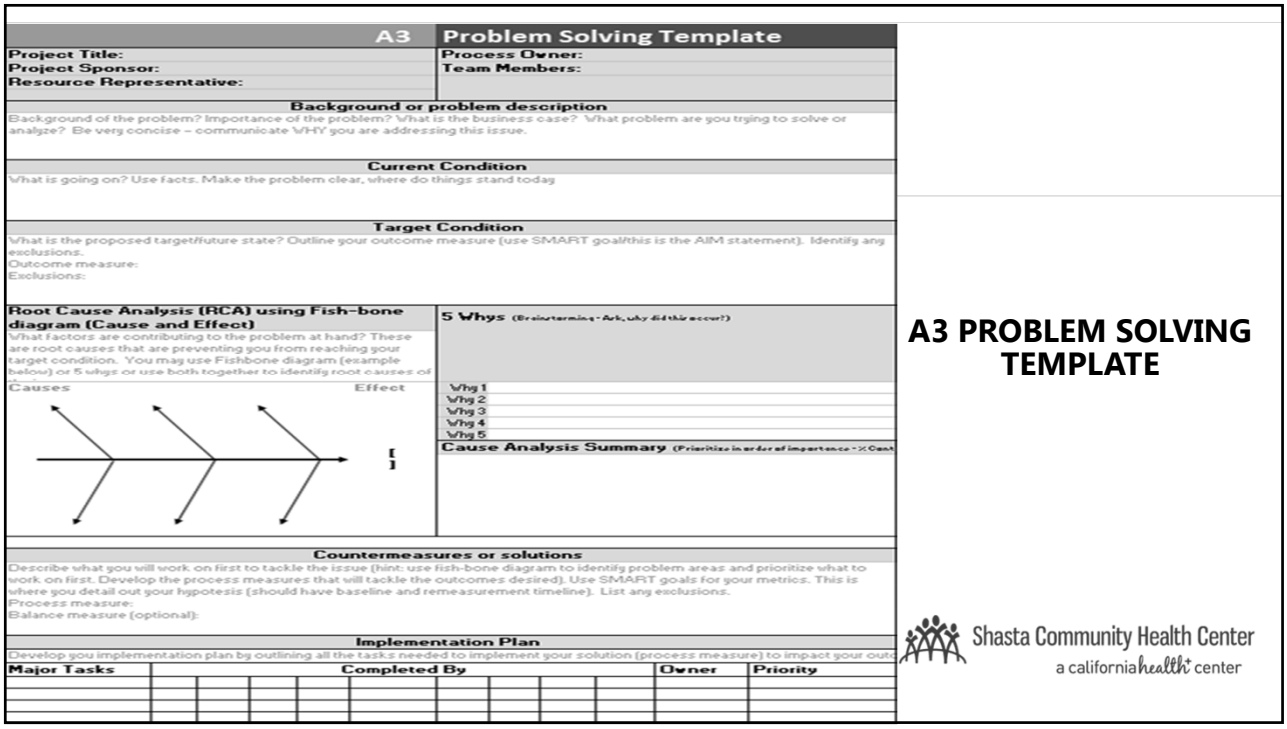

A3	Problem Solving Template
Project Title: **Project Sponsor:** **Resource Representative:**	**Process Owner:** **Team Members:**

Background or problem description
Background of the problem? Importance of the problem? What is the business case? What problem are you trying to solve or analyze? Be very concise – communicate WHY you are addressing this issue.

Current Condition
What is going on? Use facts. Make the problem clear, where do things stand today

Target Condition
What is the proposed target/future state? Outline your outcome measure (use SMART goal/this is the AIM statement). Identify any exclusions.
Outcome measure:
Exclusions:

Root Cause Analysis (RCA) using Fish-bone diagram (Cause and Effect)
What factors are contributing to the problem at hand? These are root causes that are preventing you from reaching your target condition. You may use Fishbone diagram (example below) or 5 whys or use both together to identify root causes of

Causes Effect

5 Whys (Brainstorming - Ask, why did this occur?)

Why 1
Why 2
Why 3
Why 4
Why 5

Cause Analysis Summary (Prioritize in order of importance - Cont

Countermeasures or solutions
Describe what you will work on first to tackle the issue (hint: use fish-bone diagram to identify problem areas and prioritize what to work on first. Develop the process measures that will tackle the outcomes desired). Use SMART goals for your metrics. This is where you detail out your hypotesis (should have baseline and remeasurement timeline). List any exclusions.
Process measure:
Balance measure (optional):

Implementation Plan
Develop you implementation plan by outlining all the tasks needed to implement your solution (process measure) to impact your outc

Major Tasks	Completed By	Owner	Priority

A3 PROBLEM SOLVING TEMPLATE

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Clinician Practice Snapshot

[redacted]

Access/Productivity		
# New Patients with QE	0	No recorded instances.
Expectation: 2 patients/ week.		
[redacted]		
# QE/Nominal 8-hr Clinic Day	17	1/1/2018 to 12/31/2018
Expectation: Minimum 18/day for FP, 20/day for Peds/UC, 8/LCSW, 14/day for PCN Psy., Internist 16/day, HOPE 16/day. All targets are in Qualifying encounters. Residents/fellows these targets do not apply for one year, new PCP's these targets do not apply for 6 months.		
[redacted]		
# Shifts Worked in UC or Saturday Clinics	13	1/1/2018 to 12/31/2018
Evening	[redacted]	
Saturday		
Expectation: 4 Saturdays/yr. for FT OR 2 Saturdays/yr. FT if you have inpatient hours. 4 evenings=1 Saturday worked. Part time		
[redacted]		
% Medically Complex Patients in Panel	45.40%	12/10/2018 to 12/31/2018
Expectation: 33.28%		
[redacted]		
% Panel Size	0	No recorded instances.
Expectation: Panel considered full at 110%. Sizes are determined by patients in the panel in the last 18 months. No target.		
[redacted]		

CLINICIAN PRACTICE SNAPSHOT

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Communication and Interaction		
# Portal Messages Handled	459	1/1/2018 to 12/31/2018
Expectation: No target		
[redacted]		
% Completed Documentation within 24 hrs	87.12%	1/1/2018 to 12/31/2018
Expectation: 90%		
[redacted]		
Average Action Time for Medication Tasks in Hours	24	1/1/2018 to 12/31/2018
Controlled Substance Management	[redacted]	
eRx Task		
Medication Management		
Expectation: 72 hours		

Average Action Time for PAQ Items in Hours	27	1/1/2018 to 12/31/2018
EHR Document	[redacted]	
HIE Document		
Labs		
Scanned Document		
Expectation: 72 hours		
This is the average number of actual (not business) hours between an item being placed in your PAQ and you taking action on that item by either accepting, rejecting or reassigning that item.		

Patient Care		
% Chart Review Compliance	1	1/1/2018 to 12/31/2018
Expectation: 90%		

CLINICIAN PRACTICE SNAPSHOT

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EXAMPLES OF IMPROVEMENT PROJECTS

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

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COMPLIANCE METRICS

COMPLIANCE SUPPORT OF QUALITY

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

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COMPLIANCE WORK PLAN (CWP)

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

What does that look like?

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RISK ASSESSMENT FOR CWP

2019 SCHC Compliance Work Plan Risk Assessment and Recommendations (from MCC):

	Hazard Analysis							Actions and Outcomes			
	Failure Mode: Evaluate failure mode prior to determining potential causes	**Potential Causes/Other Notes**		**Scoring**				**Action Type (Control, Accept, Eliminate)**	**Outcome Measure**	**Person Responsible**	**Management Concurrence**
				Severity	**Probability**	**Hazard Score**	**Total Score**				
A	ONGOING DEVELOPMENT OF AN EFFECTIVE COMPLIANCE PROGRAM		This is a standing item for each year's Work Plan.					Control	See Work Plan	See Work Plan	
1	HIPAA IT SECURITY & PRIVACY		See Work Plan	Catastrophic	Frequent	16	16	Control	See Work Plan	See Work Plan	
2	CONTRACTS (including BAA) MANAGEMENT		See Work Plan	Catastrophic Impact	Frequent	16	16	Control	See Work Plan	See Work Plan	
3	INCIDENT MANAGEMENT		See Work Plan	Catastrophic Impact	Frequent	16	16	Control	See Work Plan	See Work Plan	
4	340B		See Work Plan	Catastrophic	Frequent	16	16	Control	See Work Plan	See Work Plan	
5	QUALITY ASSURANCE		See Work Plan	Catastrophic	Frequent	16	16	Control	See Work Plan	See Work Plan	
6	FACILITY SECURITY		See Work Plan	Major Impact	Frequent	12	12	Control	See Work Plan	See Work Plan	
7	CREDENTIALING & PRIVILEGING PROCESSES		See Work Plan	Major Impact	Occasional	9	9	Control	See Work Plan	See Work Plan	
8	HIS CODING AUDITING & MONITORING		See Work Plan	Moderate Impact	Frequent	8	8	Control	See Work Plan	See Work Plan	
9	POLICY MANAGEMENT		See Work Plan	Moderate Impact	Frequent	8	8	Control	See Work Plan	See Work Plan	
10	ACCESS CONTROLS		See Work Plan	Moderate Impact	Frequent	8	8	Control	See Work Plan	See Work Plan	

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COMPLIANCE WORK PLAN 2019

PRIORITY FOCUS	SOURCE OF RISK IDENTIFICATION	WORK PLAN ACTIVITIES (Policies & Procedures, Training, Audits & Monitoring)
ONGOING DEVELOPMENT OF AN EFFECTIVE COMPLIANCE PROGRAM An effective compliance program is a good faith effort to ensuring and promoting integrity in our organization. The compliance program guidance for hospitals was developed and issued by the Office of Inspector General (OIG) with coordination of providers to better protect their Operations from fraud and abuse through the adoption of compliance programs. The OIG believes the development of this program guidance, for hospitals, will continue as a positive step towards promoting a high level of ethical and lawful conduct throughout the health care industry.	**Based on OIG Guidance and the Affordable Care Act**	**Policy:** Create new or revised policies to address risk areas identified in the Compliance Program Effectiveness Baseline Assessment (2018), including, but not necessarily limited to: - Compliance Documentation Practices - Enforcing Compliance Policies (including Sanctions) - Internal Investigations Policy - Compliance as an Element of Evaluations - Record Retention Policy and Schedules (Dept./Subject Matter) - Social Media - Patient Incentives - Incident/Event Reporting - Subpoenas - Managing Agency and Law Enforcement Requests (including Public Charge issues under new immigration standards) Continue identification of policies (due to changes in regulations, industry audits and other developments) that support an effective compliance program, such as: **Training:** Create annual training schedule for Compliance topics. Deploy through a combination of live training, module training and/or policy attestation and questionnaires. Utilize managers and directors for ongoing compliance discussions/trainings with staff. **Auditing/Monitoring:** Assess effectiveness of Compliance electronic tracking/reporting resources: - Ethics Point - PolicyTech - Exclusion Checks/Certiphi - IT Security/Privacy Access Monitoring Systems

HIS CODING AUDIT PROGRAM All federal and state regulations governing billing procedures are to be followed and all personnel responsible for billing, and the documentation upon which billing is based, should be trained in the appropriate rules governing billing, coding and documentation. The submission of accurate and appropriate bills to Medicare, Medicaid and other third party payers is one of the most important legal obligations for healthcare organizations.	**Based on best practice to increase coding accuracy and compliance; initial audits from new external auditors.**	**Policy:** Assess effectiveness of policies and procedures needed to support appropriate and consistent coding practices. **Training:** Assess effectiveness of current trainings. Identify gaps and address through Training Plans. **Monitoring:** Collaborate with SMEs and stakeholders to identify gaps and develop monitoring/auditing plan using internal and external resources. Develop metrics and quarterly reports for Compliance Committee.
CREDENTIALING In addition to addressing patient safety, we need to ensure our practices address individual and organizational liability under the HRSA and other Federal and State requirements (especially in preparation for our Operational Site Visit).	**Based on HRSA Site Protocol, HRSA Compliance Manual and FTCA requirements, as well as State regulations. Additionally, ECRI provides guidance for best practices.**	**Policy:** HR, Billing, Quality and Compliance collaboration to determine best practices and identify gaps. Develop/update policies and procedures to support best practices (most especially for HRSA OSV). **Training:** Train HR and others on expectations. Cross train on support processes and systems. **Auditing/Monitoring:** Conduct audit of credentialing files.

PRIORITY FOCUS	SOURCE OF RISK IDENTIFICATION	WORK PLAN ACTIVITIES (Policies & Procedures, Training, Audits & Monitoring)
HIPAA IT SECURITY (incorporating HIPAA Privacy)* Enhancements to the Privacy and Security regulations, as well as threats to data, create a need for a robust Security Assessment and Accountability Program. We will re-evaluate the items outlined in the 2016 Assessment and conduct an internal assessment to create a comprehensive, current gap analysis in the first quarter. Work will then focus, for the remaining 3 quarters of 2019, on resolving identified gaps. Subcomponent – Facility Access: Assessment of physical security of all SCHC sites, updating processes and technology to comply with best practices for role based accessed and processes for updating/changing codes and access levels.	**Based on 2016 External Risk Assessment, Industry Best Practices, and HIPAA Security, Privacy and Breach Notification Rules. Risk Management best practices for protecting people and property.**	**Policy:** Perform gap assessment of policies and resolve gaps. **Training:** Develop and Implement Annual Training Plan needed to address identified/remaining gaps. **Auditing/Monitoring:** Formalize comprehensive SOPs for breach responses. Assess electronic monitoring gaps. Address gaps.
CONTRACTS MANAGEMENT By managing all contracts in a reliable, secure platform, organizations can easily identify fraud and abuse, noncompliance with contractual provisions, vendor performance issues and manage financial stewardship against Fair Market Value, Commercial Reasonableness, and Quality Assurance standards. Subcomponent #1 – Business Associate Agreements: Recent changes to the Privacy and Security regulations within HIPAA's Business Associate Agreement (BAA) obligations to include additional focus on subcontractor relationships Subcomponent #2 – Exclusion/Sanctions Check Process Updates: To ensure that all vendors, from providers to suppliers, receive appropriate and timely sanctions review before initiating services.	**Based on HRSA and FTCA requirements, as well as Quality Assurance requirements under the Affordable Care Act (ACA), HIPAA and Omnibus Rule and OCR Audits (for BAA component). Based on Compliance Program Effectiveness Baseline Assessment 2018; HRSA OSV Site Protocol and Compliance Manual (for Exclusion Checks).**	**Policy:** Develop comprehensive Contract Management policies, forms and assessments, including practices for documenting FMV and Commercial Reasonableness (e.g. Business Justification). **Training:** Identify stakeholders (role based access) and provide comprehensive training in HCI. **Auditing/Monitoring:** In additional to auditing content during HCI implementation, conduct quarterly audits to confirm accurate payments and Quality Assurance evaluations.
INCIDENT/EVENT MANAGEMENT A number of risk areas were identified in the Compliance Program Effectiveness Baseline Assessment submitted to the Board in October 2018. Please see report for gap details. As a result, we have contracted with NAVEX Global to implement a new Event Management system, EthicsPoint. We will be implementing this new system during the first quarter (including transitioning our Hotline services). The remainder of 2019 will be spent on refining policies and procedures related to the new system, and developing reporting practices for management level trend monitoring as well as Board oversight.	**Risk Management Best Practices, FTCA requirements, Compliance Program Effectiveness Baseline Assessment (2018).**	**Policy:** Revise/develop policies to support how incidents are identified, reported to SME, investigated/resolved, and reported to SM and the Board. This includes development/agreement on reporting definitions and processes. **Training:** Identify stakeholders (role based access) and provide comprehensive training in EthicsPoint **Auditing/Monitoring:** Develop processes and reports to ensure timely and appropriate resolution and reporting of incidents to oversight bodies (internally and externally).
POLICY MANAGEMENT A number of risk areas were identified in the Compliance Program Effectiveness Baseline Assessment submitted to the Board in October 2018. Please see report for gap details. Similar to the Incident/Event Management item, we will be working with NAVEX Global to implement a significant upgrade to our PolicyTech system, which will also be integrated with our new EthicsPoint system.	**HRSA OSV Site Protocol, Compliance Manual, Compliance Program Effectiveness Baseline Assessment (2018).**	**Policy:** Revise/develop policy development procedures. **Training:** Identify stakeholders (role based access) and provide comprehensive training in PolicyTech **Auditing/Monitoring:** Conduct gap assessment to determine current processes and develop recommendations based on current industry best practices.

PRIORITY FOCUS	SOURCE OF RISK IDENTIFICATION	WORK PLAN ACTIVITIES (Policies & Procedures, Training, Audits & Monitoring)
QUALITY ASSURANCE – Incorporating Appropriate Level Responses (Event Management, Chart Review, Peer Review To ensure we meet requirements under a myriad of guidance and oversight agencies, we will need to confirm a reliable work flow from general grievances to OPPE to FPPE, etc. Incorporate into electronic management platforms from Event Management to Peer Review	**Based HRSA OSV requirements, and FTCA best practices**	**Policy:** Develop policies and ensure consistency between them to reflect the similarities and distinctions between different levels of performance/chart reviews and how findings are reported and addressed. **Training:** Identify stakeholders and develop training plans in the respective processes and electronic management systems. **Auditing/Monitoring:** Develop a monitoring plan to ensure: - Timely Response - Appropriate Review Levels - Appropriate Risk Management responses -
340B To ensure we meet the requirements under 340B federal and state requirements, specifically the prohibition against Diversion and Duplicate Discount.	**Based on Federal and State requirements respecting 340B medications.**	**Policy:** Enhance Policies and SOPs to ensure compliance with both Federal and state 340B requirements. **Training:** Develop and implement 2 different Training Programs. One for key players in 340B, and one for all staff at least annually via all staff meetings. **Auditing/Monitoring:** Implement vigorous auditing/monitoring plan, and documentation processes that help ensure compliance with all 340B regulations and best practices.

THE COLLABORATIVE

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

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QUESTIONS?

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