FALLS COMMUNITY HEALTH GOVERNING BOARD
THURSDAY, JANUARY 15, 2026
AT 12:00 PM-1:00 PM
VIRTUAL/ SECOND FLOOR, CLASSROOM 1
"Providing an open door to primary health services."

Agenda

- Call the Meeting to Order
- Approval of the Minutes of Falls Community Health Governing Board from December 18, 2025*

New Business

- Financials*
  - Productivity
- Quality
  - Peer Review
  - Ryan White Report
  - Annual Quality and Risk Management Report
- Access*
  - Amy Hogue, MD, re-credentialing, and privileging No concerns with Avera credentialing and no changes to privileging.
  - Susan Olson, DMD, re-credentialing, and privileging No concerns with Avera credentialing and no changes to privileging.
  - Troy Keyes, DDS, initial credentialing and privileging No concerns with Avera credentialing and initial privileging.
- Public Health Director Update
- Public Input –
  - If you are here for public input, please check in with the Sioux Falls Health Department for directions to the meeting or call in with the information below.

*Action required

Items added after the agenda deadline: the Falls Community Health Governing Board may include such other business as may come before this body.

RSVP to Lisa at 367-8181 or Lisa.Stensland@siouxfalls.gov -your attendance to the Falls Community Health board meeting.

Join from the meeting link
https://siouxfalls.webex.com/siouxfalls/j.php?MTID=maf00ccf2802961dfd65c8ac26277b2d1

Join by meeting number
Meeting number (access code): 2504 412 8243
Meeting password: fN44rJRJ2RZ

Join by phone
+1-408-418-9388 United States Toll
Global call-in numbers

Falls Community Health Governing Board Minutes
Thursday, December 18, 2025, at 12:00 pm

Present: Amanda Willard, Moses Pessima, Lee Jensen, Madeline Shields, Josh Keller-Virtual, Dr. Bill Schultz, Jaci Kramer-Virtual
Absent: Gwen Fletcher, Murat Sincan, Carlos Castillo,
Staff Present: Joe Kippley, Amy Richardson, Dr. Jen Tinguely, Vanessa Sweeney, Lisa Stensland, Michelle Jarding, Lori Hestad, Jaimie Roggenbauer

Call to Order: Amanda Willard called the meeting to order at 12:06 pm. Roll call: _A_ Murat, _V_ Jaci, _P_ Madeline, _P_ Lee, _P_ Moses, _A_ Gwen, P_ Amanda, P_ Bill, A_ Carlos, _V_ Josh

A motion was made to approve the minutes for Falls Community Health Governing Board dated November 20, 2025, supported by Madeline seconded by Moses, motion carries. Roll call: _A_ Murat, _Y_ Jaci, _Y_ Madeline, _Y_ Lee, _Y Moses, _A_ Gwen, Y_ Amanda, Y_ Bill, _A Carlos, _Y_ Josh

FINANCIALS:
The Falls Community Health reports attached are through the month ending November 30, 2025. We are 92% through the fiscal year. The last financial statements presented were through the month of October 31, 2025.

Operating Revenues:
- Net Patient Revenue consists of all patient charges and adjustments. Total Net Patient Revenue for November came in at $363,508, YTD actual is 115% compared to annual budget.
- Total Grant Revenue of $297,772 includes grant revenue from Community Health Center, Ryan White Part C and HIV Prevention.
- Total Other Revenue for November is $48,940 which consists mostly of Medicaid Managed Care payments and Health Home Provider Incentive.

Total Operating Revenue YTD November is $7,392,878, which is 106% YTD actual to annual budget.

Operating Expenses: Operating expenses are classified within 7 categories. Total expenses were $873,934 for the month of November.
- Personnel expenses are 81% of the budget and November had 2 pay periods. 2025 is $945,968 favorable to YTD budget.
- Professional Services are 85% of the YTD budget. This category includes payments for services to Center for Family Medicine, interpreter services, transportation for patients, clinic security, Lewis Drug pharmacy, etc.
- Rentals are 99% of the YTD budget. Technology charges occur in March of every year.
- Repair and Maintenance is 20% of the YTD budget.
- Supplies and Materials are 102% of YTD budget. Category includes expenditures like general medical, lab and dental supplies, office supplies, immunization & pharmaceuticals, electronic medical and dental software system fees, and claims processing.
- Training is 53% of the YTD budget. Most expenses are continuing education expenses and licensure renewals.
- Utilities are at 55% YTD budget. Most of this expense occurs quarterly and the last payment occurred in September 2025.

Total Operating Expenses YTD November are $10,947,721 which is 82% YTD actuals to annual budget.

Non-operating Revenue (Expense):
- Total nonoperating revenue (expenses) is 94% of the YTD budget and includes payments from AAA recovery collections, USD dental clinic rent, and interest for November.

Net Income (Loss):

- November actual amounts show a net loss of ($135,114) and YTD net loss of ($3,268,000).

A motion was made to accept the financial report as presented, supported by Bill, seconded by Jaci, motion carried. Roll call: _A_ Murat, _Y_ Jaci, _Y_ Madeline, _Y_ Lee, _Y Moses, _A_ Gwen, Y_ Amanda, Y_ Bill, _A Carlos, _Y_ Josh

Productivity:

The providers had 16,075 visits year to date. The nurses have had 50 visits year to date. Total medical visits year to date are 16,125.

The dentists have had 6,243 visits year to date. Hygiene has 1,301 visits year to date. Total dental visits are 7,544.

The dietitian had 181 visits this year. Mental Health had 1,114 YTD visits. CD Counselor had 40 visits YTD. Case Management has 1,103 visits. Year-to-date totals are 26,107 total visits, which is 89% to goal.
Dental is still looking for a full-time dentist.

QUALITY:

There are 20 quality measures now. Staff are working on getting some baseline data in the system for reference. Currently there are 10 of the measures that are being met and 3 are very close. Initiatives being worked on include Mammogram double booking-tracking no-shows, Dental sealants, no-show survey, patient intake audit and review.
Risk Updates a new process was implemented for turnaround time within 15 days. The average for Q1 was 21 day, Q2 was 23 days and Q3 is 21 days. The risk team is working on reducing errors by 5% each quarter. Demographic errors were reduced from 28% to 19% from Q2 to Q3. Lab ordering errors increased from 43% to 59% from Q2 to Q3.
Safety Updates- Initiatives include overhead paging system, a crosswalk planning with traffic department, active shooter training, monthly safety newsletters, emergency response cards and an updated code of conduct.
Ryan White Update- a site visit will be conducted July 14 & 15, 2026. There are 138 patients in the program and 9 are pending. In 2025 there have been 11 new patients in the program. Pneumonia vaccines and pregnancy tests were the quality measures worked on this year. 58% of the Ryan White patients have been vaccinated for pneumonia and all patients that had a new diagnosis or change in medication were tested for pregnancy.

ACCESS: Deferred due to loss of quorum.

PUBLIC INPUT:

None at this time.

Due to lack of quorum meeting ended.

1:00 pm

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Amanda Willard –Chair January 15, 2026
Upcoming meeting: February 19, 2026

Lisa Henshaw

Quality Improvement and Risk Management Plan

Effective Date: 1.15.2026

Expiration Date: 1.15.2029

SECTION 1: QUALITY IMPROVEMENT AND RISK MANAGEMENT STRUCTURE

A. DEFINITIONS and ACRONYMS

1. **Quality:** is the degree of excellence of the center's processes, provider and support staff performance, decisions, and human interactions. Quality is the consistent delivery of efficiency and effectiveness.

2. **Risk Management:** refers to the practice of identifying potential risks in advance, analyzing them, and taking precautionary steps to reduce or eliminate risk and adverse outcomes.

3. **Acronyms:**
   - A. CC- Care Coordinator
   - B. CDO - Chief Dental Officer (Dental Director)
   - C. CEO - Chief Executive Officer (Public Health Director)
   - D. CHW- Community Health Worker
   - E. CMO - Chief Medical Officer (Medical Director)
   - F. CFO - Chief Financial Officer (Assistant Public Health Director)
   - G. CCO - Chief Compliance Officer (Health Administration Manager)
   - H. COO-Chief Operations Officer (Clinic Administrator)
   - I. EMR - Electronic Medical Record
   - J. FCH - Falls Community Health
   - K. HEDIS - Healthcare Effectiveness Data and Information Set
   - L. HIT - Health Information Technology
   - M. NCM/RN/LPN - Nurse Care Manager/Registered Nurse/Licensed Practical Nurse
   - N. NCQA - National Committee for Quality Assurance
   - O. PCMH - Patient Centered Medical Home
   - P. PDSA - Plan-Do-Study-Act
   - Q. PI - Process Improvement
   - R. PST - Patient Support Technician
   - S. QA - Quality Assurance
   - T. QI - Quality Improvement
   - U. QM - Quality Management
   - V. RM - Risk Management
   - W. SBH - School Based Health
   - X. UDS - Uniform Data Set

B. PURPOSE:

The purpose of the health center's Quality Improvement and Risk Management program is to ensure ongoing excellence in the quality, safety, access, and cost of the care at Falls Community Health. Falls Community Health accomplishes this using the following principles:

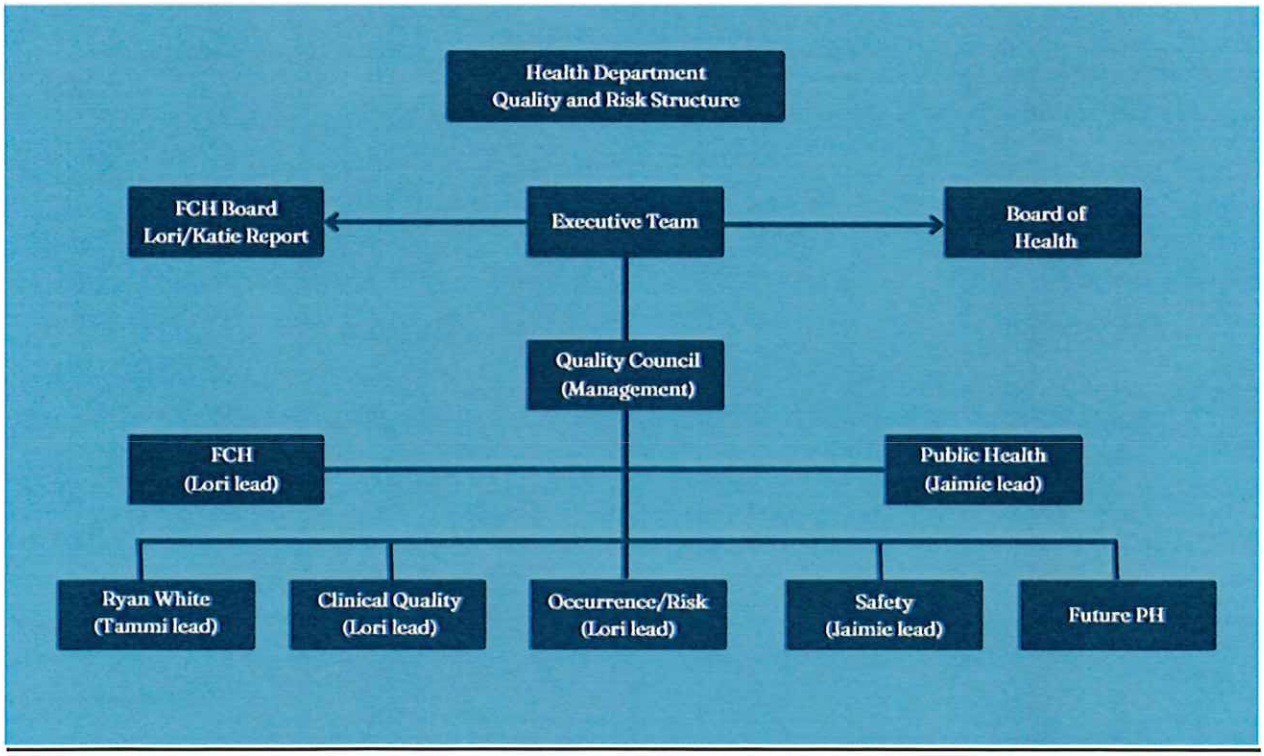
1. Systematic evaluation of clinical, risk management and operational services delivered.

2. Continuous quality improvement and risk mitigation on all clinical and operational activities impacting patients and health center staff.
3. Monitoring of metrics in the areas of clinical services, clinical management, quality of care, patient access, patient experience, care coordination, risk management events and network quality.
4. Delivery of care utilizing current and applicable based clinical guidelines, standards of care, and standards of practice.
5. Maintains patient confidentiality and safeguards patient information.

C. **SCOPE**: The Quality Improvement and Risk Management Program is comprehensive and includes all clinical and administrative departments and activities that have an influence on the quality, safety, and outcome of care delivered to all FCH patients. The scope includes FCH's defined Health Resources and Services Administration (HRSA) scope of services and sites and various other grant-supported programs and initiatives. Quality and risk management must extend to all facets of the organization's clinical, managerial, administrative, and environment of care. The Quality Improvement and Risk Management Program addresses each of the health center's clinical programs using the following standards and recommendations:

- National Council on Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) PCMH
- HRSA
- Federal Tort Claims Act (FTCA)
- State and local government

D. STRUCTURE OF QI/RM PROGRAM



QI/RM Reporting Structure			
Role	**Who**	**Accountabilities**	**Logistics**
FCH Governing Board	11 members	The FCH Governing Board takes an active role in ensuring the quality of care and safety at FCH. • Accountable for safety and quality of health center. • Approval of the QI/RM Plan at a minimum every three years. • Receive and approve clinical reports. • Receive and approve clinical quality improvement plans. • Review and approve clinical quality policies. • Approval of the Annual QI/RM Program Evaluation. • Approval of the Annual Risk Management Report.	• Meeting frequency: Monthly. • Review: Quarterly QI/RM Report. • Materials: Minutes, agendas, and documents posted to siouxfalls.gov.
Executive team	Chief Executive Officer (CEO) Chief Dental Officer (CDO) Chief Medical Officer (CMO) Chief Operations Officer Assistant Public Health Director (CFO) Health Administration Manger (CCO) Clinic Administrator (COO)	Maintains accountability in ensuring quality of care and safety at FCH. Designates QI/RM oversight to CMO, CDO, and CCO	• Meeting frequency: monthly and as needed. • Participates in Clinical Quality Committee and subcommittees regularly. • Responsible for daily operational oversight of FCH and the execution and evaluation of the Quality Plan. • Reports to FCH Governing Board a minimum of quarterly.

Chief Medical Officer	CMO	The CMO is designated by the FCH Governing Board and CEO as accountable for the implementation of the QI/RM Plan, QI operating procedures and related assessments, monitoring QI outcomes, and updating QI procedures. • Work with QI committee to prepare, monitor, and execute Quality Plan. • Identify and define set of metrics to measure organizational quality and patient safety. • Oversee and evaluate provider adherence to quality and evidence-based standards.	• Reports to CEO • See reporting schedule for quality improvement reporting to the Clinical Quality Committee.
Chief Dental Officer	CDO	The CDO is designated by the FCH Governing Board and CEO as accountable for the implementation of the QI/RM Plan, QI operating procedures and related assessments, monitoring QI outcomes, and updating QI procedures. • Work with QI committee to prepare, monitor, and execute Quality Plan.	• Reports to CEO • See reporting schedule for quality improvement reporting to the Clinical Quality Committee.

		• Identify and define set of metrics to measure organizational quality and patient safety. Oversee and evaluate provider adherence to quality and evidence-based standards.	
Risk Manager	Quality and Risk Coordinator and CCO, Health Administration Manager	The Quality and Risk Coordinator acts as the RM Chairperson, is designated by the FCH Governing Board and CEO as accountable for the RM operating procedures related to assessments, monitoring RM outcomes, and updating RM procedures. Identify and define set of metrics to measure organizational risk management. • Develops Annual Risk Management Plan. • Ensures the completion of quarterly risk management assessments. • Reports the results of risk management activities quarterly to the FCH Governing Board.	• See the reporting schedule for risk management reporting to the Quality Council.
Chair of the Clinical Quality Committee	Clinical Quality and Risk Coordinator	The Quality and Risk Coordinator, CMO, and CDO collaborate and are responsible for the overall implementation and	• Reports to CCO for RM activities; CMO and CDO for QI accountability. • Provides quarterly update to FCH Governing Board.

		day to day management of the Clinical Quality Committee priorities and activities. • Reports QI/RM to the CMO and CDO, CCO and the FCH Governing Board. • Monitors Clinical Quality Committee outcomes. • Monitors PDSA cycles and other PI activities. • Ensures subcommittees are monitoring activities and adhering to protocols. • Leads monthly Clinical Quality Committee meetings. • Responsible for achieving and maintaining PCMH activities. • Provides an Annual QI Program Evaluation to the FCH Governing Board. • Coordinates annual FTCA deeming application. • Provides an Annual Risk Management Report to the FCH Governing Board.	• Reports progress to organization quarterly.
Committee Structure			
Clinical Quality Committee	CC/CHW CMO Dental HIT	The Clinical Quality Committee is responsible for monitoring the	• Meeting Frequency: Monthly. • Reviews: measure analysis monthly.

	Lab Nursing Pharmacist Provider PST Quality and Risk Coordinator Ad Hoc: COO/Risk Manager Dentist/Hygienist Enabling Finance Officer Lab Manager Nursing Manager Patient Access Supervisor Resident Physician SBH	organizational performance on clinical and operational quality as well as safety and risk management activities. • Assures the chosen metrics are being monitored. • Assures the necessary data is being collected. • Assures continuous process improvement and process improvement plans for measures below goal or not performing to expectations. • Monitors quality related problems until fully resolved. • Incorporates current clinical guidelines and evidence-based practices, standards of care, and standards of practice in the provision of health center services. • Reviews and provides input on all policies and procedures impacting patient care. • Reviews, addresses, and approves subcommittee reporting with	• Reviews: subcommittee reports as designated by reporting calendar.

		regards to risk management. • Provides input to and approval of revisions to the QI/RM Plan. • Maintains an annual FCH Quality work plan. • Provides input to and approval of the Annual QI/RM Program Evaluation. • Provides input to and approval of the Annual Risk Management Report.	
Safety Committee	One member of FCH management team, one provider, and five frontline staff.	The safety subcommittee is responsible for the monitoring of safety within the organization. • Reviewing incident and occurrence reporting. • Reviewing building safety • Organizing safety drills • Performing quarterly environmental safety and risk assessments. • Revision of safety policies and procedures. • Reviewing patient complaints. • Oversight of root cause analysis of incidences and occurrences.	• Meeting Frequency: Every other month (odd months). • Reviews: incidents, occurrences, complaints, reports and building inspections. • Monthly update to Quality and Risk
Pharmacy & Therapeutics Subcommittee (P&T)	COO, CMO, CCO, Nursing Manager, Pharmacist, and	The P&T Team is accountable and responsible for: • 340B compliance.	• Meeting Frequency: Monthly. • Monthly updates to Quality Council

	Quality and Risk Coordinator	• Improve patient access to affordable medications. • Monitor for medication adherence and safety. • Development/Revision of Medication Policies and Procedures.	
HIV Quality Committee	Health Program Manager, Provider(s), NCM/RN/LPN, Quality and Risk Coordinator, Care Coordinator and Pharmacist.	The HIV subcommittee ensures compliance with all HIV grant requirements and monitors performance.	• Meeting Frequency: no less than quarterly • Monthly update to Quality Council.
Risk Committee	Quality and Risk Coordinator Dental Lab NCM/RN/LPN Provider PST	The Risk Subcommittee is responsible for the monitoring of risk within the organization. • Reviewing incident and occurrence reporting. • Revision of safety policies and procedures. • Reviewing patient complaints. Oversight of root cause analysis of incidences and occurrences.	• Meeting Frequency: every other month (even months) • Monthly updates to Quality Council
Staff			
Providers	All providers employed by or contracted to FCH.	All providers are essential to ensuring the quality and safety of the health center program. All providers are expected to participate in QI activities as explained throughout this plan	• Provider meetings monthly at a minimum.

		and as required by FTCA. • Identification and adoption of evidence-based clinical guidelines. • Participation in peer review process at a minimum quarterly. • Provider PI activities to resolve clinical issues.	
Nurses	All nurses employed by FCH	• Review nursing dashboards • Review updates to workflows/policies	• Nursing meetings monthly at a minimum.
Nursing/Providers	All providers and nurses employed by FCH	• Review provider dashboards • Review quality metrics • Review nursing dashboards • Review updates to workflows/policies	• Nurse/Provider meetings monthly at a minimum.
Dental	Hygienists/Dentists/Dental Assistants	• Review productivity reports • Review updates to workflows and policies • Review quality metrics	• Dental meetings monthly at a minimum.
All Staff	All staff employed or contracted by FCH.	All staff are required to follow policies, procedures, and protocols in the best interest of promoting quality and safety for FCH staff and patients. All staff are expected to participate in PI Activities.	• All Staff meetings: monthly at a minimum.

SECTION 2: Quality Improvement Operational Components

A. Quality Assessment

Under the direction of the CMO and Quality and Risk Coordinator, the Clinical Quality Committee selects important components of the total health center that have the potential to impact the health and safety of FCH patients, directly or indirectly. For each of these components, specific indicators are developed or selected, measured, and monitored on a continuing basis. The Clinical Quality Committee tracks these activities, as well as all the resulting improvement activities within the annual FCH QI-RM work plan.

Quality indicators are objective, measurable, and may be based on benchmarks and external standards. Indicators will relate to access, cost of care, clinical quality, health management/improvement, utilization, credentialing and privileging requirements and satisfaction of health center patients, employees, and community stakeholders.

Indicators and benchmarks can be chosen from the following sources:

a. Uniform Data System (UDS)
b. NCQA
c. Payers and insurers
d. Centers for Medicare and Medicaid Services (CMS) Electronic Health Record (EHR) Incentive measures
e. Healthcare Effectiveness Data and Information Set (HEDIS)
f. Patient satisfaction survey questions
g. Scheduling performance and appointment utilization measures
h. Risk Management Assessments and Events (See D. Risk Management Program)

For each measure selected, the CMO and Clinical Quality Committee will suggest how to define the frequency of measurement and the target/goal for each measure. Data is available by provider and is trended over time. The data is utilized to proactively identify opportunities for performance improvement. The Clinical Quality Committee will look for trends and performance against benchmarks, they will suggest and implement actions plans for improvement. Data is collected via the EHR or population health tool. Confidentiality of patient information is maintained during QI activities in accordance with FCH's Patient Confidentiality and Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Policies/Procedures.

Data Quality Assurance: Data accuracy and integrity are essential to monitoring performance. Falls Community Health will implement the following:

i. Routine validation: Quarterly audits of selected performance measures to compare EMR entries against source documentation.
ii. Error correction process: Discrepancies identified through audits will be corrected within 30 days, with corrective action tracked by the Program Manager.
iii. Standard operating procedures: Written procedures will guide data entry, reporting, and validation, and will be reviewed annually.

iv. Training: All staff responsible for data entry and reporting will receive annual training on data quality standards.

Data is shared on a monthly basis to the Clinical Quality Committee for oversight and continuous quality improvement. Data is shared electronically with staff monthly and reported quarterly at all staff meetings. QI/RM reports are provided to the Quality Council monthly, and the Executive and the FHC Governing Board on a quarterly basis for the purposes of management decision making.

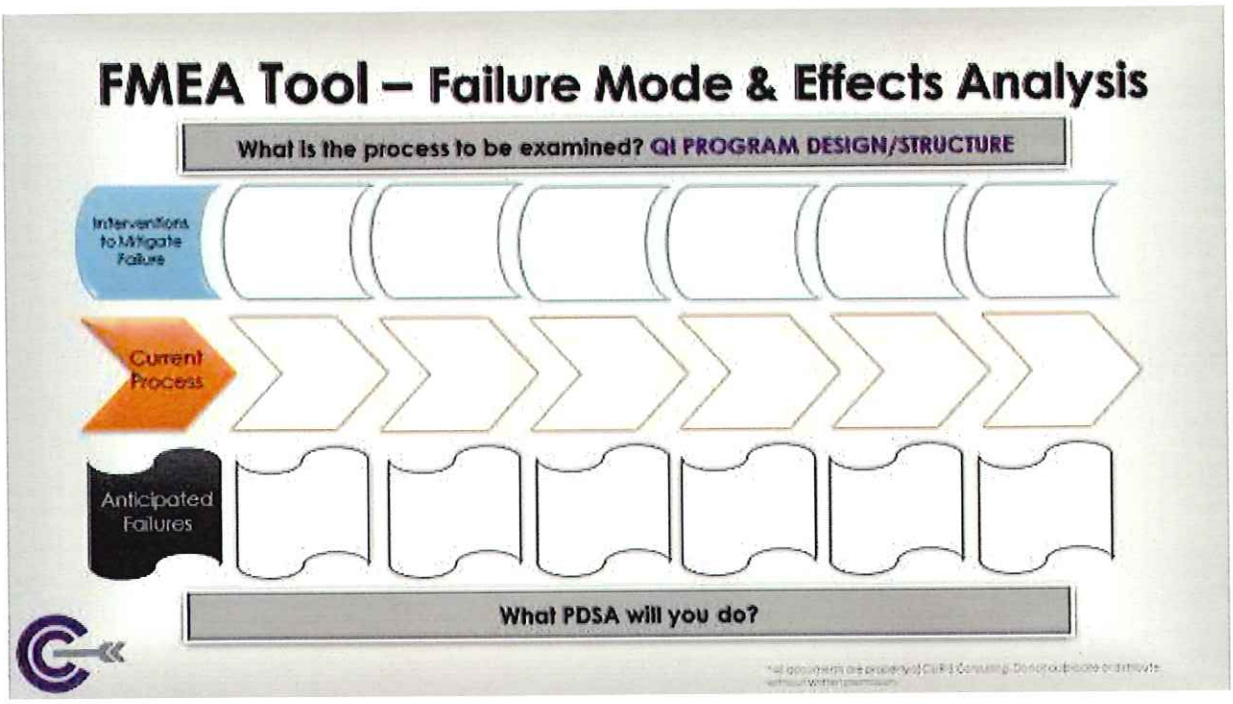
1. Evaluative Topics on QI Dashboard:

    a. Clinical Quality: Clinical quality is monitored on a monthly basis. Quality measures are sourced from funders, local, state and federal governments, payers, and other partners. Priority clinical measures are identified and prioritized over an 18-month time period.
    b. Patient Satisfaction: Patient satisfaction is conducted continuously from each visit. A more comprehensive survey is distributed annually. The survey covers the topics of Access, Communication, Whole Person Care, and Care Coordination. The results are analyzed and shared with the staff and FCH Governing Board annually.
    c. Operational Quality: Operational quality is monitored through measures that monitor FCH's ability to influence efficiency and patient experience. These may include but are not limited to appointment availability, cycle time, patient retention, and transition of care tracking.
    d. Financial Quality: Financial quality is monitored via ongoing trending of denials, coding, and cost of care. This includes the monitoring of external utilization and interventions resulting in an increased cost of care or utilization.
    e. Employee Engagement: FCH conducts employee engagement surveys annually.
    f. Risk Management: Risk Management measures are monitored on a quarterly basis. Reference Section D for additional information.

B. Continuous Quality Improvement

Outcomes and processes are identified as an opportunity for improvement through the ongoing monitoring and analysis of indicators by the Clinical Quality Committee. Continuous quality improvement activities focus on all measures in the Quality Plan.
FCH utilizes various methodologies to conduct process improvement.

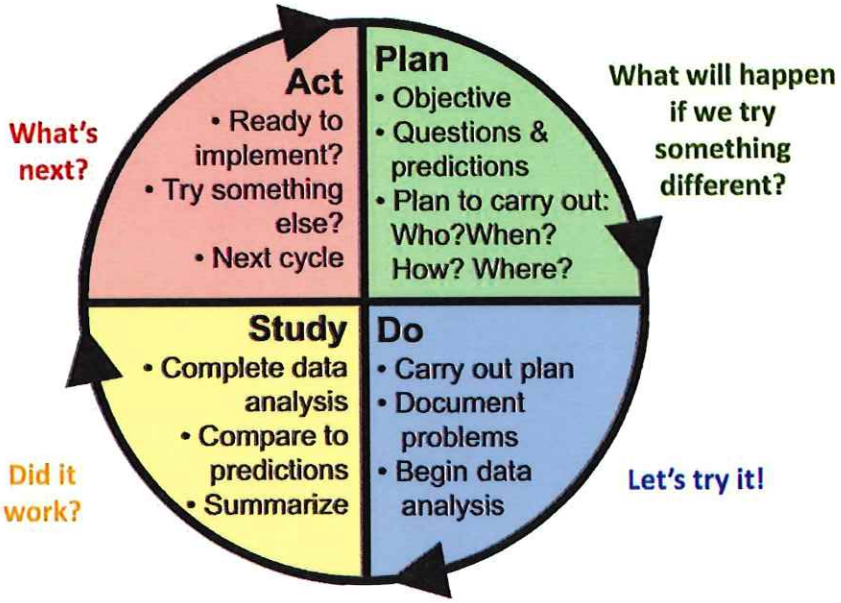
1. Failure Modes Effect Analysis (FMEA). The FMEA is a process improvement tool that proactively identifies potential and current failures in a process and working to identify activities that will mitigate those failures resulting in a continuous, reliable process.



The Clinical Quality Committee serves as the primary director of QI plans and identifying opportunities for improvement. All staff will participate in process improvement activities and will be trained in the methodologies described above as necessary to participate.

2. Plan-Do-Study-Act (PDSA): The PDSA process guides teams through identifying an opportunity and plan for change, doing/piloting the change, studying the results of the change, and acting in a way that will result in long term improvement.

The PDSA Cycle for Learning and Improvement

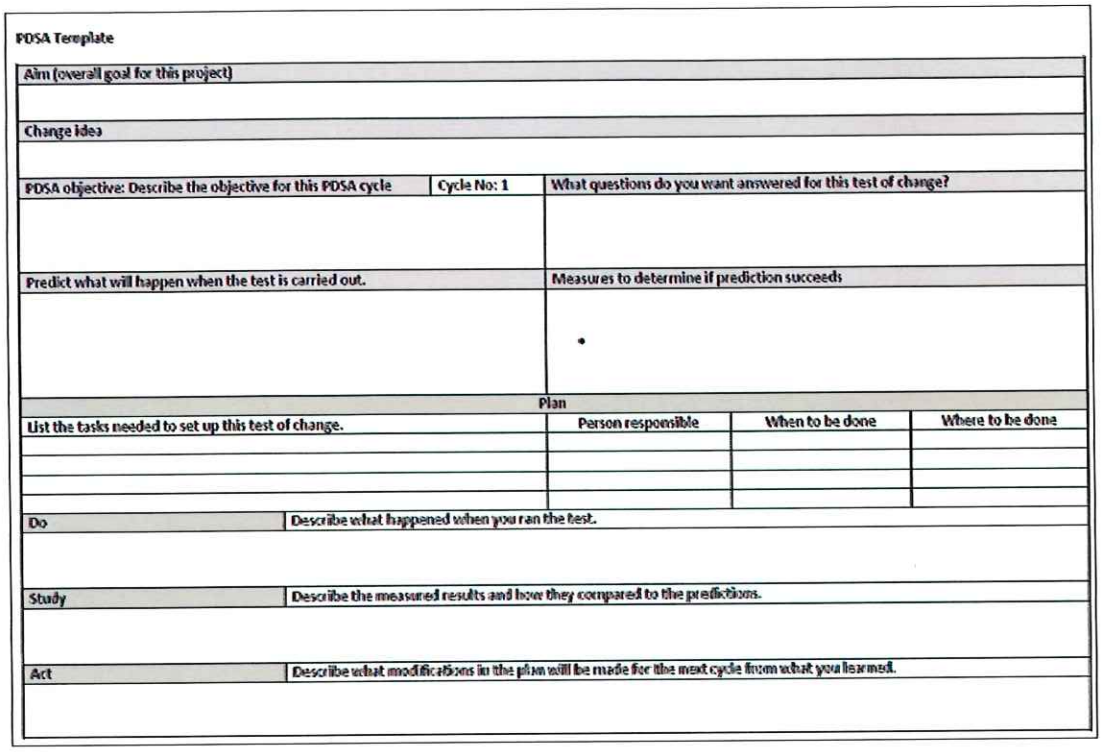


Plan: Plan a change or a test, aimed at improvement. Look for areas that hold opportunities for change and analyze the intended improvement. Prioritize areas that offer the most return.

Do: Carry out the change or test, initially on a small scale. Implement the change identified during the Plan phase.

Study: Analyze the results and determine what was learned and what went wrong. This is a crucial step in the PDSA cycle.

Act: The identification of processes the organization will use to either adopt the change, abandon it, expand it or run the PDSA cycle again.



PDSA Template

Aim (overall goal for this project)				
Change idea				
PDSA objective: Describe the objective for this PDSA cycle	Cycle No: 1	What questions do you want answered for this test of change?		
Predict what will happen when the test is carried out.		Measures to determine if prediction succeeds		
Plan				
List the tasks needed to set up this test of change.		Person responsible	When to be done	Where to be done
Do	Describe what happened when you ran the test.			
Study	Describe the measured results and how they compared to the predictions.			
Act	Describe what modifications in the plan will be made for the next cycle from what you learned.			

C. Provider Performance Assessment and Peer Review

Peer Review Audits are conducted every quarter for all services in scope. These audits periodically assess the appropriateness of utilization of services and the quality and safety of those services, as well as their adherence to established guidelines. Audits are based on systematic collection and evaluation of patient records and are conducted by licensed professionals under the supervision of the CMO and CDO. Peer review is completed between providers within the same service line who are similarly credentialed. The CMO is responsible for medical and behavioral health providers. The CDO is responsible for dental providers. Peer Review Audits contribute to measuring the overall quality of care delivered by providers and opportunities for financial or clinical risk. Peer Reviews will be utilized for the process of reappointment and performance evaluations.

The Peer Review Audit is completed quarterly at the Quality Committee. The Clinical Council and FCH Governing Board will receive a report of any known issues resulting from the Peer Review Audit. Results will be presented to demonstrate trends.

See FCH Peer Review Standard Operating Policy Procedure for detailed procedures.

D. Risk Management Program

The Quality Improvement and Risk Management Plan monitors the presence and effectiveness of risk management activities, including incident reporting, sentinel events, infection control, lab quality control, facility safety, patient safety, and patient complaints. The Risk Management Program facilitates the development of policies and procedures addressing events that may create liability exposures occurring with patients, staff, visitors, and other assets. The QI/RM

Plan operationalizes those policies and procedures to support the mission as it pertains to operational risk, clinical risk, and patient safety. Risk Management is part of FCH's overall compliance with the provisions of federal, state, and local statutes, applicable scope of practice and regulations. The risk management program is overseen by the Risk Manager and is detailed in the Health Department-Falls Community Health Standard Operating Policy/Procedure for Risk Management. The Quality Council, as well as the Risk and Safety subcommittees, are responsible for the ongoing monitoring of the RM plan components.

The goals of the risk management program include:

- Enhance patient satisfaction.
- Continuously improve patient safety.
- Identify and analyze risk of loss, errors, events and system breakdowns leading to harm of patients, staff, and visitors.
- Enhance environmental safety.
- Implement effective processes to manage identified risks.
- Monitor the effectiveness of interventions.

Risk Management Program Functions include:

a. Systems for identifying and reducing the risk of adverse outcomes and potentially unsafe conditions across the health center's activities.
b. Proactive resolution of identified areas of risk.
c. Continuous monitoring of near misses, patient incidents and adverse events.
d. Annual risk management training for all staff on required and relevant topics include but not limited to:
    a. HIPAA
    b. Blood-borne Pathogens
    c. General infection prevention and control
    d. Fraud waste and abuse
    e. Workplace violence prevention or active shooter training
    f. Follow up on adverse test results
    g. High-risk medications in pregnancy
    h. Preventing medication errors
    i. Risk management training on obstetrical procedures will be maintained through the Family Medicine Residency program, who contractually provide prenatal, labor, delivery, and postpartum services for the health center.
    j. Specific training will also be completed based on provider groups such as dental, pharmacy and family practice.
    k. The CCO completes risk management training annually (for example, the risk manager completes at least one course on topics such as risk program management, principles of risk management, or advanced risk management).
e. Quarterly risk management assessments.
f. Monthly reporting to health center leadership and quarterly reporting to FCH Governing Board on performance, areas of risk and plans of action.
g. Development of policies and procedures related to claims management, incident reporting, training and tracking access and risk management activities.
h. Supporting Quality Improvement and Assurance activities throughout the organization.

i. Implementing Provider Credentialing and Privileging program that ensures compliance with all state, local and federal requirements to ensure appropriate vetting of health center clinical staff.

Risk Management evaluative categories include, but are not limited to:

1. Risk Management Evaluative Categories:
   a. Event/Incident/Occurrence Reporting: Continuous monitoring, action and quarterly reporting of events, incidences, and occurrences with the potential for causing adverse patient outcomes or other injuries to people, property or other assets of the organization.
   b. Patient Complaint and Grievances: Continuous monitoring, action and quarterly reporting of patient complaint and grievances to minimize patient dissatisfaction and minimize risk to provider or organization reputation and sustainability.
   c. Environment of Care: Continuous assessment, action and evaluation of safety within the health center facilities to minimize potential risk to patients, staff and visitors through annual interior and exterior facility walking inspection; annual medical/dental equipment safety check; annual fire alarm and AED inspection.
   d. Clinical Risk: Continuous monitoring, evaluation and adoption of evidence-based guidelines and clinical protocols to minimize poor clinical outcomes and discontinuous care across the health center for all patients.
   e. Financial Risk: Continuous monitoring, action, and reporting of financial processes to minimize financial risk of organization.

Section 3. Quality and Risk Management Supporting Policies and Procedures:

A. Risk Management
B. Adverse and Near Miss Reporting
C. Patient Inquiry - Concern
D. Claims Management
E. Referral Tracking
F. Lab and Diagnostic Test Ordering, Tracking, and Patient Notification
G. Hospital Tracking
H. Credentialing and Privileging
I. Peer Review
J. HIPAA Privacy/HIPAA Security

Section 4. Program Evaluation

The Clinical Quality Council evaluates the QI/RM Program, including the QI/RM Plan and Annual QI/RM Work Plan, during the last month of each calendar year. The evaluation includes a review of the results of pre-established goals, targeted measures, quality activities and overall effectiveness of the Annual QI/RM Work Plan. The results of the QI/RM Program Evaluation is presented to the FCH Governing Board during the first quarter of the calendar year and utilized by the Clinical Quality Council to revise the QI/RM Plan and Annual QI/RM Work Plan for the subsequent year. The QI/RM Work Plan may be amended at any time during the calendar year to respond to any negative trends observed or changing needs of the organization.

FCH Board Chair

Date

Addendums:

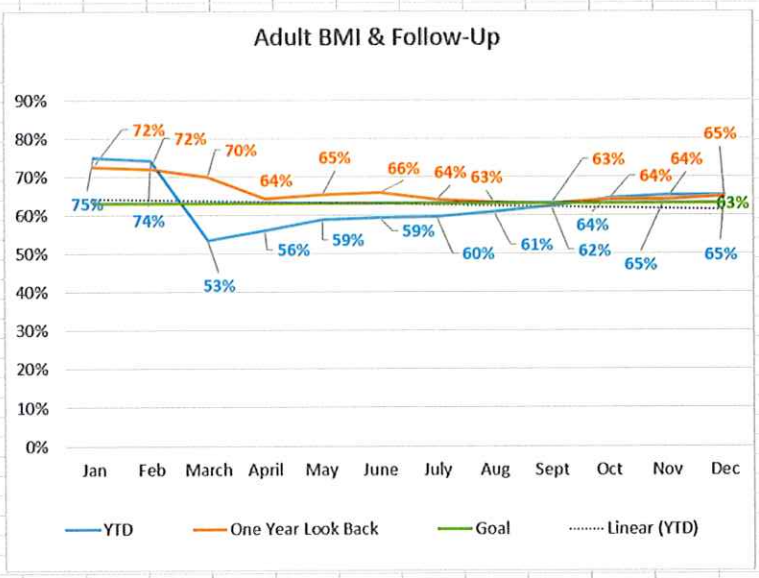
Addendums are for operational purposes and do not require FCH Governing Board approval.

Addendum: Annual Work Plan

1. Below is screenshot of the FCH QI-RM Work Plan that is updated annually.

Month	YTD	One year look back	Goal
Jan	75%	72%	63%
Feb	74%	72%	63%
March	53%	70%	63%
April	56%	64%	63%
May	59%	65%	63%
June	59%	66%	63%
July	60%	64%	63%
Aug	61%	63%	63%
Sept	62%	63%	63%
Oct	64%	64%	63%
Nov	65%	64%	63%
Dec	65%	65%	63%

Previous UDS Measures	
2020	31%
2021	46%
2022	33%
2023	28%



Body Mass Index (BMI) Screening & Follow-Up 18yrs and older

Addendum: QI Committee Reports and Review Schedule

	Reporting Schedule											
	January	February	March	April	May	June	July	August	September	October	November	December
Priority Clinical Measures												
Cervical Cancer Screening	x	x	x	x	x	x	x	x	x	x	x	x
ession Screening and Follow Up	x	x	x	x	x	x	x	x	x	x	x	x
Breast Cancer Screening	x	x	x	x	x	x	x	x	x	x	x	x
Depression Remission	x	x	x	x	x	x	x	x	x	x	x	x
CRC Screening	x	x	x	x	x	x	x	x	x	x	x	x
UDS Clinical Measures (All)	x	x	x	x	x	x	x	x	x	x	x	x
Care Coordination/Cost Measures												
No show rate	x	x	x	x	x	x	x	x	x	x	x	x
H measure - (Continuity of Care)	x	x	x	x	x	x	x	x	x	x	x	x
Risk Management Measures												
HPTE Management		x		x		x		x		x		x
uments not reviewed dashboard		x		x		x		x		x		x
Referral Dashboard		x		x		x		x		x		x
Pt Experience Measure												
Knowledge of Sliding Fee	x	x	x	x	x	x	x	x	x	x	x	x
financial barriers to the medication you take?	x	x	x	x	x	x	x	x	x	x	x	x
After hours advice	x	x	x	x	x	x	x	x	x	x	x	x
Operations												
Phone call abandon rate	x		x			x			x			x
Emergency Exercises			x			x			x			x
Peer Review			x			x			x			x
Providers			x			x			x			x
Counselors			x			x			x			x
*Nursing			x			x			x			x
PST			x			x			x			x
Policies/Procedures	x	x	x	x	x	x	x	x	x	x	x	x
Sub-Committee Report												
Pharmacy & Therapeutics/Controlled		x		x		x		x		x		x
Controlled Substance Module		x		x		x		x		x		x
RW HIV	x		x		x		x		x		x	

Addendum: Training Calendar

All staff Training 2026

January	• About Infection Control Prevention	Relias Relias Relias Relias Relias Relias
February	• Cultural Competence • Pregnancy Test Workflow - Attest	Relias Relias Relias
March	• Basics of Hand Hygiene • Ethics and Corporate Compliance	Relias Relias
April	• HIPAA: Privacy Rule • Bloodborne Pathogens • 340B Training	Relias Relias All Staff
May	• Referral Tracking: Attest • Emergency Medical Policy – Attest • CDC: You Call the Shots	Relias Relias Relias
June	• Lab/DI: attest • Hospital Tracking: attest • Perinatal Mood and Anxiety Disorders	Relias Relias Relias
July	• Minimizing Trips, Slips, and Falls • Understanding Workplace Violence	Relias Relias
August	• Preventing Medical Errors	Relias
September	• Basics of Effective Documentation • The Basics of Workplace Safety	Relias Relias
October	• Active Shooter Training	All Staff Training
November	• HIPAA: Basics • Providing Customer Service	Relias Relias
December	• Reducing the Risk of Medication Errors for Nurses	Relias

City of Sioux Falls Health Department dba Falls Community Health

Ryan White Clinical Quality Management Plan (CQM)

April 2025-March 2028

Approved January 2026

Last revised November 2025

II. The quality management plan follows the Ryan White Clinical Quality Policy Clarification Notice 15-02.

III. **Quality Statement**

a. CQM Priorities:

i. Falls Community Health Ryan White Part C Quality Management Program ensures the delivery of the highest quality medical care and supportive services for people living with HIV/AIDS (PLWHA) in eastern South Dakota.

ii. Falls Community Health Ryan White Part C Quality Management Program Adopts US Public Health Service guidelines set forth by the HHS, International Antiviral Society- USA, Centers for Disease Control and Prevention (CDC) and other professional guidelines.

IV. **Annual Quality Goals**

a. Reduce HIV transmissions through programmatic integration of Ryan White Part C and HIV Prevention activities.

b. Increase access to care and improving health outcomes for people living with HIV through linkages to care, community collaborations, and provision of comprehensive support services.

c. Assessing the extent to which HIV health services provided to clients under the grant are consistent with the most recent DHHS guidelines for the treatment of HIV disease and related opportunistic infections.

d. Reduce HIV-related health disparities through patient engagement and tracking.

V. **Quality Infrastructure**

a. Leadership staff member(s): Chief Executive Officer (Public Health Director), Chief Financial Officer (Assistant Public Health Director), Chief Operating Officer (Clinic Administrator) and Chief Medical Officer (Medical Director)

i. Accountable for the Ryan White CQM program.

ii. Provide support and resources for the CQM needs of the quality teams and committees.

iii. Maintain CQM of the Ryan White program as an organizational priority.

iv. Receive and approve reports and improvement plans.

v. Meet monthly to review organizational progress, to include Ryan White program as applicable.

vi. Receive monthly reports from the Ryan White HIV Quality Committee.

vii. Delegate Ryan White CQM plan management.

b. HIV Quality Committee staff member(s): Ryan White program manager, Ryan White nurse case manager, Ryan White Care Coordinator, Quality and Risk Coordinator, HIT Coordinator, Providers, Pharmacist, nursing staff, and consumer representation on an ad hoc basis.
    i. Chaired and facilitated by the Ryan White Health Program Manager.
    ii. Meeting frequency- monthly when possible; no less than quarterly.
    iii. Purpose- To continuously improve the quality of care and services of the HIV/AIDS programs provided by Ryan White Part C staff and to be in alignment with Department of Health and Humans Services Guidelines, the National HIV/AIDS Strategy, the Human Resources and Services Administration Monitoring and Standards of Care, and research-based best practices.
c. The HIV Quality Committee is responsible for developing and implementing the CQM plan.
    i. Ryan White Health Program Manager- analyzes performance data; monitors PDSA cycles; develops and implements the clinical quality management program and related activities;
    ii. Quality and Risk Coordinator - functions as a bridge between broader organizations, quality council, and the Ryan White quality committee to ensure continuity; brings Ryan White QA/QI topics and PDSAs to the QI team as needed; provides subject matter expertise regarding quality, reports QA/QI to the governing board.
    iii. Ryan White Nurse Case Manager, Ryan White Care Coordinator, Physician, Pharmacist, nursing staff, and consumer- brings subject matter expertise (determined by credentials and/or lived experience) to the review and monitor the Ryan White Part C program; finalizes and approves the CQM plan annually; ensures data is supplied and reviewed including Ryan White work plan and all other FCH metrics within quality, access, safety and cost from a Ryan White program perspective.
d. The Health Program Manager and Quality and Risk Coordinator are responsible for writing and updating the CQM Plan with review and final approval from the HIV Quality Committee and the Falls Community Health Governing Board.
e. Consumer and stakeholder involvement- Ryan White Part C consumer(s) participate on the Falls Community Health Governing Board, which receives quarterly updates and provides an opportunity to ask questions and provide feedback. Updates may include performance measure data and quality work plan updates. Part C staff participates in the state-wide HIV prevention planning group (PPG). The PPG meets

quarterly and other members include Ryan White Part B consumers and staff, community members and State of South Dakota Department of Health staff. On an annual basis consumers are asked to participate in client satisfaction surveys, quality improvement initiative needs, needs assessment activities, and semi-structured interviews.

f. Evaluation of quality plan- This is assessed by continuous monitoring, as well as reviewing the performance measures, goals and patient satisfaction results. The program manager will review the plan on a monthly basis and bring forth any additional information or training required to meet the plan's goals. Progress towards the overall plan will be completed quarterly, in line with the performance measurement cycle. The quality committee and stakeholders will provide input and feedback to achieve the goals set forth in the plan. Any changes needed to effectively carry out the plan will be vetted by the quality council and documented.

VI. Performance Management

a. Selection and review- the HIV Quality Committee selects and prioritizes quality metrics in alignment with HRSA metrics and patient needs. As defined in Policy Clarification Notice (PCN) 15-02, the Part C program will monitor HRSA measures quarterly, in addition to the measures selected for ongoing quality improvement projects. The exact number of performance measures chosen will align with PCN 15-02 and based on the percentage of clients utilizing each funded service category- see table below. These measures should be selected from the HRSA HIV/AIDS Bureau measures and HHS measures. Measures should align with national goals, as well as internally identified needs. Quality measures selected outside of required HIV/AIDS Bureau Performance Measures will be reviewed until goal has been met over a selected period as determined by the Ryan White Quality Committee.

b. Process to collect data- Data is retrieved and analyzed from Population Health Tool and/or the electronic medical record to identify opportunities for improvement within the Ryan White Part C program. Emerging trends affecting HIV care, health disparities and service delivery in South Dakota are addressed. Performance results for clinical outcomes are also reviewed against prior performance, the state benchmark and established national benchmarks.

c. Analysis- Data will be analyzed a minimum of quarterly to ascertain performance in comparison to key metrics, including national and regional benchmarks, stratification of gender, race, and ethnicity to identify disparities, etc. If the data shows a low performance, the measure will be considered for a quality improvement project. If the measure is consistently performing well, it may be kept but further stratified or a new measure will be considered for the following fiscal year. The table below serves as an example and may be updated with different measures, or stratifying the current measures by vulnerable populations.

Funded Service Category	*Percentage clients utilizing at the end of last measurement period*	HRSA **Performance Measure**	Baseline Data Num/Dem	Goal Num/Dem	Q1 (April-June) Num/Dem	Q2 (July-Sept) Num/Dem	Q3 (Oct-Dec) Num/Dem	Q4 (Jan-March) Num/Dem
Outpatient/Ambulatory Health Services (1)		Waiting Time for Initial Access to Outpatient/Ambulatory Medical Care						
Outpatient/Ambulatory Health Services (2)		Viral Load Suppression Among Persons in HIV Medical Care						
Oral Health Care (1)		***Receiving oral healthcare***						
Non-medical Case Management (1)		***Housing Status***						
Non-medical Case Management (2)		***Linkage to HIV Medical Care***						
Medical Case Management (1)		***Antiretroviral Therapy Among Persons in HIV Medical Care***						
Pneumonia Vaccines		***Quality Measure #1***						
Pregnancy Test		***Quality Measure #2***						
Patient Satisfaction		***Annual Survey***						

VII. Quality Improvement

a. Selection of priorities: A combination of data and staff feedback will be used to selected quality improvement priorities. The HIV Quality Committee will consistently review the available data to identify opportunities for improvement within the Ryan White Part C program. This will include a special focus on vulnerable populations, if applicable. New priorities may also be included based on emerging trends affecting HIV care and service delivery in South Dakota. Performance results for clinical outcomes will be reviewed against prior performance, the state benchmark and established national benchmarks. This comparison will provide a clear picture of what metrics are doing well versus need improvement and will help improve goals. In addition to data, improvement dialogue within the HIV Quality Committee may lead to the selection of priorities. The defined approach of the PDSA model informs if quality improvement projects are stopped, adopted or if another round of activity is initiated. The change made within the project will be refined based on what was learned from the pilot and the impact on the improvement area.

b. Documentation- Documentation of quality improvement projects will be in the form of meeting minutes and the quality work plan.

c. Staff Training and Capacity Building: All Ryan White staff, including new and continuing employees, will participate in ongoing training to strengthen quality improvement capacity.
    i. Onboarding: New staff are linked to AETC training within 90 days of hire.
    ii. Ongoing training: FCH will work with AETC to provide access to trainings on topics such as competencies, HIV care guidelines, data collection, and quality improvement methods.

d. Data Quality Assurance: Data accuracy and integrity are essential to monitoring performance. Falls Community Health will implement the following:
    i. Routine validation: Quarterly audits of selected performance measures to compare EMR entries against source documentation.
    ii. Error correction process: Discrepancies identified through audits will be corrected within 30 days, with corrective action tracked by the Program Manager.
    iii. Standard operating procedures: Written procedures will guide data entry, reporting, and validation, and will be reviewed annually.
    iv. Training: All staff responsible for data entry and reporting will receive annual training on data quality standards.

e. Subrecipient engagement- Falls Community Health does not currently fund or oversee subrecipients for Ryan White Part C services.

VIII. Quality Work Plan

a. Format: The performance measure work plan includes:

Objective	Action Steps	Person Responsible	Data Range	Key Performance Measures
Update the plan annually to reflect key indicators and federal guidance	1. Update quality measures 2. Present the updates to quality commit for approval	Program Manager and quality committee	Yearly	1. List of HRSA program measures 2. Completed performance measure and work plans
Monitor measures quarterly	1. Collect all required data 2. Run reports from medical record 3. Create a reporting calendar	1. Quality committee 2. Program manager	Quarterly	Identified HAB measures
Provide training to all new Ryan White staff	1. Link new staff to AETC for trainings	Program Manager	Ongoing	Training needs are identified, fulfilled and logged
Stratify key performance indicators by vulnerable cohorts, if indicated	1. Stratify by vulnerable populations from needs assessment	Program Manager	Quarterly	Update performance measure plan with additional cohorts

b. Communication of plan: The governing board will be updated on the progress of the QI team quarterly. Copies of the plan, initiatives and results will be made available to all consumers based on interest. Notification of availability will be communicated to all consumers yearly. Part C staff participates in the quarterly state-wide HIV prevention planning group (PPG) in an effort to provide updates to all lead agencies, consumers and direct recipients.

Annual Risk Management Board Report and Plan 2025

Definitions

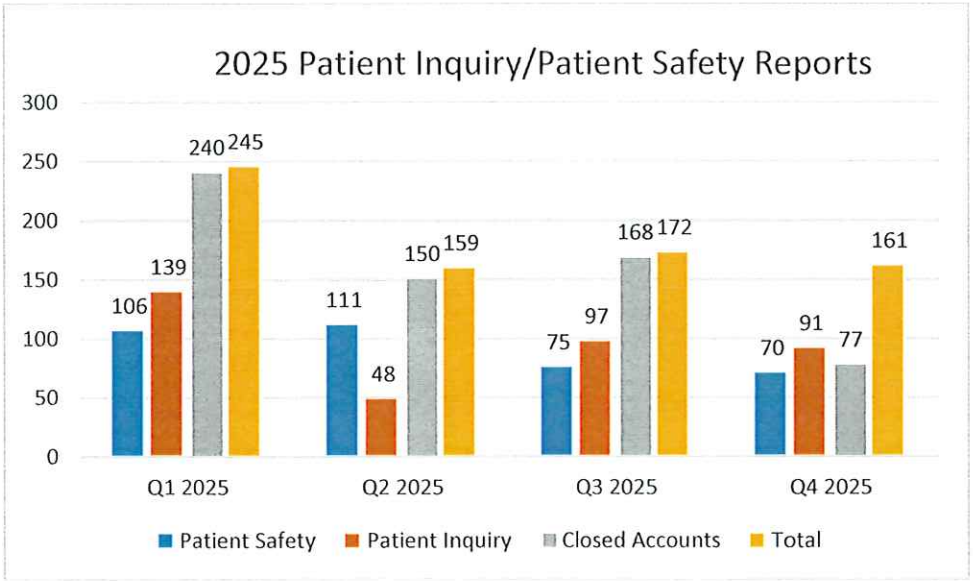
Patient Inquiry: Patient Inquiry forms are used for any patient concern by phone or in person or any other event that is not related to patient harm such as billing.

Patient Safety: Patient safety forms are used for any of the following reportable events:

- Any situation that could have caused or did cause injury to a patient (e.g., a medication error or adverse reaction, fall, delay in delivery of needed care, unexpected death, major permanent loss of function)
- Any condition or situation that could or did result in an injury to a patient (e.g., misfiling diagnostic test results, failure to follow up on abnormal test results, scheduling problem, equipment malfunction)
- Failure to comply with established policy or protocol, with or without patient, provider, employee, or visitor injury
- Any injury, potential injury, or unusual occurrence involving a patient, visitor, or employee on the facility grounds (e.g., a fall, falling object, assault, suicide)
- Any suggestion or threat of lawsuits, contacting legal counsel, or claims for restitution
- Anything unusual or not in compliance with everyday activities

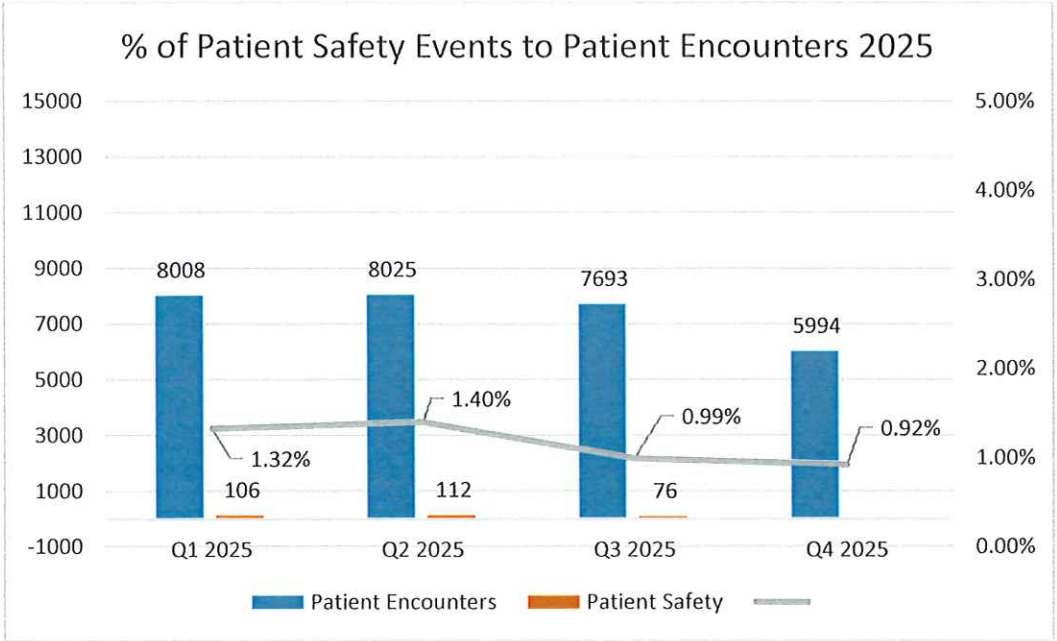
Event trends 1/1/25-12/31/25

In 2025, a comprehensive review was conducted of 737 Patient Safety and Patient Inquiry reports. Among these, 362 reports were identified as directly related to Patient Safety, while 375 were classified as Patient Inquiries. 86% of Patient Safety and Patient Inquiry reports have been closed for 2025.



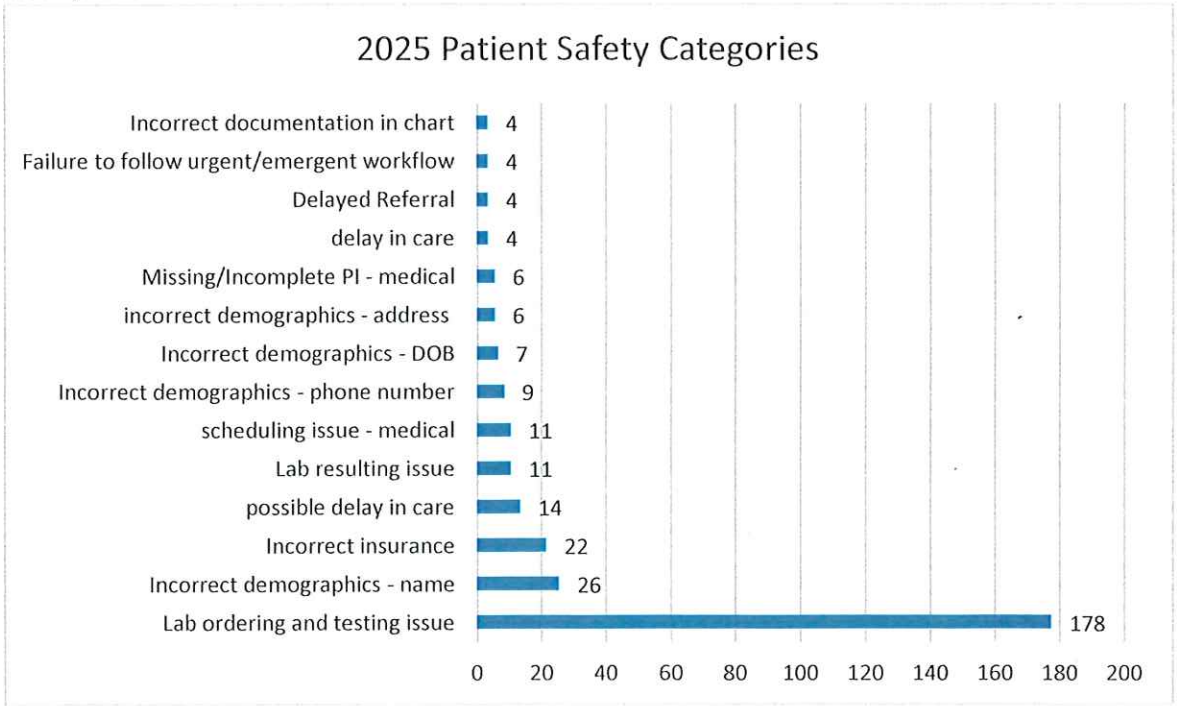
Percentage of Patient Safety Report to Patient Encounters

In 2025, Patient Safety Reports accounted for less than 1% of all patient encounters. This is consistent with the industry standard, which suggests that the percentage of patient safety reports to encounters remains below 1%.



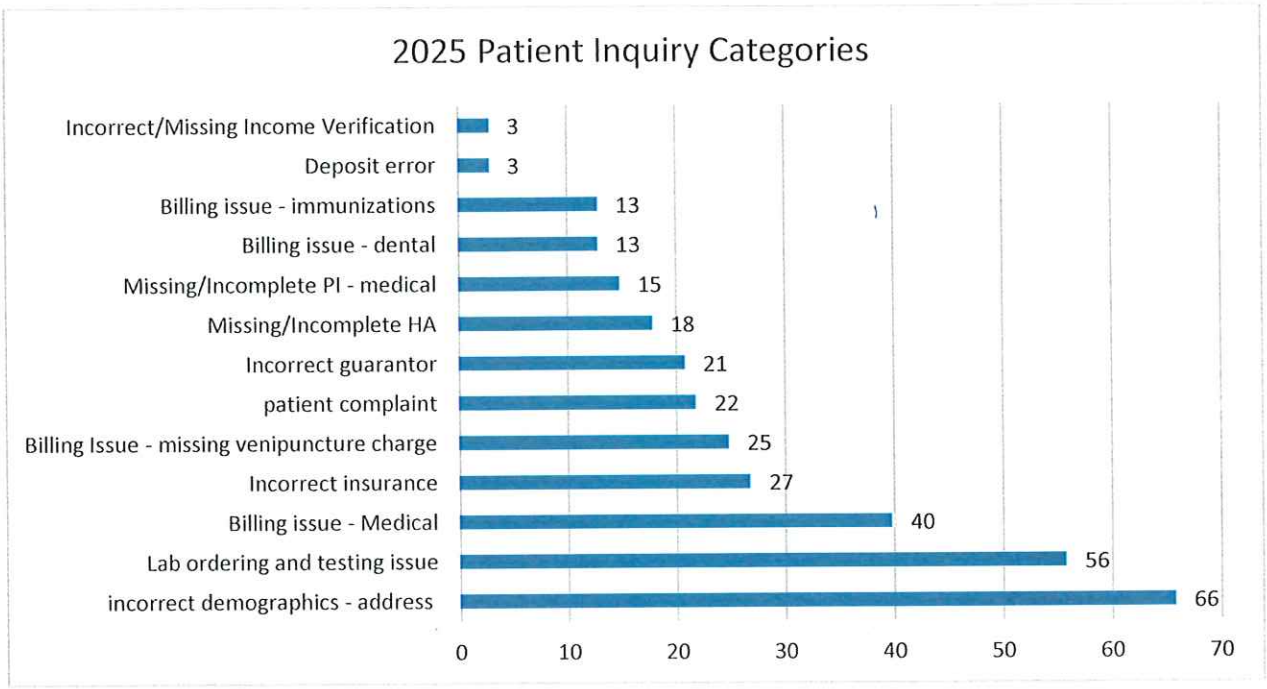
2025 Safety Categories

The majority of safety events were related to laboratory ordering issues, inaccurate patient demographics, incorrect insurance information, or potential delays in care. These categories were reviewed on a quarterly basis to identify trends and develop targeted action plans aimed at improvement.



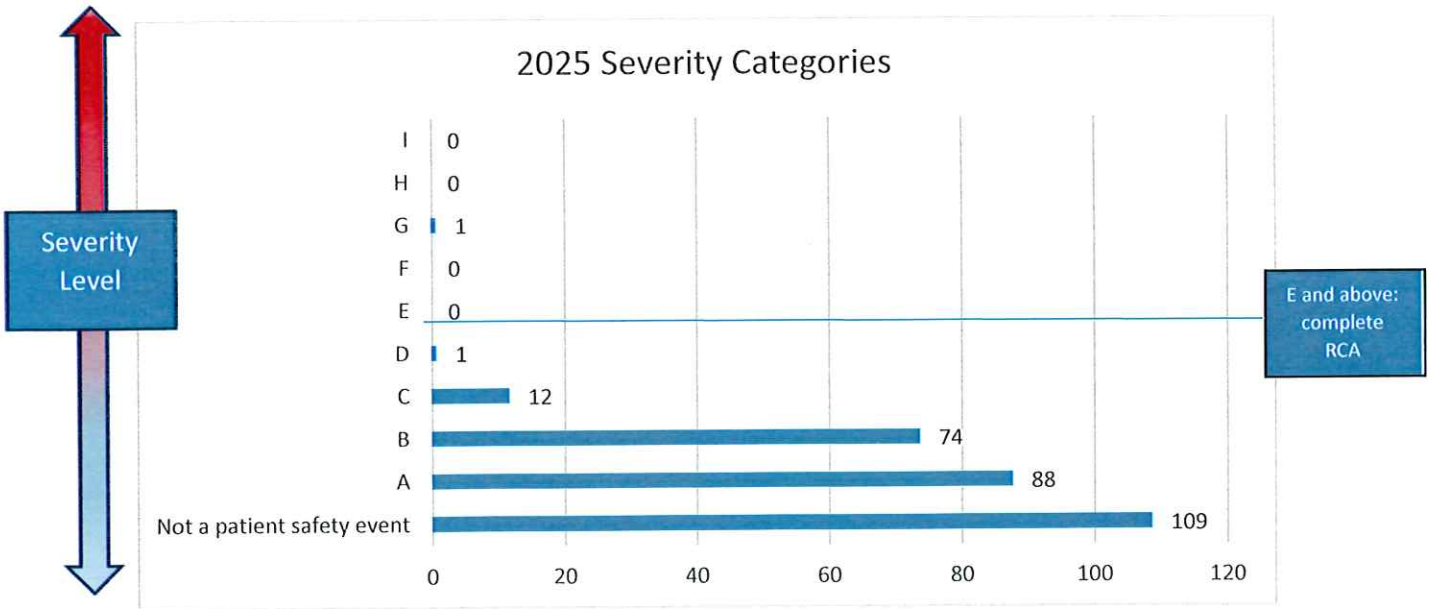
2025 Patient Inquiry Categories

The majority of patient inquiries were related to incorrect demographics, lab ordering, billing, insurance issues, venipuncture charges, and incorrect guarantors assigned. These categories were also reviewed on a quarterly basis to identify trends and develop targeted action plans aimed at improvement.



Severity Categories

Severity categories ranged from category D (higher severity) to A (lower severity). The majority of categories fell into the category of A meaning an event exists to have the capacity to cause injury, accident, or healthcare error or an adverse effect. Although most Safety or Patient Inquires did fall into the categories that could cause less harm, the review encouraged the team to take decisive action to strengthen our protocols and improve patient safety effectively. For category G, an RCA was completed and documented (see below).



Severity Categories

A. Potentially hazardous conditions, circumstances, or events **EXIST** that **have the capacity** to cause injury, accident, or healthcare error (e.g., look-alike medications, confusing equipment, etc.). = Potential to have an adverse effect

B. An event occurred but it **did not reach** the individual (an error of omission, however, such as a missed medication dose, does reach the individual).

C. An event occurred that **reached** the individual but **did not** cause harm.

D. An event occurred that required **monitoring** to confirm that it resulted in no harm and/or required intervention to prevent harm.

E. An event occurred that contributed to or resulted in **temporary harm** and **required treatment or intervention**.

F. An event occurred that contributed to or resulted in **temporary harm** and required **initial or prolonged hospitalization**.

G. An event occurred that contributed to or **resulted in permanent harm**.

H. An event occurred that resulted in a **near-death event** (e.g., required ICU care or other intervention necessary to sustain life).

I. An event occurred that may have contributed to or resulted in **death**.

Category G RCA

One incident in 2025 was categorized at a level G: An event occurred that contributed to or resulted in permanent harm. An RCA was completed by 12/1/2025. Updated workflows and standardized documentation practices were implemented across CHW/CC and dental services, including enhanced charting templates, interpreter documentation, emergency standards of care, post-procedure patient follow-up, and procedural safety requirements. Dental assistant workflows were formalized with confirmatory procedures and time-out standards, supported by visual tools and templates. Dental staff received education on all updates through staff meetings and assigned training, and compliance was verified through completed CHW and dental chart audits to ensure accuracy and adherence to standards of care.

Dental Category G Action Plan – Patient #98445

Assessment Completed By: Risk Management Committee Date: 7/3/2025

Risk Assessment Follow up Actions	Action Required	Responsibility	Target Date	Action	Action Completed	
					Date	Initials
1. CHW/CC needs to document conversations with patient in patient's chart	CHW/CC workflow review and attestation.	Tammi	9/12/2025	Enabling: Updated Standard Operating Procedures and created the Referral and Documentation workflow. Training date for CHW's/CC: 9/12/2025. CHW/CC templates have been implemented.	10/15/2025	TM

Risk Assessment Follow up Actions	Action Required	Responsibility	Target Date	Action	Action Completed	
					Date	Initials
2. Dental team documentation – use of interpreter visit	Workflow review and attestation. Audit charts for accuracy after attestation.	Michelle/Dr. Olson	8/1/2025	Templates created for Providers. Michelle and Dr. Olson will decide which workflow will be used. Add to workflow and policy. Added to workflow – Appointment Standards of Care for Providers	11/1/2025	MJ
3. Dental team - reach out to patients who have had invasive or non-routine appointments follow up to verify patient status.	Update workflow	Michelle/Dr. Olson	8/1/2025	Added to workflow – Appointment Standards of Care for Providers	11/1/2025	MJ
4. Add detail to chart documentation	Implement standardized template	Michelle/Dr. Olson	8/1/2025	Complete – added to template	6/27/2025	MJ
5. Emergency Standards of Care	Update workflow – appointment standard of care	Michelle/Dr. Olson	8/1/2025	Added to workflow – Appointment Standards of Care for Providers, add CDSS alerts	11/1/2025	MJ

Risk Assessment Follow up Actions	Action Required	Responsibility	Target Date	Action	Action Completed	
					Date	Initials
6. Standardize dental assistant field of vision, time out/confirmatory procedure, repeat back/time out for procedures	Create new workflow	Michelle/Dr. Olson	8/1/2025	Created visual flowchart, add template for confirmatory language/time out	9/25/2025	MJ
7. Education to Dental staff – updated workflows	1. Education about workflow, templates, flowchart	Michelle/Dr. Olson	December Dental Staff Meeting	1. Dental staff meeting	12/10/25 – dental all staff meeting, 12/11/25 assigned workflow in Relias	MJ
8. Conduct regular chart audits/Peer reviews	2. CHW Audits 3. Dental Audits – procedure confirmation and time out performed	Tammi/Michelle/Dr. Olson	November 2-25	2. CHW Audits – Review 7 accounts, goal of 100% accuracy 3. Dental audits – review 7 procedural charts -add	11/5/25	MJ

Risk Assessment Follow up Actions	Action Required	Responsibility	Target Date	Action	Action Completed	
					Date	Initials
				elements to peer reviews		

Dental Audits

1. Provider templates for interpreter visit
2. Procedure confirmation
3. Time out communication
4. Phone call to patient, if non routine or invasive procedures
5. CDSS alerts for emergency appointments

2025 Quarterly Risk Assessment Action Plan update

A quarterly risk assessment was conducted to identify gaps, mitigate potential liability, and support continuous quality and safety improvement. The following is a summary of action plan activities completed for 2025:

Q1-Q3 2025 Action Plan Risk Assessment	Action Required	Responsibility	Target Date	Action Completed	
				Date	Initials
After Hours Call – test	Lori - Test	Lori	By 9/30/25	11/11/2025	LEH
Diagnostic Test Tracking - Outside Lab Orders Policy	Update Policy	Melissa	By 9/30/25	11/13/2025	MS
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?	Infection Control Policy updated -needs to be accessible to staff (last updated12-12-2024) One Team Portal or briefcase	Katie/Lori	End of Q2 2025	3/23/2025	LEH/KW
Is there a control plan to identify and manage suspected transmittable diseases (e.g., tuberculosis, COVID-19)?	Dental needs to be included (ECP)	Jaimie/Katie/Lori	End of Q2 2025	9/13/2025	LEH/KW
Do cleaning procedures adhere to manufacturers' guidelines, state and federal guidelines, and acceptable standards of practice regarding the cleaning, disinfection, and sterilization of instruments, equipment, and supplies?	Sterilization policy for medical and dental to be updated for sterilization. The policy needs to state adherence to manufacturers' guidelines. Look at bedbugs-cleaning policy and can we combine. Bedbugs/lice policy	Michelle/Katie/Lori	End of Q2 2025	11/13/2025	MS/LEH/JT

Are there systems 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 and state requirements?	Implement random audits with computer security/locking, Safety Team	Jaimie	End of Q2 2025	7/14/2025	JR
Are there any systems or operations that may present a risk? Putting in orders for lab	Medical Director review and provide education	Dr. Tinguely	Q1 2025	CFM provider training, 04/08/2025,signage in lab, training at Nurse/provider quality meeting 06/04/2025. New resident orientation 6/03/2025.	JT
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?	Finish editing referral workflow by end of Q1 2025	Jol'na/Vanessa	Q1 2025	Audits are being completed for PST staff.	JK/VS

2025 progress update

Category	Objectives	Status	Priority Level	Target Completion Date
Implementation of Technology Systems	Sunoh AI – Clinical documentation	Complete	Medium	Complete
	Automated Scheduling Process in eCW	Complete	Medium	Complete
	Electronic Consents	Complete	Medium	Complete
	On Base Project	Electronic process for patient inquiries/patient safety forms	Medium	In Progress
	Vyne Dental – electronic claim attachments	Implemented with dental billing	Medium	Complete
	Med Bank	Training complete	Medium	Ongoing
	X-Ray Software - Symmetry	Implemented with staff	Medium	Complete
	AI Faxing	Training for staff/implementation	Low	In Progress
Reporting Structure	Implement reporting structure to align with Quality Plan	Developed new reporting structure	High	Complete
	Implement Risk Committee	First meeting: 2/26/25	High	Complete
Patient Support Technician (PST) Intake Process Improvement	Analyze intake process and training to create efficiencies and reduce errors	Ongoing – started Buddy Headset to improve training, create check in workflow, onboarding process	High	In progress. Continue to provide training to PST staff, reset with new supervisor
	Survey Monkey Quizzes for PST's	Guarantor Quizzes sent to PST staff	Medium	In Progress – ongoing education and quizzes for staff
	PST Dashboard/Scorecard	Dashboard to display phone abandon rate, phone productivity, self-attested income, and signature date	Medium	Complete
	Front Desk and Pre-Registration checklists	Reminders for patient parking and televisits, guarantor assignment	Medium	Complete
Key Performance Indicators Oversight	Controlled Substance Module	Azara Dashboard	High	In Progress
	Integrated HIE Database	Azara and eCW Dashboard – streamline hospital tracking	High	Complete

Workflow and Policy Consistency/Updates	Organize Policies	Digital shortcut on desktops for policies	High	Complete
	Nursing Workflow	Overview of nursing process to improve rooming workflow	High	Complete
	Lab Patient Notification Policy	Update to reflect timely review of labs and patient notification	High	Complete
	Red Card Workflow	Added to Medical and Dental Emergency Policy	High	Complete
	Update Critical Value Reporting	Add timeframes for lab notification	High	Complete
	Update Laboratory, Diagnostic, and Procedural Order Processing	Updated critical lab follow up	High	Complete April 2025
	Quality Plan	Reviewed and updated	High	Complete April 2025
	Infection Control Policy	Follow up to 2024 Risk Assessment	High	Complete
	Medical Chaperones Policy	Follow up to 2024 Risk Assessment	Medium	Complete
	Adverse and Near Miss Policy	New process for patient inquiry/safety reporting	High	Complete
	Update Dental Emergency Policy	Updated Emergency Cards/Red Card Workflow/policy aligns with medical policy	High	Complete
	PRAPARE Screening	Added to nursing template	Medium	Complete
Education/Training	Nurse/Provider Quality Meetings	Monthly Quality meetings to review Provider Dashboards/UDS measures	Medium	Ongoing
	Azara Training/Technical Assistance	Review Azara dashboards with staff on a regular basis	Medium	Ongoing
	Flow Charts for UDS Measures	Develop visuals of how to complete UDS measures	Medium	In Progress
	OB Packets in Spanish	PCMH	Medium	Complete
Emergency Preparedness	Emergency Exercises with Manikin	Implement various training exercises each year	High	Ongoing

	Update Emergency Medical and Dental Policy	Updated to include inspections and placement of Fast Response Kit, Red Card Workflow, and Emergency Response Cards	High	Complete
	Implement Safety Committee	First Safety Committee: 3/26/25	High	Complete
	Overhead Emergency Paging	Sean Franken has been in touch with ITS to follow up (12/3/25)	High	In Progress
	Fire Drill	Full Scale Exercise	High	Complete
	Cybersecurity Drill	Full Scale Exercise	High	Complete
	Scavenger Hunt	Emergency and Safety Items	Low	Complete
	Point of Dispensing	Full Scale Exercise – October 15th	High	Complete
	Point of Dispensing	O'Gorman Oct 23rd	High	Complete
	Point of Dispensing	Full Scale Exercise – Makeup Nov 4th	High	Complete
	Update Emergency Maps	Updated Maps throughout the building	Low	Complete
	Update Employee Contact List	Update all employee phone contacts	Low	Complete
	Update Manager Calling Cards	Phone numbers for managers and environmental staff	Low	Complete
	Update Emergency Protocol Cards	New overhead system information	Low	Complete
	Crosswalk Initiative	Present to traffic board, get additional visuals, make crosswalk flyers for crossing safely	Low	Complete
	Violent Persons SOP	Update Violent Persons SOP	Low	Complete
	Tornado Drill	Full Scale Exercise	High	Complete
	Building Code of Conduct	Work with county to update code of conduct	Low	Complete
Patient Satisfaction Survey 2024	Patient Parking	Updated medical and dental appointment cards	Medium	Complete
	Knowledge of Televisits	Added option of televisits to registration guides.	Medium	Complete
	Barriers to Medications	Added question to Comprehensive Health Assessment,	Medium	Complete

		review monthly at Quality Committee		
Patient Satisfaction Survey 2025	Knowledge of Sliding Fee	Added slide to tv lobbies in Medical and Dental	High	Complete
	Able to get advice when the office is closed	Added message to MD, audited after hours calls, made test calls	High	Complete
	Considers your personal and family beliefs	Added to eCW template	Medium	Complete
Reporting/Dashboards	Mayor Scorecard	PM Team updates Monthly	Medium	Complete
	Point of Care Alerts	PM team sends weekly	Medium	Complete
One Team Portal	Build out/add resources/create news posts	Monthly/weekly meetings to update	Medium	In Progress
Quality	Mammogram double booking	Implemented with scheduling	Medium	In Progress
	Two new UDS measures	Data validation/testing	Medium	In Progress
	Non-compliant lists for scheduled High Priority measures each month	Dashboards/reports distributed to Providers	Medium	Ongoing
	Monthly newsletter	Encourage staff engagement, provide education	Medium	Ongoing

Priorities for 2026:

Priority Task	Responsible	Priority Level	Target Date
Emergent exercises/competency training (Follow up from OSV Technical Assistance)	Katie/Jordan/Dr. Tinguely/Dr. Olson/Jaimie	High	Ongoing
Nursing Competency training schedule	Jordan/Lori	High	Ongoing
Analyze intake process and training to create efficiencies and reduce errors	Jol'na/Lori/Sara	Medium	Ongoing
Policy Review and Implementation Oversight	Amy/Vanessa/Lori/Melissa/Sara	High	Ongoing
On Base Project	Vanessa/Lori	High	Q2 2026
Standardized New Employee Training	Jaimie/Sara/Lori	Medium	Q1 2026
Dental Bus	Michelle/Dr. Olson/Sara/Amy	Medium	Q1 2026
CHW – Medicaid Billing	Tammi/Sara/Vanessa	Medium	Q2 2026
Security Risk Assessment	Sara/Amy	High	Q3 2026

Falls Community Health
Board Meeting
January 15, 2026

Public Health Director's Report

City Updates

- New city councilor, Vernon Brown, appointed to fill the seat vacated by Sarah Cole
- New city-wide policy related to credit card fees went into effect in the new year. We will bring more information on how that impacts the Health Department / Falls Community Health at the February meeting

Clinic Updates

- Mobile bus collaboration with Delta Dental on track for February
- We expect legislation to be introduced this month that would increase the Medicaid reimbursement rate for Federally Qualified Health Centers within the state