TITLE: **Performance Improvement and Compliance Committee**
Meeting: **July 14, 2026 at 7:30 AM**
LOCATION: **Zoom and Executive Board Room**

I. CALL TO ORDER

The Valor Health Performance Improvement and Compliance Committee meeting was called to order at 7:30 a.m. by Dave Shaw.

Board Member Attendance: Dave Shaw – Committee Chair; Angie Phillips – Committee Board Member; Brad Turpen – CEO.

Committee Attendance: Sara Otto – Quality Manager; Kathy Prindle – Executive Dir. Clinical Services; Briana Steele – Quality Improvement Specialist; Jessica Mackey – PSEC; Michael Groessinger – Pharmacy; Dr. Zachary Bastian – Medical Staff.

Staff/Guest Attendance: Victoria Mendoza – Executive Assistant/Med Staff Coordinator.

Absent:

II. STANDING AGENDA

A. Action Items

1. Consent Agenda
2. Approval of Minutes - PICC 5/12/2026

MOTION: Brad Turpen made a motion to approve the consent agenda with corrections to the minutes. Dave Shaw seconded the motion. All in favor, no objections. The motion carried.

B. Public Commentary – *Dave Shaw*

1. No public comments

C. Quality Department Summary – *Sara Otto*

1. Sara reviewed the Quality Dashboard:
    - The NTracts contract transition is complete. Department Leaders have been receiving notifications to create their user accounts and will receive notifications when contracts are due for review. Training and review will be completed at the Department Head Meeting.
    - Quality Assurance met on June 23 and continued its focus on reducing medication variances and increasing annual wellness visits to enhance Value-Based Care (VBC).
    - The Idaho Health Association completed the annual QAPI (Quality Assurance Performance Improvement) review. Opportunities for improvement included:
        - Maintaining a comprehensive list of contracted services on our flyers and website including hours of operation.
        - Ensuring policy and procedures have headers updated for revision date.
        - Ensuring clinical departments such as Swing Bed, Observation and Inpatient have consistent charting with the MOON (Medicare Outpatient Observation Notice) form.

Discussion: Kathy requested copies of the charts submitted for review so she can review them with Billie Osterhoudt, Acute Care Manager, and identify opportunities for improvement in departmental workflows.

D. **Patient Experience**

1. Compliments & Opportunities
   - Compliments
     - Ambulatory Surgery was recognized for their expertise in processes and procedures. The patient also stated they were happy to get this service of care close to home.
     - Emergency Department was acknowledged for their low waiting times. Providers were recognized for their thorough care.
     - Dr. Zachary Bastian and Dr. Trevor Martin were recognized for their professional and quality care.
   - Opportunities for Improvement
     - A patient commented that they would have appreciated more information regarding post-procedure care.
     - A patient requiring Emergency Department services reported having to ring the doorbell for assistance to be seen. This complaint has been escalated to a grievance.
   - Press Ganey
     - Undeliverable rates decreased in June.
     - Inpatient continues to have no data available now that it is not required by CMS.
     - Surgery and Medical Practice are currently at high points for the "Definitely Recommend" graph.
     - Ambulatory Surgery consistently increased for May and June.
     - Emergency Department results showed small shifts due to low survey response rates.
     - Valor Health Center survey data will be available at the next meeting now that the site has been mapped.

E. **DNV Progress Tracking – 2025**

1. DNV Survey Audit was completed in June. They were able to close 6 of the non-conformities from last year, with 2 remaining open:
   - NC-1-3: Restraints – mainly related to physician orders on chemical restraints and ensuring documentation on face-to-face orders per our policy.
   - NC-2-2: Contract Services – This NC was moved to a level 1 NC – we need to ensure our contracts are reviewed regularly based on the risk rating in our Contract Management Policy.

F. **DNV Progress Tracking – 2026**

1. 6 NCs were closed from the 2025 survey, leaving 2 open which were related to Restraints and Contract Evaluation.
2. NC1-1 Review of Contracts – ensure our contracts are reviewed regularly based on the risk rating in our Contract Management Policy.
3. NC1-1 – Listing of Contracted Services – maintain a comprehensive list of all contracted services as a flyer and on our website including location and hours of operation.
4. NC1-2 – Restraints – this is mainly related to physician orders on chemical restraints and ongoing nurse monitoring.
5. NC1-3 – Fire Sprinkler Head Maintenance – We are required to replace any fire sprinkler heads older than 20 years.
6. NC2-1 – Medical Staff Performance Data – Incorporate specialty-specific metrics and available national benchmarks into the Peer Review process. Rolling 12-month scorecards will be developed for each specialty and presented quarterly to the Medical Executive Committee.
7. NC2-1 – Medical Staff Performance Data – Review the Peer Review and Procedure Policy to ensure we are specifying non-physician frequency and participation in Peer Review processes.
8. NC2-2 – Patient Grievance Acknowledgement Letters – patient acknowledgment

letters need to be sent within 7 days of receiving the patient grievance. Previously only verbal acknowledgement was provided for the patients who called or met with us in person.

9. NC2-3 – Negative/Positive Air Pressure – Development and Implementation of a plan to correct air flow for clean utility in the Medical-Surgical suite and Laboratory.

Discussion: Dave stated that he believed Level 1 NCs could not be rolled over. Sara explained that Level 1 NCs may either remain at that level or be escalated to a Conditional Level NC. Sara further explained that because this NC was primarily systemic and did not involve patient harm, it was able to remain a Level 1 NC.

G. Risk & Compliance Report

- The total competency completion rate is currently 89%, demonstrating a positive increase. Sara will work with Laboratory leadership regarding approximately 253 incomplete competencies within the department. Kathy will also be involved in conducting a deeper review of the report to identify underlying issues and opportunities for improvement and education.
- There is a total of 38 additional documents that will be due for review at the end of July.

H. Patient Safety & Experience – *Jessica Mackey*

1. **May**
   - Complaints – 1 – One complaint was received in May and discussed in depth with PICC. Jessica coordinated the investigation with the appropriate departments, and a resolution was established.
   - Medication Variances – 33 total medication variances for May with 14 of them being controlled substances. Quality Improvement has created good action items to continue progression on improvement workflows. Currently the challenges are trying to find a good baseline for the variances, as the current data is subjective.
   - Safety Event – 1
   - HIPAA – 1 – There was a form scanned to the wrong patient's account. The error was found in time and there was no breach that occurred.
   - Fall – 3
   - Process/Procedure – 4 – All process and procedure events were discussed in depth with PICC.
     - Service recovery was completed for a patient who experienced a three-hour wait in preoperative. Matt Godfrey, Physician Director, was involved in improvement efforts related to provider and procedure scheduling to help prevent recurrence.
2. **June**
   - Complaints – 4 patient complaints in June with 3 of them involving Urgent Care Clinic.
     - Urgent Care complaints involved lack of staff availability for X-ray services, billing concerns, and laboratory results not being sent to the patient's Primary Care Provider (PCP).
   - Medication Variances – 34 medication variances for June with 9 of them being controlled substances.
   - Employee Incidents – 1
   - Process/Procedure – 2
   - Google Reviews are averaging at 4.2. Jessica did attempt to provide service recovery to the 2-star Google Review, with no success in reaching the

patient.

Discussion: Brad asked whether national benchmarks are available for medication variances. Sara reported that she will reach out to the Idaho Health Association. Michael noted that a new workflow for medication orders has been implemented in the EHR and anticipated that medication variances may temporarily increase as staff work through the process improvements.

I. **Quality Improvement (QI) – *Briana Steele***

1. QI Workgroup Update
   - Briana reviewed the minutes from the last QI meeting.
     - Project 1: Annual Wellness Visits - There was a monthly monitoring process established to ensure accurate and reliable data is available for outcome measurement for each payer.
     - Project 2: a medication variance tracking spreadsheet will be created to support trend and identification to begin distributing monthly to department leaders. Michael will collaborate with Sara to develop a progressive framework related to medication variances and recurring non-compliance.
2. IQC Dashboard
   - Closed
     - Outpatient Registration Accuracy IQC – there has been several transitions in supervisors over the last year resulting in challenges on creating consistent processes. Once a clear goal is set for this department, the IQC will be reopened.
     - Price Transparency/Good Faith – CMS sent a letter we are now in compliance effective April 21 for our Price Transparency. Once the Chargemaster is updated, Good Faith Estimates will be re-evaluated.
     - Employee Health Screening – Benchmark was adjusted to 90%. Christina Ostrem, Infection Preventionist, will continue to monitor to sustain 90% compliance.
     - Accreditation Coaching – CAPs are established for the 2026 DNV audit. Sara Otto will continue to offer support to Department Leaders.
   - Yellow
     - Undeliverable Press Ganey's – Sara continues to monitor undeliverable rates until we achieve 4% or lower by August 31, 2026.
     - Infusion Documentation & Coding – May coding timeliness was 92%. The IQC will continue to be monitored with a goal of achieving greater than 90% for three consecutive months.
     - Cash Handling – Eriko developed new policies and forms that are pending final approval by the Executive Team. Once approved, competencies will be assigned to applicable staff.
     - ED Patient Callbacks – Monitoring will continue to ensure documentation of all ED post-discharge callback attempts reaches 80% of audited charts by the end of the year.
     - ED Return Admitted/Transferred – Ongoing monitoring is in process to maintain annual average of under 13% by the end of the year.
   - Red
     - Medical Staff Peer Review – June OPPE completion rate is at 73% with the goal to be above 90% by the end of 2026.
     - Restraint Log – June ED Competency completion rate is at 44%.
     - Patient Status Orders – Billings Clinic is working on building charges for patient status transitions.
   - Green
     - Lab Outreach Task Force – the first meeting was held on June 3 to

establish an action tracker and begin implementation on workflow improvements. The next meeting will be on July 22.
- Medical Records Releases – IQC opened on July 13. There will be a monitoring spreadsheet created for patients that are requesting records from over 40 years ago.

J. Administration Update

1. General Update
- This item was given in Executive Session.

K. Chair Lead Discussion – *Dave Shaw*

1. Future PICC Agenda Items
- Sara requests any PICC agenda items be given to her the week before the PICC meeting.

2. Identify outputs to be reported to Medical Staff and Board.
- Dave would like to have the Quality packet included in the Board packet.

L. Open Items – *Dave Shaw*

1. No open items.

III. NEW BUSINESS

A. Executive Session –

MOTION: Brad Turpen moved to go into Executive Session, per Idaho Code Idaho Code §74-206(1)(d) – Records Exempt from Public Disclosure and Idaho Code §74-206(1)(i) - Communicate with Risk Manager/Insurer regarding claims. Dave Shaw seconded the motion.

Roll Call
- ✓ Dave Shaw
- ✓ Angie Phillips
- ✓ Brad Turpen
- ✓ Kathy Prindle
- ✓ Dr. Zachary Bastian
- ✓ Sara Otto
- ✓ Briana Steele
- ✓ Jessica Mackey
- ✓ Michael Groessinger

Committee Chair Dave Shaw adjourned the Executive Session, and the regular session resumed at 9:14am.

IV. ADJOURNMENT

Being no further business, the meeting was adjourned at 9:14am